IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 003200

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

INQUEST INTO THE DEATH OF JODUS TENETAHI MURPHY

Findings of:	Coroner John Olle
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street, Southbank, Victoria, 3006
Inquest Hearing Dates:	17 and 18 February 2025
Counsel Assisting the Coroner:	Ms Katherine Farrell of Counsel instructed by Mr Ralph Zeeman, Senior Coroners Solicitor, Coroners Court of Victoria
Chief Commissioner of Police:	Ms Sarala Fitzgerald of Counsel instructed by Hall & Wilcox
Keywords:	Missing person, Unascertained causes

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INTRODUCTION

1. Jodus Murphy was 18 years old when he was found deceased near the bank of the Goulburn River just outside of Seymour on 14 June 2023.

2. Jodus was dearly loved by his family who described him as a smart, kind and generous person. He was good at art and spent a lot of time drawing. Jodus also enjoyed riding his scooter and doing tricks.

3. In his statement to the Court, Jodus' grandfather said the following:

> *'Jodus was such a kind generous person. He wasn't selfish. If you needed something and he had the means he would gladly help… Jodus was someone that you could immediately warm to. Jodus was able to talk to anyone, whether you were 5 years old or 100 years old. He was such a likeable kid.'*

4. Jodus lived with his grandparents, Leon and Linda Anderson since he was about two years old. I acknowledge the support, care and love Leon and Linda gave to him, and the treasured relationship they shared with Jodus throughout his life. Their joint coronial impact statement, which Leon read to the court at the close of evidence was a powerful and eloquent outpouring of love and loss.

5. I take this opportunity to thank Leon and Linda for their generous comments to myself and in respect of the inquest proceeding.

6. I also acknowledge with gratitude the coronial impact statements of Maddison Maloney, Shayde Murphy, Leah Murphy, Suede Timu and Jake Murphy which were provided to me for reading in chambers. Each family member spoke of loss and enduring love, and provided a unique perspective, which gave me valuable insight into the life of Jodus.

INVESTIGATION

7. Jodus' death constituted a 'reportable death' pursuant to section 4(2)(a) of the *Coroners Act 2008* (Vic) (**the Act**) as the death occurred in Victoria and the death appeared to have been unnatural and unexpected.

8. Victoria Police assigned Detective Leading Senior Constable (**DLSC**) Naomi Bennett to be the Coronial Investigator for the investigation of Jodus' death. DLSC Bennett conducted inquiries on my behalf and submitted a coronial brief of evidence. I direct that a copy of the coronial brief remain on the court file.

Purpose of the Coronial jurisdiction

9. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[1] The role of a coroner is to independently investigate reportable deaths to establish, if possible, the identity of the deceased person, the cause of death, and the circumstances in which the death occurred.[2]

10. The expression 'cause of death' refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

11. For coronial purposes, the phrase 'circumstances in which the death occurred' refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in 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 Court's 'prevention' role. Coroners are empowered to advance their prevention role by:

    (a) reporting to the Attorney-General on a death;

[1] Section 89(4) of the *Coroners Act 2008* (Vic) ('*Coroners Act*').
[2] Preamble and s 67 of the *Coroners Act*.

(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

(c) making recommendations to any Minister or public statutory authority or entity on any matter connected with the death, including public health or safety or the administration of justice.[3]

13. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[4] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

Standard of proof

14. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[5] The strength of evidence necessary to prove relevant facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[6]

15. In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*.[7] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals or entities, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

16. 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.[8] Facts should not be considered to have been proven on the balance of probabilities by inexact proofs,

[3] Sections 67(3), 72(1) and (2) of the *Coroners Act*.
[4] *Keown v Khan* (1999) 1 VR 69.
[5] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[6] *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 170–1 per Mason CJ, Brennan, Deane and Gaudron JJ.
[7] (1938) 60 CLR 336.
[8] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336.

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.[9]

17. This finding draws on the totality of the material obtained in the coronial investigation of Jodus' death: the coronial brief prepared by DLSC Bennett, further material obtained by the Court, exhibits tendered at the inquest, the transcript of the proceedings, and closing submissions of the family and members of counsel.

18. In writing this finding, I do not purport to summarise all the material evidence or submissions but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity. It should not be inferred from the absence of reference to any aspect of the evidence or submissions that it has not been considered.

INQUEST

19. The holding of an inquest into Jodus' death was not mandatory under the Act. However, in the circumstances I determined that it was appropriate to hold an inquest in the exercise of my discretion under section 52(1) of the Act.

20. I convened the Coroners Court of Victoria for the inquest on 17 and 18 February 2025.

SCOPE OF INQUEST

21. The scope of inquest was finalised pursuant to section 64(b) of the Act. The scope of the inquest was to determine:

    1) The circumstances in which Jodus' death occurred, including:

        a. The disappearance of Jodus from his mother's home on 12 May 2023; and

        b. Jodus' whereabouts, including his interactions with other people, between 12 May 2023 and 14 June 2023.

    2) The cause of Jodus' death.

[9] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at pp 362–3 per Dixon J.

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

Identity of the deceased, pursuant to section 67(1)(a) of the Act

22. On 16 June 2023, Jodus Tenetahi Murphy born 27 April 2005 was identified via dental record comparison and circumstantial evidence.

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

The medical cause of death, pursuant to section 67(1)(b) of the Act

24. On 20 June 2023, Dr Judith Fronczek, Forensic Pathologist at the Victorian Institute of Forensic Medicine (**VIFM**) performed an autopsy and prepared a report of her findings dated 12 September 2023.

25. Toxicological analysis of post-mortem blood samples showed detection of methylamphetamine and its metabolites in blood and urine and bromazolam in blood.

26. Methylamphetamine is a strong stimulant drug. Interpretation of methylamphetamine levels is problematic due to post-mortem changes, and a big overlap between toxic and non-toxic concentrations. Overdose may cause anxiety, cardiac arrhythmias, circulatory collapse, coma, confusion, convulsions, hallucinations, hypertension and hyperthermia. However, death attributable to methylamphetamine is uncommon in the setting of acute use. Chronic methylamphetamine users have an increased risk of cardiovascular and cerebrovascular disease.

27. Bromazolam is a novel benzodiazepine and considered a novel psychoactive substance. Bromazolam is not approved for medicinal use and has no established therapeutic dose. Its pharmacology and toxicology are not well-known, making the interpretation of any measured concentration difficult. Novel benzodiazepines have been linked to fatalities, commonly when used in combination with other depressants.

28. Tetrahydrocannabinol (**THC**), the active form of cannabis, was detected in blood and urine.

29. The ketone bodies acetone and isopropanol detected in blood and urine are likely the result of decomposition.

30. Dr Fronczek formulated the cause of death as *1(a) Unascertained*.

31. I accept Dr Fronczek's opinion.

Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act

Events prior to Jodus' disappearance

32. Jodus resided with his grandparents who were moving back to New Zealand and wanted Jodus to move with them, however Jodus decided not to move and instead decided to live with his mother. He had decided to resume taking medication for his attention-deficit/hyperactivity disorder (**ADHD**) and was planning to obtain his learner driver's licence and get a job.

33. On 8 February 2023, shortly before his grandparents left, he told his General Practitioner (**GP**) that he was unhappy.

34. On 11 February 2023, his grandparents moved back to New Zealand. After they left, Jodus stopped responding to Alan Clarke (**Mr Clarke**), a family friend and paediatric psychologist, who was attempting to organise an appointment with him.

35. On 14 February 2023, Jodus again told his GP that he was unhappy.

36. On 27 March 2023, he told a consultant psychiatrist, who he saw in connection with resuming his ADHD medication, that he was very sad about his grandmother moving to New Zealand and that he was seeing a psychologist fortnightly. There is, however, no evidence that he was seeing anyone.

37. His family reported that his demeanour had changed in the three to four weeks prior to 14 May 2023. His mother advised police that shortly before he disappeared, he had stopped answering his grandmother's calls.

38. At approximately 5:00 am on 12 May 2023, he left his mother's home in Seaford.

Events between 12 and 15 May 2023

39. Bank records showed that an ATM in Highett was used to withdraw money from Jodus' bank account at 6:46 pm on 12 May 2023 and at 8:38 am and 8:42 am on 13 May 2023. It is likely that Jodus stayed somewhere in the Highett area overnight.

40. By the evening of 14 May 2023, Jodus had made his way to Seymour, and it was at the Seymour train station where he met Corey Christie and Thomas Howe. He asked them when the next train to Murchison was. They looked it up and told him that there were no more trains. Corey kindly offered for Jodus to stay at his house overnight as there were no more trains. He organised for a friend of his to give them all a lift to his mother's house.

41. CCTV footage obtained from the train station is consistent with his account, it shows Corey, Thomas and Jodus getting into a car that drives away.

42. Corey lived at home with his mother, Jennifer Tennant. Jennifer explained she was unhappy that Corey had invited Jodus to spend the night as last time he brought someone home to stay the night, they had stolen from her.

43. She asked Jodus a number of questions about where he had come from and where he was going. He told her he had come from Craigieburn and was wanting to go to either Wodonga or Murchison, she described him as being *'a bit all over the place'*. He said he had a sister who lived up there.

44. Jennifer took a photograph of Jodus sitting on her couch for security and described his appearance as that of a little frightened possum. Ultimately, she felt sorry for him and gave him something to eat and drink. He looked cold so she offered him a blanket to keep warm. Around 10:00 pm, she left for work.

45. Corey, Jodus and Thomas stayed up all night talking. Corey has given evidence that over the evening all three of them smoked ice. Thomas and Jodus also took alprazolam and smoked cannabis.

46. On the morning of 15 May 2023, Corey told Jodus that he had to leave because his mother would be coming home from work. Jodus really wanted to stay but Corey was worried his mother would be upset so he told him to leave.

47. Jodus left and shortly afterwards, Corey went outside and saw him sitting on the corner of Marengo Road with a trolley. He described him as *'confused'* and *'out of it'*. He felt bad and asked Jodus to come back to his house but explained '*he was just sitting there'*.

48. When Jennifer returned home from work at about 7:30 am, she saw Jodus sitting on the street. When she went back outside a short time later, she could see him at the top of Abdullah Road.

49. Neither Corey nor his mother were aware that Jodus was a missing person when they took him in that night.

50. It was clear from the evidence delivered at inquest that Corey and Jennifer were kind people who had taken in a stranger with nowhere to go, fed him, and kept him warm for the night. In the short time they knew him, Jodus clearly had a significant impact on them, in particular Corey.

51. Between 7:30 and 8:30 am, Jodus was seen by local Seymour residents Valerie Sherwood, Renee Henderson and Gail Strahan.

52. Valerie called her daughter Renee to report that she had seen a dark-haired young man pushing a trolley up Marengo Road.

53. At 8:20 am, Jodus approached Renee and asked if she could help him and if she had maps on her phone. She told him she was in a bit of a rush, and he insisted he was okay and did not want to make her late. She described Jodus as polite and friendly.

54. I am satisfied the last confirmed sighting of Jodus occurred at approximately 8:30 am on 15 May 2023, at which time Jodus approached Gail Strahan and asked her if she could help him find a friend's house. He told her that he had lost his phone. She let him look at Google Maps on her iPad, but he did not seem to find anything. Gail reported the interaction to Seymour Police and provided a description of the young man.

55. At about 9:10 am on 15 May 2023, police conducted a patrol of the area but unfortunately were unable to locate a young male as described by Gail. At that time, the Seymour Police were not aware that Jodus was the person who had been sighted.

56. At 10:00 am on 15 May 2023, Senior Constable Sharon Tranter, the police officer then in charge of the missing person investigation, organised for an internal circular to be submitted.

Events of 17 May 2023

57. Shortly after 5:00 pm on 17 May 2023, Mitchell Berens was captured on CCTV using Jodus' bank card to withdraw money from a Commonwealth Bank ATM in Seymour.

58. When subsequently spoken to by police, Mitchell maintained Jodus had approached him at the bus shelter at Seymour Railway Station and asked him to go to the ATM and withdraw money for him. That he asked Jodus why he could not withdraw the money himself and Jodus said it was because *'they were watching me'* and that Jodus gave him the PIN for the card. He stated having withdrawn the money, and returning the cash and card to Jodus, he caught the bus to Nagambie.

59. Police investigated Mitchell's account and found that CCTV footage from the bus shelter on 17 May 2023 did not show any interaction between Mitchell and Jodus at the bus stop. Nor did it show Mitchell catching the bus to Nagambie. Michell's phone records were obtained and showed that he did not leave the Seymour area after withdrawing the money and in fact used his phone to contact a local drug dealer.

60. In his evidence given at the inquest, Mitchell denied telling police that he met Jodus while waiting for a bus to Nagambie or that after his interactions with Jodus, he left to catch a bus to Nagambie.

61. He admitted that he had seen Jodus' family in Seymour when they were looking for Jodus and told them that he last saw Jodus at the train station and that he said he was going to Melbourne. He did not tell them about using Jodus' bank card. He denied making contact with a local drug dealer shortly after withdrawing the money from Jodus' account.

62. Mitchell gave evidence that he was using drugs at the time. He could not refute the accuracy of contemporaneous notes of his conversation with police, and subsequently in evidence conceded he was often drug affected, and further conceded the possibility that his interaction with Jodus occurred on 15 May 2023, and not on 17 May 2023. However, he refuted the suggestion he had not returned the bank card or money to Jodus.

Events following the discovery of Jodus' body

63. On 14 June 2023, Jodus' body was discovered approximately 30 metres from the bank of the Goulburn River, just outside of Seymour.

64. DLSC Bennett, who observed Jodus' body in situ, gave evidence that the position of his hair and jewellery were consistent with him having been carried to that position by water. His body was below a recent high tide mark and flow data obtained showed that the river was inundated with water from 9 June 2023 with a peak on 10 June 2023. The flow had reduced by 15 June 2023.

65. I endorse Counsel Assisting's submission that it is unlikely Jodus died where he was found. On the contrary, I am satisfied he was carried there by floodwater, which would also explain why his backpack and belongings were not found with him. I am satisfied that the location of Jodus' death is an undetermined location upstream from where his body was found.

66. An autopsy was conducted but the cause of death could not be ascertained as his body was significantly decomposed. There was, however, no evidence of injury.

67. Toxicological analysis of his blood and urine revealed the presence of methylamphetamine, bromazolam and cannabis.

68. Significant and compelling evidence was given by the VIFM Chief Toxicologist Dr Dimitri Gerostamoulos that, having regard to the nature of the substances found and the concentrations in which they were found, it was likely Jodus consumed the methylamphetamine and bromazolam within a day or so of his death.

69. Corey Christie gave evidence that Jodus consumed methylamphetamine and alprazolam on the night of 14/15 May 2023. Alprazolam is a benzodiazepine, and bromazolam is a synthetic benzodiazepine that has been substituted for alprazolam in counterfeit drug products.

70. The substances detected in Jodus' body are therefore consistent with the substances he was said to have consumed on the night of 14 and 15 May 2023.

71. In my view, the unequivocal evidence of Dr Gerostamoulos provides comfortable endorsement that Jodus likely died within 24 hours or so of use the substances at Corey Christie's home on 15 May 2023.

72. Jodus, a stranger in the small country town of Seymour, was noticed and/or interacted with several people over 14 and 15 May 2023. However – leaving aside the initial account of Mitchell Berens, the veracity of which I will shortly address – despite three local women interacting with Jodus within an hour or so of leaving Corey Christie's house on 15 May 2023, thereafter, there was not a solitary report of sighting Jodus until his body was located on 14 June 2023.

73. Counsel Assisting submitted that I should reject Mitchell Berens' evidence that he returned Jodus' bank card and cash to him.

74. The CCTV footage and bank records confirm that shortly after 5:00 pm on 17 May 2023, Mitchell Berens withdrew money from Jodus' account using an ATM in Seymour.

75. Mitchell could only have obtained the PIN from Jodus. There is no evidence Jodus provided the bank card or PIN under duress. The issue remains – what was Jodus' expectation in providing Mitchell his bank card and PIN?

76. Counsel Assisting submitted that I could be satisfied that Mitchell, who was struggling with drug use at the time, met Jodus sometime on 15 May 2023. Jodus gave him his bank card and PIN to withdraw money. That Mitchell took the bank card and did not return it to Jodus. That Mitchell subsequently used Jodus' bank card to withdraw funds at a Seymour ATM on 17 May 2023.

77. DLSC Bennett was a witness of truth, who provided compelling evidence. I accept without demur her evidence in respect to the accounts Mitchell provided her. Importantly, I accept he told her he caught the bus to Nagambie on 17 May 2023. He clearly did not. Further, he was not forthcoming about his use of the bank card and did not mention it to anyone until he was specifically asked about it.

78. When Mitchell finally conceded to police that he used Jodus' bank card to withdraw funds, he claimed he *'told Jodus to be careful who he asked because a lot of people would take the card and not bring it back'*. Counsel Assisting submitted I should be satisfied that this is the very thing Mitchell did.

Evidence relevant to the cause of death

79. I accept the submission of Counsel Assisting that Jodus did not die from a drug overdose. While the concentration of methylamphetamine found in his body could cause heart arrhythmias, the evidence of Dr Gerostamoulos was that it was unlikely that the drugs found in his system were the cause of his death.

80. Dr Fronczek gave evidence that both drowning, and hypothermia were possible causes of death. The presence of Wischnewsky Spots can be indicative of hypothermia, but it is also indicative of a long agonal period, which could be caused by drowning.

81. Dr Fronczek was provided with a table of the daily minimum and maximum temperatures and gave evidence that, having regard to the temperatures during the period 15 May to 14 June 2023, hypothermia as a cause of death would be possible.

82. It is likely that Jodus died from hypothermia, possibly in combination with drowning. There are no definitive findings for either cause of death. While fluid was found in both of his pleural cavities, this can be due to drowning or the decomposition process. I accept the submission of Counsel Assisting, that there is insufficient evidence on which I could make a definitive finding as to the specific cause of Jodus' death.

83. Dr Fronczek gave evidence that some persons who suffer hypothermia experience a paradoxical phenomenon where they feel hot and remove their clothing. This could explain

why Jodus was found only in underwear. He may have died of hypothermia directly, or he may have decided to go for a swim to cool off – due to the effects of hypothermia – and drowned. His consumption of drugs may well have contributed to him drowning or becoming hypothermic, either by reducing his ability to swim, or to notice or respond appropriately to becoming cold.

84. In respect to items in Jodus' possession, Jennifer Tennant and Corey Christie gave evidence that Jodus did not appear to have a sleeping bag or any camping equipment. I unequivocally accept the evidence of Jennifer who explained Jodus had a thin blanket which she described as a doona cover. There is no evidence that Jodus had possessions other than those described by Jennifer and Corey – he certainly had no camping equipment or sleeping bag or any item necessary to provide him with adequate warmth to spend an extremely cold winter's night outdoors in Seymour.

85. I am satisfied that Jodus was totally ill-equipped to sleep outdoors on the bank of the Goulburn River. His first evening on 15 May 2023 found him sleeping rough in near freezing conditions. Having accepted the evidence of Dr Gerostamoulos that Jodus likely died within 24 hours or so of consuming the illicit drugs detected in post-mortem samples, I am comfortably satisfied that he suffered hypothermia. He exhibited known behaviours of paradoxically undressing to his underwear despite freezing conditions. For reasons unknown, Jodus entered the river and in so doing, either drowned or succumbed to hypothermia. His body travelled downstream, until flood waters washed his body onto the bank, at which it was deposited when the flood water subsided.

FAMILY CONCERNS

86. Jodus' family expressed concerns about the delay in obtaining his bank records. His bank account details were provided to Senior Constable Tranter on 16 May 2023. On 31 May 2023, Senior Constable Tranter emailed the Commonwealth Bank requesting the details of all transaction activity on Jodus' bank account since 12 May 2023. The following day, the Commonwealth Bank provided the requested records which showed the withdrawals made by Mitchell Berens in Seymour.

87. It was as a result of this information that the police investigation turned its focus to Seymour.

88. Had the transaction record request been made on 16 May 2023, the transactions in Seymour would not have been captured by the transaction report provided by the bank. Even assuming that a request was made shortly after the Seymour transactions occurred, and the report received on 18 May 2023, the last reliable sighting of Jodus in Seymour was on 15 May 2023.

89. Of significance I have found that Jodus likely died within 24 hours or so of ingesting substances on the evening of 14/15 May 2023 at the Tennant home.

90. It is understandably upsetting to the family that no explanation has been provided for the delay between 16 and 31 May 2023. However, noting my finding as to time of death above, though preferable had Senior Constable Tranter requested the details sooner, sadly the tragic outcome would not have been averted.

91. Though the police investigation does not fall within my scope of inquest, the police statements and notes demonstrate that the investigation was otherwise conducted consciously.

92. I thank Mr Clarke for his submissions. I am satisfied however I have herein addressed the family concerns which fall within the scope of inquest.

93. What happened to Jodus was a tragedy. He was a loved young man with great potential. Whilst my investigation has sought to provide answers, I acknowledge some questions will remain unanswered. I trust however the evidence has answered critical issues. In particular, the evidence provided by Dr Gerostamoulos and Dr Fronczek, my Coronial Investigator DLSC Bennett and Jennifer Tennant.

94. I take this opportunity to reiterate comments made by me at the outset of the inquest. It is important to ensure those who loved and cared for Jodus, notably his grandparents but also his mother, and many family members and friends understand they should not embark on

self-recrimination – 'What did I miss? Why didn't I see this? Why didn't I do more?'. Jodus was loved and his tragic demise could not have been reasonably foreseen.

95. There is no evidence he was suicidal. In hindsight, unbeknown to others, he had withdrawn from mental health treatment.

96. Jodus seems to have been a private person, who kept the depth of his feelings to himself. No doubt had his family known how he was feeling, or what was to come, they would have done everything in their power to help him.

FINDINGS AND CONCLUSIONS

97. Having held an inquest into Jodus' death, I make the following findings, pursuant to section 67(1) of the Act:

    (a) the identity of the deceased was Jodus Tenetahi Murphy, born on 27 April 2005;

    (b) the death occurred between 15 May and 14 June 2023, in Seymour, Victoria;

    (c) from *unascertained causes*; and

    (d) that the death occurred in the circumstances set out above.

I convey my sincerest sympathy to Jodus' family for their loss.

Pursuant to section 73(1) 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:

Marilyn Murphy, Senior Next of Kin

Chief Commissioner of Police

Detective Leading Senior Constable Naomi Bennett, Coronial Investigator

Signature:

Coroner John Olle

Date: 14 April 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 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.