VICTORIA POLICE

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Coroner Giles
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By email: cpuresponses@coronerscourt.vic.gov.au

Subject: Simon Christopher Gaskill - Finding into death with Inquest
Court Reference: COR 2022 2051
Date of Recommendations: 17 April 2026

Dear Coroner Giles

Victoria Police response to recommendations in the Finding into the Death of Simon Christopher Gaskill

This document provides the response to your recommendations as they relate to Victoria Police, arising from the Finding into the death of Simon Christopher Gaskill delivered on 17 April 2026.

Recommendation 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'

The Coroner's sub-recommendation 1(a) is supported and implemented.

VPM Body Worn Cameras, supported by the *BWC Practice Guide*, already establishes a comprehensive compliance framework. This includes defined activation requirements, obligations on members to report non-compliance, and supervisory responsibilities for monitoring usage.

Compliance is actively monitored at the local work unit level, with supervisors responsible for reviewing BWC usage, conducting periodic audits, and identifying members with low recording rates relative to operational duties. This reflects a decentralised assurance model, aligned to frontline supervision and operational accountability.

While organisation-wide visibility of compliance metrics is limited, existing arrangements are considered fit for purpose. Established controls ensure compliance and provide transparency.

(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

The Coroner's sub-recommendation 1(b) is supported and implemented.

The intent of this sub-recommendation aligns with existing training practice:

BWC activation expectations are currently reinforced through:

- biannual OSTT cycles, incorporating scenario-based training;
- foundation training programs, where BWC use is introduced and embedded;
- ongoing reinforcement through training preambles, operational instruction, and scenario delivery; and
- training scenarios which increasingly incorporate decision-making under stress and cognitive load, consistent with the Coroner's observations.

This component is therefore assessed as already implemented, with BWC use embedded within routine training practices.

(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

The Coroner's sub-recommendation 1(c) is supported and implemented.

Existing processes require members to report BWC faults or technical issues through established ICT support channels, including the Victoria Police Helpdesk.

System oversight, maintenance, and fault management are the responsibility of Continuous Improvement, Uplift & Technology (**CIUT**). These arrangements provide a clear and structured mechanism for identifying and addressing technical issues.

The introduction of an additional reporting pathway would likely:

- duplicate existing ICT processes;
- create ambiguity around reporting responsibilities; and
- extend beyond the scope of operational policy ownership.

Consideration and implementation of future technology and process change will be considered by CIUT.

Recommendation 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.

The Coroner's recommendation 2 (and its sub-recommendations) are supported and will be implemented, with an estimated completion date of: within 12 months.

Recommendation 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.

The Coroner's recommendation 3 is supported and has already been partially implemented.

This recommendation has been partially implemented through recent updates to the *VPM Property Management*. The revised *VPM Property Management* is currently pending final Deputy Secretary endorsement for promulgation.

The revised VPM includes a new requirement at section 16.1 that "*The file class must be updated to reflect a change in status (for example, a found item that becomes classed as seized if identified to be connected to an investigation*".

The revised VPM will be supported by practice guidance which will be developed through continuous improvement. The circumstances surrounding Mr Gaskill's mobile phone may be used (anonymised) as an illustrative example of the importance of changing property categorisation if circumstances change and/or linking it to other related property files.

Full implementation of the Coroner's recommendation will require changes to Victoria Police's Property and Laboratory Management (PALM) system's software. These changes may take up to 12 months to fully test and implement.

The Coroner's recommendation will be implemented once the revised *VPM Property Management* is promulgated.

Recommendation 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

The Coroner's sub-recommendation 4(a) of amending the *VPM – Deceased Persons* is supported in principle but there are unresolved issues that need to be addressed.

The recommendation for the proposed amendment to include searches of the LEAP database is supported, but there are significant limiting factors in widening this further to NEO and Axon Evidence.com. Both NEO and Axon Evidence.com remain restricted to a subset of Victoria Police members. Technical limitations prevent providing unfettered access to those programs. Victoria Police instead propose to conduct an assessment of the feasibility of granting wider access, including a consideration of the restrictions of data access pursuant to, amongst other things, the *Surveillance Devices Act* and the *Victoria Police Act*.

However, the need for this expanded access should be mitigated by compliance with current expected police processes. Matters, such as Mr Gaskill's, are expected to be escalated to investigators at first instance. Those investigators would have the appropriate access to the relevant information.

(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'

The Coroner's sub-recommendation 2(b) is supported. This will require change to the policy and Form VP83 including amendments to an electronic version.

(c) ensure that any relevant body worn camera footage of such interactions be retained until otherwise directed by the Coroner

The Coroner's sub-recommendation 2(c) is supported in principle but will not be implemented. Current resourcing is insufficient for the retention of all body worn camera footage for an indefinite period to account for the possibility that a person with whom police interacted will later die in circumstances that will necessitate a notification to the Coroner. .

Recommendation 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 Detective Sergeant Smyth's evidence about the timeframes in which notification to family should occur, and when escalation to criminal investigation units must be initiated.

The Coroner's recommendation is supported in principle but there are unresolved issues to be addressed, with an estimated completion date of: within 12 months.

Implementation of this recommendation will require the review of internal documents, policy and memoranda of understandings with VIFM.

I trust that the contents of this letter assists. Please do not hesitate to contact us should further information be required.

Yours sincerely,

Mike Bush CNZM
Chief Commissioner

10 / 08 / 2026