IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 003969

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	Judge John Cain, State Coroner
Deceased:	CDE
Date of birth:	[redacted]
Date of death:	29 July 2019
Cause of death:	1(a) Sharp force neck and chest injuries
Place of death:	[redacted]
Keywords:	Family violence; homicide; intimate partner violence; mental health

INTRODUCTION

1. On 29 July 2019, CDE was 33 years old when she was fatally assaulted by her partner, SS.[1] CDE is survived by her mother, stepfather and stepbrother. She worked numerous jobs in the beauty industry, working at the company 'Waxed' from March 2018 until the time of her passing.

2. SS was 36 years old at the time of the fatal incident. He was unemployed at the time, however previously worked as a labourer and forklift driver. SS had a significant history of mental illness, including schizophrenia, anxiety and depression. He was subject to varying opinions and diagnoses over several years. He also had a history of perpetrating violence towards intimate partners that was not found to be related to mental illness and was not permitted to see his children from prior relationships. SS had a history of drug abuse, reportedly using methylamphetamine from about 2009.

3. CDE and SS met on an online dating website in August 2017 and commenced a relationship. At the time, CDE was living with her mother, stepfather and stepbrother and shortly after beginning the relationship, SS moved into the family home. CDE's stepfather, YTR, advised that SS needed to leave the address after about three months. SS moved out and lived in CDE's vehicle for a while, before the pair began renting a property together in Noble Park. The pair resided together at the Noble Park address until the fatal incident. At the time of the fatal incident, a limited family violence intervention order (**FVIO**) was in place against SS, protecting CDE. It prevented SS from committing family violence and damaging CDE's property.

THE CORONIAL INVESTIGATION

4. CDE's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

5. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related

[1] SS is the pseudonym used by the Supreme Court of Victoria in its sentencing remarks – *DPP v SS* [2021] VSC 779.

to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

6. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

7. Victoria Police assigned Detective Senior Constable Kallyn Gent to be the Coronial Investigator for the investigation of CDE's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

8. This finding draws on the totality of the coronial investigation into the death of CDE including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the deceased

9. On 31 July 2019, CDE, [redacted], was visually identified by her stepfather, YTR.

10. Identity is not in dispute and requires no further investigation.

Medical cause of death

11. Forensic Pathologist Dr Heinrich Bouwer, from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 30 July 2019 and provided a written report of his findings dated 14 October 2019.

[2] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

12. The post-mortem examination revealed complex incised and stab injuries to the neck with injury to the major blood vessels, larynx and oesophagus. There were also two stab wounds to the left side of the chest with associated internal injuries to the left lung and a stab wound on the left lateral chest wall which had injured the spleen and inferior vena cava.

13. There were incised injuries to the hand which could be considered typical so-called defence-type injuries.

14. The ribs were not incised or fractured, and no knife blade was present inside the body.

15. The injuries were consistent with being caused by a sharp-edged implement, and in particular, the two stab wounds on the chest wall appeared to have been caused by a single edged knife or a similar implement. Dr Bouwer reviewed images of the knives alleged to have been used and opined that it was possible that the injuries were sustained by one and/or both knives in the photographs.

16. There was no significant natural disease that may have caused or contributed to the death.

17. The mechanism of death was one of exsanguination (significant blood loss).

18. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or other common drugs or poisons.

19. Dr Bouwer provided an opinion that the medical cause of death was *1(a) sharp force neck and chest injuries.*

20. I accept Dr Bouwer's opinion as to the medical cause of death.

Circumstances in which the death occurred

21. At about 7.00am on 26 July 2019, CDE and SS had a verbal argument after SS disclosed that he had cheated on CDE. CDE reportedly grabbed SS by his shirt and shouted at him. At about 8.55am, SS attended the Dandenong Police Station to report this incident to police.

22. CDE attended her workplace later that day and told her manager that SS disclosed some infidelity while in Sydney recently. CDE was visibly upset by the disclosure and told her manager that she was going to give him the "*cold shoulder*".

23. That evening, between 10.30pm and 11.00pm, SS called CDE's parents to complain about her being intoxicated. Her parents attended their home, where CDE was noted to be intoxicated and had contacted 000 requesting police attendance. Police attended the Noble Park address at about 11.15pm and observed the pair arguing with one another. Police determined that an FVIO breach had occurred, and SS voluntarily left the property to spend the night at his parents' home.

24. At about 6.00am on 27 July 2019, SS's parents called for an ambulance after SS reported problems with his blood pressure. He appeared to be in an altered state of consciousness, with his parents finding him slumped on the toilet. Paramedics attended SS' parents' home and observed SS was substance affected and appeared to be experiencing a panic attack. He was transported to Dandenong Hospital, however, did not remain long enough to have a full assessment. He left the hospital to have a cigarette and never returned. Police were called to do a welfare check on SS.

25. Police attended CDE's home to perform the welfare check, however SS was not there. CDE told police that she had spoken to SS earlier and had arranged for him to drop off her keys later that day. CDE also attended work that day and received a call from a family violence response worker, however CDE declined any need for support, explaining that she and SS were having a "*break*".

26. At 11.57pm that evening, SS called 000 and requested police attendance, alleging that CDE was "*going off*", holding a knife and threatening self-harm. Police arrived at their Noble Park address at 12.07am on 28 July 2019 and observed SS outside the property. The members entered the property and spoke with CDE. She explained that she was asleep, and SS woke her up, rambling about wanting to go to the beach. She noted that she picked up a knife while talking to SS and stated to him, "*What do you want me to do, kill myself?*". CDE disclosed to the members that she was feeling stressed due to her relationship with SS, however repeatedly confirmed that she had no intention to harm herself.

27. Police also spoke to SS, who was rambling and behaving erratically. He was placed under section 351 of the *Mental Health Act 2014* (Vic) and conveyed to Dandenong Hospital for a mental health assessment. CDE was also conveyed to Dandenong Hospital (voluntarily) for assessment.

28. Upon arrival at Dandenong Hospital, SS was assessed by a doctor who noted "*Nil acute psychiatric symptoms evident. Patient does express some unusual ideas about 'authorities' and 'overuse of control in the community'…Suitable for discharge home once medically cleared*". SS was medically cleared and was found not to meet the criteria for compulsory treatment, and he subsequently left the hospital.

29. During CDE's assessment, she explained that although she held a knife to her throat and said she was suicidal, that was not accurate. She reported concerns about SS's welfare and that he was released without treatment. After her release, CDE initially attended her parents' home, however left shortly thereafter and returned to her Noble Park address.

30. At 4.34am on 29 July 2019, SS called 000 and requested to report a matter on behalf of CDE that occurred 27 years earlier. During the phone call, CDE could be heard in the background, answering SS's questions. Later that morning, at about 8.30am, SS used CDE's phone to call CDE's mother, NJI, however NJI did not answer. 30 seconds later, SS called NJI again, and she answered the call.

31. NJI recalled that she could hear CDE screaming on the phone, telling SS to "*stop stop*" several times. While on the phone with JKI, SS is believed to have taken a knife from the kitchen and stabbed CDE in the lounge room. CDE moved from the lounge room to the kitchen, where SS stabbed her again and the knife blade broke off from the handle. SS collected a filleting knife from the kitchen and used it to fatally cut CDE's neck.

32. Alarmed by the phone call, NJI woke up her son, JKI, and he called 000 to request a welfare check on CDE. SS absconded from the Noble Park address, before police arrived. SS left in CDE's vehicle and drove to Frederick Street in Dandenong, where the car ran out of fuel. He then entered a taxi and told the driver to take him to Carrum Downs. When the driver approached an intersection and slowed down, SS exited the vehicle and fled on foot.

33. At 8.59am, SS was observed by witnesses on Lonsdale Street, Dandenong, yelling from a distance. SS approached the witnesses, appeared to collapse on the ground and told the witnesses to "*Call the police…They're going to kill my mother*". The witnesses observed blood on SS's hands and pants, so they called 000.

34. Police located SS walking outside a car dealership on Lonsdale Street, Dandenong, about three minutes later. They observed SS with blood on his pants and a black jumper

wrapped around his hand. He refused to provide any information to police and walked away from them.

35. At 9.06am, CDE's stepfather called 000 to report the phone call that his wife had experienced earlier that morning. At 9.10am, police spoke to SS again outside an address on the Princes Highway, Doveton. He provided the members with his details, before stating "*I sacrificed her, the house, the car, everything*". One of the attending members noted that the address provided by SS was the same as a welfare check that had been called through earlier that morning, so they placed SS under arrest. SS disclosed that he assaulted CDE with a knife.

36. Police attended CDE's Noble Park home at 9.21am and located CDE deceased in the kitchen area, in a pool of blood with significant injuries to her neck. Paramedics also attended and confirmed CDE was deceased.

37. SS was found not guilty by way of mental impairment on 27 April 2023 by the Supreme Court of Victoria. He was sentenced to a 25-year custodial supervision order.

FURTHER INVESTIGATIONS AND CPU REVIEW

38. As CDE's death occurred in circumstances of family violence, I requested that the Coroner's Prevention Unit (**CPU**)[3] examine the circumstances of her death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**)[4]. I also requested the CPU consider the mental health treatment provided to SS in the lead-up to the fatal incident.

39. I make observations concerning service engagement with CDE and SS as they arise from the coronial investigation into his death and are thus connected thereto. 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 CDE's death.

40. I further note 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

[3] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[4] The VSRFVD provides assistance to Victorian Coroners to examine the circumstances in which family violence deaths occur. In addition the VSRFVD collects and analyses information on family violence-related deaths. Together this information assists with the identification of systemic prevention-focused recommendations aimed at reducing the incidence of family violence in the Victorian Community.

"*the potentially distorting prism of hindsight*".[5] I make observations about services that had contact with CDE and SS to assist in identifying any areas of practice improvement and to ensure that any future prevention opportunities are appropriately identified and addressed.

Family violence history

41. CDE and SS were in an intimate relationship for about two years and there were four incidents of family violence reported to police (including the fatal incident). Three of the four incidents occurred in July 2019, with the first incident occurring in January 2018. This incident is outlined below.

15-21 January 2018

42. On 15 January 2018, CDE and SS had been smoking synthetic marijuana when they left their Noble Park address to go for a drive. SS began driving erratically, running red lights and telling CDE "*I am the creator, I am god, I can end people's lives*". SS reportedly tried to get CDE to chant "*I want to kill my mother*" however CDE refused, and SS began physically assaulting her. In her statement to police, CDE recalled

> *I refused to say this so he punched me in the head with a closed fist multiple times. I was hit all over my face; he was throwing punches wildly while driving. We drove from the city all the way to [a town] where his cousin lived. He parked in a dark street in the middle of nowhere and started kicking and pushing his leg against my rib cage. He was grabbing my skin and twisting it very hard. I can't remember the rest of the night, everything was a bit of a blur that day.*

43. From 15 to 21 January 2018, SS refused to allow CDE out of his sight. When CDE tried to escape, SS chased her and held onto her car keys so she could not leave.

44. At about 4.30am on 21 January 2018, CDE and SS were at SS's parents' house in Eumemmering. CDE was asleep in the rear bungalow when SS grabbed her by her left hand with force. When she tried to run to the door, SS grabbed her and stated "*how dare you try run away from me*". CDE repeatedly apologised to SS, as she was afraid of being assaulted or killed. She told police that SS said, "*I could end your life right now I could*

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

put my fist right through your head." She was in fear of her life and thought she would be killed.

45. Later that morning, at about 6.40am, police were called to the address. Police conveyed SS under section 351 of the *Mental Health Act 2014* (Vic) to Dandenong Hospital for psychiatric assessment. Upon assessment at the hospital, SS was placed on a temporary treatment order (**TTO**) as a compulsory patient, where he remained until the TTO was revoked on 1 February 2018. SS was discharged from the mental health service on 12 February 2018 and absconded to New South Wales.

46. CDE also attended Dandenong Hospital on 21 January 2018 where she underwent a psychiatric assessment. She was also placed on a TTO and remained a compulsory patient until 25 January 2018, when the order was revoked. As a result of the assaults CDE sustained from 15 to 21 January 2018, she suffered two black eyes and significant bruising to her body including to her legs, arms and stomach. SS also punched the windshield of CDE's vehicle, causing it to shatter.

47. Upon her discharge from the hospital, CDE attended Dandenong Police Station to report the incidents that occurred between 15 and 21 January 2018. Police compiled a criminal brief, and a warrant was obtained from the Magistrates' Court of Victoria to serve on SS. SS was not served whilst he was an inpatient, and police were not notified of his discharge. The associated criminal charges for the assaults and property damage were outstanding at the time of the fatal incident in July 2019. Police applied for a complaint and warrant, mirroring the conditions of a full, no-contact FVIO. The complaint and warrant were cancelled as SS left Victoria, and police placed a 'whereabouts' on LEAP.

48. The Dandenong Magistrates' Court granted a full interim FVIO on 22 February 2018. This was replaced with a limited final (safe contact) FVIO on 9 April 2018.

49. In May 2018, SS was convicted and sentenced to a term of imprisonment in NSW for driving offences committed in that state. He remained in prison until 14 October 2018. The final FVIO was served on SS by a NSW Police member on 12 April 2018 while SS was on remand in NSW.

50. On 8 October 2018, CDE attended the Dandenong Family Violence Investigation Unit (**FVIU**) where she provided a statement withdrawing her complaint. SS was released

from prison on 14 October 2018. He remained in NSW until about June 2019, when he travelled back to Victoria to live with CDE at the Noble Park address.

51. On 4 June 2019, SS was arrested and interviewed due to the active 'whereabouts' in relation to the January 2018 charges. SS largely gave a 'no comment' response, however on occasion stated that he could not remember. A decision was made not to charge SS.

Review of Victoria Police contact with SS and CDE

52. Victoria Police completed a Family Violence Death Assessment (**FDA**) on 25 February 2020 in relation to this case. I note that the FDA is completed as a desktop review and statements were not obtained from the members involved with CDE and SS. It is important to note this limitation, given that I intend to accept the findings of the FDA. The FDA's findings are summarised below:

    a) The incidents in January 2018 and 28 July 2019 were treated primarily as mental health incidents, and not family violence incidents when there was evidence to the contrary. This meant that L17 family violence risk assessments were not completed, and specialist family violence referrals were not provided, namely in relation to the 28 July 2019 incident.

    b) Police allowed SS to abscond to NSW after leaving the mental health ward in February 2018. No actions were taken to extradite SS to Victoria after completing his prison sentence in NSW and no follow-up actions were taken to pursue the criminal charges from January 2018. This is despite Victoria Police making arrangements to serve the final FVIO on SS while he was on remand in NSW.

    c) Police released SS with an 'intent to summons' following his apprehension on 4 June 2019, despite the significant amount of evidence available to prosecute him for the January 2018 offences, including a statement from CDE, photos of CDE's injuries and damage to her car. This is concerning given that Victoria Police have a pro-prosecution position in relation to family violence offences to ensure that perpetrators are held to account.

53. The FDA also provided four recommendations in response to the findings, namely:

    a) To ensure consistency and continuity throughout the State and to mitigate any adverse criticism or litigation, Family Violence Command (**FVC**) review the FV VPMG in

relation to pending family violence incidents. FVC would be required to identify if the current practise of 'Pending' a LEAP narrative when a whereabouts has been submitted or an Interpose investigation commenced is still appropriate. FVC would be required to analyse a way to ensure once a whereabouts has been 'cleared' the incident is marked 'active' to ensure appropriate supervision.

b) Review the DHHS and Victoria Police protocols for mental health. This has since occurred due to changes in the underlying legislation (see below).

c) FVC review the appropriateness of an FVIU investigating a respondent while uniform members manage the FVIO and whereabouts of the same respondent. Further education to be provided to frontline members to ensure when a section 351 transfer has occurred in relation to a family violence incident then L17s must still be completed.

d) Education in relation to the submission of a family violence report when either party are the subject of a section 351 transfer.

54. I also note that the members involved with CDE and SS in the lead up to the fatal incident were subject to a Professional Standards Command (**PSC**) investigation. A final PSC report was produced, which noted some instances of alleged duty failure by the members involved and discussed the challenging intersection between family violence and mental health, noting that incidents can have features of both.

55. The issue of treating family violence incidents as mental health incidents was discussed in my Finding into the death of Caitlin O'Brien (**'O'Brien'**).[6] In that case, there were multiple apprehensions of the offender under section 351 of the *Mental Health Act 2014* (Vic) arising from incidents that were family violence-related but were treated as mental health incidents.

56. Victoria Police acknowledged in the case of O'Brien that the mental health incidents should have been processed as family violence incidents and confirmed that since 2019, Victoria Police have undertaken various reforms. The *Victoria Police Manual (**VPM**) – Family Violence* as of 28 January 2025 states (amongst other matters):

[6] Finding into death without inquest – Caitlin O'Brien (COR 2019 3251).

a) The presence of family violence should be considered at all incidents attended by police, even where family violence was not the initiating report. For example, family violence is commonly seen in mental health, property damage and animal abuse incidents and should be considered during welfare checks.

b) When attending a family violence incident, members must complete and submit an FVR (L17) to record the incident and make appropriate referrals prior to the end of their shift.

57. Following the implementation of the *Mental Health and Wellbeing Act 2022* (Vic) in September 2023, Victoria Police has released its *VPM Care and control under the Mental Health and Wellbeing Act 2022* (**'VPM Care and Control'**). The VPM Care and Control includes information regarding the intersection of family violence and mental health, including:

a) Police, PSOs and mental health clinicians should be aware of increased risk where family violence is evidence or intervention orders exist. After a threat, the conditions of any existing intervention order should be reviewed. If no intervention order exists, members should consider obtaining an order.

b) Members are directed to the VPM Family Violence for further information about family violence and obtaining an FVIO.

58. I accept that in the five and a half years since CDE's passing, Victoria Police has undertaken further work to improve its response to family violence and there have since been significant changes in the legislation that underpins the apprehension of people experiencing a mental health episode.

59. The Court provided Victoria Police with an opportunity to respond to the adverse findings of the FDA. Victoria Police acknowledged the findings and restated its commitment to continuous improvement in relation to the way police investigate, prosecute and manage the risks of family violence.

60. In those circumstances, I am of the view that I do not need to make any recommendations for change in this case.

61. I am also satisfied that the issues identified in the FDA did not cause or contribute CDE's death, nor that the absence of these deficiencies would have prevented CDE's death.

However, I note that Victoria Police's treatment of the January 2018 was a missed opportunity to prosecute SS and hold him to account for his behaviour.

Review of mental health treatment

62. Both SS and CDE were subject to multiple section 351 apprehensions by police and were taken to Dandenong Hospital on several occasions for assessment and treatment. SS was conveyed to hospital on 21 January 2018, 27 and 28 July 2019. At the time of these presentations, Monash Health (the operator of Dandenong Hospital) was not aligned with the Multi-Agency Risk Assessment and Management Framework (**MARAM**). Monash Health's alignment with MARAM commenced in March 2021.

27 July 2019 presentation

63. As noted above, SS was taken to Dandenong Hospital by ambulance. Upon arrival, he was observed to be "*teary, emotionally upset*" and was hugging his mother, who was also present. SS was triaged shortly after his arrival. The triage nurse observed difficulties assessing SS due to a language barrier. SS appeared anxious and unsettled and he denied any use of alcohol or drugs.

64. SS indicated that he wanted to go outside to have a cigarette. He was not subject to the *Mental Health Act 2014* (Vic), so he was advised that he could go outside for a cigarette but should return for an assessment. SS left the waiting room with his mother, and another patient advised the triage nurse that he had left. The Nurse in Charge (**NIC**) was notified and they decided to contact Victoria Police to conduct a welfare check.

65. There were no deficiencies identified in the actions and service provided by Monash Health on this occasion. The NIC exercised appropriate caution in requesting a welfare check by police.

28 July 2019 presentation - SS

66. SS was conveyed to Dandenong Hospital under section 351 of the *Mental Health Act 2014* (Vic). The attending paramedics' records state that SS was "*continually answering questions with questions…content delusional, flow erratic*". SS was assessed by a mental health clinician in the Dandenong Hospital ED who documented:

> *Nil formal thought disorder. Content spontaneous and coherent. Denies any auditory or visual hallucinations. Nil delusional ideas. Nil thought passivity. Mild paranoid*

themes in the context of negative view about "authorities" eg. judge who made the decision that he was not able to see his children "how dare they". Not happy with all the "rules" about everything. Guarded with some responses. Odd views about how the world should be. Denies any suicidal thoughts, plan or intent. Denies any thoughts to harm others. Nil delusional ideas expressed. Called police concerned about partner's safety. Cognition grossly intact. Insight limited. Judgement partial.

67. The clinician also noted a significant substance use history, specifically that SS "*has tried all known substances*", however denied any current alcohol or illicit substance use. There are no apparent concerns regarding the quality of the assessment that occurred on this occasion. It did not appear that there were sufficient grounds to subject SS to involuntary mental health treatment, so the decision to discharge appeared appropriate.

28 July 2019 presentation - CDE

68. The assessment CDE received in the ED appeared to be thorough and comprehensive. Whilst she was 'elevated' in the context of a conflict with SS, she did not appear to be acutely unwell and did not appear to meet the threshold for involuntary mental health treatment.

69. No prevention opportunities have been identified regarding the mental health treatment provided to SS and CDE.

Intersection of family violence and mental health

70. I also note that mental health issues are recognised as both a risk factor for the perpetration and/or victimisation of family, domestic and sexual violence (**FDSV**) and an outcome of FDSV[7] and continue to be observed family violence related deaths, such as this one.

71. The Royal Commission into Family Violence recognised the complex relationship between mental health and family violence and made numerous recommendations to enhance risk management and information sharing across sectors[8]. While CDE's passing occurred during implementation of relevant reforms, this finding again highlights the ongoing and critical importance of Victoria continuing to refine its ability to respond to individuals whose challenges are not siloed, and nor should the responses be.

[7] https://www.aihw.gov.au/family-domestic-and-sexual-violence/understanding-fdsv/factors-associated-with-fdsv.

[8] See, for example Report IV Chapter 19 - the role of the health system). Royal Commission into Family Violence: Report and Recommendations Volume 4.

FINDINGS AND CONCLUSION

72. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

a) the identity of the deceased was CDE, [redacted];

b) the death occurred on 29 July 2019 at [redacted] from *1(a) sharp force neck and chest injuries*; and

c) the death occurred in the circumstances described above.

I convey my sincere condolences to CDE's family for their loss.

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

[redacted] **Senior Next of Kin**

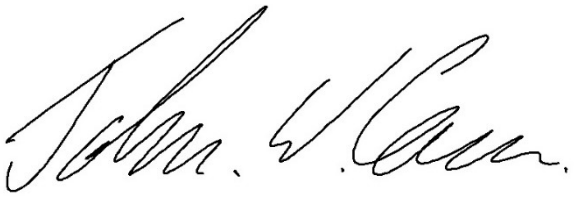
Monash Health

Victoria Police (C/- Victorian Government Solicitor's Office)

Detective Sergeant Craig Burge, PSC Oversight Investigator

Detective Senior Constable Kallyn Gent, Coronial Investigator

Signature:



Judge John Cain
State Coroner
Date: 20 May 2025

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 investigation. 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.