IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2022 002051

IN THE MATTER OF THE INQUEST INTO THE DEATH OF SIMON CHRISTOPHER GASKILL

COSTS RULING AND ORDER

CORONER:	Ingrid Giles
DATE MADE:	17 April 2026
DECEASED:	Simon Christopher Gaskill, born 2 September 1971
APPLICATION:	Application for Costs pursuant to section 74(2) of the *Coroners Act 2008*
ATTENDANCE:	Via hearing and on the papers
OTHER MATTERS:	On 24 February 2026, Amanda Gaskill made an application pursuant to section 74(2) of the *Coroners Act 2008* (**Costs Application**). The Costs Application sought an order that the Chief Commissioner of Police (**Chief Commissioner**) pay the costs incurred by Ms Gaskill in engaging legal representation for the inquest. The application was opposed by the Chief Commissioner. Oral submissions were made at inquest on 24 February 2026 in respect of the application on behalf of Ms Gaskill and the Chief Commissioner, as well as Counsel Assisting. The interested parties were invited to file any written submissions in relation to the application. The Court subsequently received submissions on behalf of Ms Gaskill and the Chief Commissioner, as well as submissions in reply on behalf of Ms Gaskill. No other interested party sought to be heard.

I, Coroner Ingrid Giles, having considered the Costs Application of Amanda Gaskill (**Ms Gaskill**), and the oral and written submissions made on behalf of Ms Gaskill and the Chief Commissioner of Police (**Chief Commissioner**), make the following determination and **Order** in respect of the application:

BACKGROUND

1. An inquest into the death of Simon Christopher Gaskill ('**Simon**') was held on 23 and 24 February 2026.

2. I exercised my discretion to hold an inquest into Simon's death in order to:

    a) facilitate the public hearing of evidence on issues concerning the adequacy of the police investigation into Simon's death, with the view of assisting in the discharge of my statutory functions and promoting public confidence in the administration of justice and the conduct of coronial investigations in the State of Victoria;

    b) hear further evidence about the forensic investigations into Simon's medical cause of death and the circumstances leading to his death; and

    c) hear further evidence regarding the medical care Simon received in the months before his death to assist in determining whether there were any opportunities for systems improvements in the treatment of, and interventions for, people suffering from chronic alcohol dependence who face barriers to accessing treatment and support services.[1]

3. At inquest, I heard evidence from Ms Gaskill, the Coronial Investigator Detective Leading Senior Constable Leigh Smyth (**DLSC Smyth**), the Forensic Pathologist Dr Judith Fronczek (**Dr Fronczek**), and the Chief Medical Officer of Barwon Health, Professor Ajai Verma.

4. The interested parties were Ms Gaskill, the Chief Commissioner (who also represented the interests of all police members involved in the incident except for the current coronial

[1] I outlined these reasons in brief at the commencement of Inquest – *see* Transcript of inquest (**T**), T-2, line 15 to T-3 line 1 – '*We are here today because I have determined it appropriate to hold an inquest into Simon's death. It is not a mandatory inquest. It is being held in order to facilitate the public hearing of evidence on some very important issues connected with the adequacy of the police investigation into Simon's death, the cause and circumstances of his death and the medical care he received some months prior to his death as a man who was facing homelessness and who had ongoing health issues, including as to his alcohol use*'. *See also* Scope of Inquest dated 5 February 2026.

investigator), and Barwon Health. All interested parties were represented by experienced counsel, and made submissions at the conclusion of the evidence.

5. On 24 February 2026, at the conclusion of the inquest hearing, Ms Gaskill made an application for costs pursuant to section 74(2) of the *Coroners Act 2008* (‘**the Coroners Act’**). Ms Gaskill sought an order that the Chief Commissioner pay expenses incurred by Ms Gaskill in engaging legal representation for the inquest (an **order for costs**).

6. The ground relied upon for seeking an order for costs, was that the conduct of the Chief Commissioner during the investigation into Simon’s death was such as to justify an award of costs because ‘*the inquest has only been necessary because of the complete failure of Victoria Police to adequately and properly investigate the death of Simon Gaskill for the first two years after the discovery of his body’*.[2]

7. The application is opposed by the Chief Commissioner, who submitted that: ‘*the default position under s 74(1) – that each party bears their own costs – is not a position to departed from whenever unreasonableness can be identified at some point in the history of an investigation. It requires the Court to be satisfied that the statutory conditions are met and that, in the exercise of its discretion, a costs order is warranted.*’[3]

8. The Chief Commissioner also submitted that coronial investigators are Victoria Police members conducting investigations at the behest of the Coroners Court and therefore ‘*it would be incongruous in that context, in this case, to treat the Chief Commissioner as a kind of party akin to an adversarial party against whom costs should be ordered […]’*.[4]

9. In reply, Ms Gaskill submitted that ‘*the bulk and the central concern of this inquest hearing was concerned with the systemic (and specific) failures of Victoria Police and particular members, and the examination of what could be done to ensure such failures do not eventuate again*’, and further that it ‘*may be unusual to award costs in an inquest such as this. But these circumstances are highly unusual*’.[5]

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[2] Submissions as to Costs, filed on behalf of Ms Gaskill, 3 March 2026.
[3] Submissions in response to the Costs Application, filed on behalf of the Chief Commissioner of Victoria Police, 10 March 2026 (**Chief Commissioner’s Response**).
[4] Submissions of Counsel for the Chief Commissioner at inquest, T-293, lines 13-16.
[5] Submissions in reply, filed on behalf of Ms Gaskill, 12 March 2026.

LEGAL FRAMEWORK

10. Section 74 of the Coroners Act establishes the power of the coroner to award costs for persons appearing before the Coroners Court.

11. The default position is that every person appearing before the Court who is legally represented is to bear their own costs.[6]

12. However, section 74(2) provides that:

> *If, in a particular case, a coroner is of the opinion that a person (the **first person**) has acted unreasonably during an investigation or inquest, the coroner may order the first person to pay all, or a specified part, of the expenses (other than economic loss) reasonably incurred by another person (the **second person**) –*
>
> *(a) as a result of the unreasonable actions of the first person; and*
>
> *(b) that relate to the participation of the second person in the investigation or inquest.*

13. That is, I am empowered to make an order to award costs under section 74(2) if:

a) I am satisfied that the first person (here, the Chief Commissioner) has acted unreasonably during the investigation or inquest (the **first limb**); and

b) the costs have been reasonably incurred by the second person (here, Ms Gaskill) as a result of the unreasonable actions of the first person, and that such costs relate to the participation of the second person in the investigation or inquest (the **second limb**).

DETERMINATION

Has the Chief Commissioner acted unreasonably during the investigation or inquest?

14. It is common ground between Ms Gaskill and the Chief Commissioner that no criticism of the latter is warranted as it relates to their conduct during the *inquest,* held on 23 and 24 February 2026. I accept this submission.

15. However, it is evident that the police *investigation* into Simon's death was, for more than two years, deficient in a number of significant aspects.

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[6] Coroners Act, s 74(1).

16. As detailed in my Finding into Death Following Inquest into the Death of Simon Christopher Gaskill, such deficiencies included, *inter alia*, failures in the initial investigations to:

    a) seize and analyse items of evidentiary value located at the scene of death, including Simon's laptop, travel card, and personal documentation relevant to the investigation of the identity of the deceased and the circumstances in which Simon died;

    b) establish a timeline (or an accurate timeline) of Simon's last movements and when, and by whom, he was last sighted alive;

    c) identify and inform the Coroner that Simon's death followed recent police contact, and that two of the last people to have seen Simon alive were police members who had dropped him off at a campground – near to the sand dunes where he was found deceased – in the early hours of 25 March 2022, with no comprehensive contemporaneous records made of that interaction;

    d) identify that Simon's mobile phone was in the possession of Victoria Police at the time his death was reported to police, nor to identify its potential relevance to the coronial investigation into his death, and the subsequent destruction of it without recourse to his family; and

    e) inform Simon's family in a timely manner of the death of a person believed to be Simon.

17. These matters are largely conceded on behalf of the Chief Commissioner in the two internal reviews that were prepared in relation to the police investigation that followed Simon's death, and which were provided to the Court to assist my investigation. While certain of these matters were the subject of later submissions which sought to justify steps police members took with respect of certain issues (such as the timing of the delivery of the death message to Simon's family and process for identification of his body),[7] I am satisfied that, unless otherwise stated in my finding, the outcomes of those two internal reviews faithfully reflect the numerous deficiencies in the initial police investigation into Simon's death.

18. These identified deficiencies in the investigation gave rise to the highly unusual step of assigning a member of the Homicide Squad to be the coronial investigator for this case,

[7] *See* Chief Commissioner's Response, paras 21-24.

DLSC Smyth. His contribution to the investigation was commendable – taking an approach that was thorough, compassionate, and – through his diligence – has enabled a reasonable picture of Simon's last days to be reconstructed through Myki records, laptop analysis, divisional van footage (that required manual analysis of multiple desktop computers), and further witness statements. Given the successive and significant investigative failures noted above, this was fortunate indeed.

19. Nonetheless, DLSC Smyth's investigation was hampered by the passage of time, having been appointed the coronial investigator in August 2024, some 2 years and 4 months after Simon's death was first reported to the Court. While DLSC Smyth's investigation has assisted in addressing many of the questions surrounding the circumstances, it remains unknown what additional material or evidence concerning the circumstances of Simon's death may have been identified had such inquiries been undertaken in the period immediately following Simon's body being found.[8]

20. These were the primary issues that – in my opinion – gave rise to the need for inquest, to assist me to discharge my statutory functions under ss 67 and 72, and to help maintain public confidence in the administration of justice and other public agencies (in this case, Victoria Police). Further, to help reduce the chances of something like this happening again by identifying and addressing any systemic defects or risks in the conduct of police investigations into reportable deaths and making any required recommendations for improved guidance to police members conducting investigations for the coroner. Consistent with this purpose, at inquest DLSC Smyth was asked questions about such potential improvements, given his considerable experience as an investigator, including as a coronial investigator.[9]

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[8] By way of example, DLSC Smyth obtained a statement from a resident of Ocean Grove who reported that she had contacted Ocean Grove Police Station in April 2022 when Simon's body was located in the sand dunes to provide information she believed may assist the investigation into Simon's death. However, she was not contacted by police until the end of August 2024, some two years later, after DLSC Smyth took over conduct of the investigation. *See* Inquest Brief, p. 41.

[9] *See for example* question to DLSC Smyth from the Coroner: '*Ms Cafarella has asked you some questions yesterday and today in relation to I suppose potential systems improvements that you might have come up [with] during this investigation, and given your extensive experience as a police member, is there anything that you'd identified that you haven't yet told the court in relation to that potential systems improvements that you think might assist police members being the role of coronial investigator? The reason why I ask is because my impression is that police members might very often be tasked with, for example, preparing a criminal brief of evidence, but they might only ever be a coronial*

21. While there is no cogent evidence that any police member involved in the initial investigation attempted to actively mislead the Court, which is a matter I raised during Inquest,[10] I am satisfied the deficiencies identified constitute unreasonable conduct during an investigation for the purposes of section 74(2) of the Act, given their seriousness, pervasiveness and departure from certain established practices outlined in the Victoria Police Manual (**VPM**).[11] Indeed, it was conceded by Counsel for the Chief Commissioner that the Chief Commissioner acted unreasonably during the investigative phase.[12]

22. It is important to note that not every discrete investigative deficiency by a police member in the investigation of a reportable death would amount to unreasonable conduct during an investigation. However, borrowing the words of Counsel Assisting, the '*complete [initial] failure to conduct the relevant enquiries and identify the relevant evidence*',[13] coupled with the extraordinary reliance on family to identify such evidence and proffer it for examination and assessment (when such evidence was present at the scene of death, and ought to have been seized by police investigators), leads in my view to the finding of unreasonable conduct in the investigation.

23. Finally, while police members acting as coronial investigators are required to assist the Court and to act at the direction of the Coroner,[14] police members simultaneously act as the delegate of the Chief Commissioner who is also responsible for: (i) nominating a police officer to assist a coroner in relation to the investigation; and (ii) developing the guidance in the VPM pertaining to death investigations.[15] There are numerous actions coronial investigators are required to take as part of their role without specific coronial direction, and

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investigator once within their careers, so it's conceivable that they'll need robust guidance in preparing a coronial brief and in undertaking all of the various tasks associated with that role'. T-177 line 27 to T-178 line 11.

[10] T-284 line 16 to T-285 line 21.

[11] The Victoria Police Manual is issued under the authority of the Chief Commissioner pursuant to section 60 of the *Victoria Police Act 2013*, and comprise the Chief Commissioner's instructions for the general administration of Victoria Police and for the effective and efficient conduct of the operations of Victoria Police. Non-compliance with or a departure from the VPM may be subject to management or disciplinary action.

[12] *See* T-294 lines 4-7: '*I could not stand here and argue that the Chief Commissioner of Victoria Police has not acted unreasonably in the investigation, of course I couldn't and I wouldn't*'.

[13] Submissions of Counsel Assisting, T-285 lines 13-15.

[14] *See* ss 15A and 36 of the Coroners Act.

[15] The position of coronial investigator was enshrined in the Coroners Act on 11 October 2023 following the commencement of the *Justice Legislation Amendment Act 2023*, and defines the role of coronial investigator 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*'.

relevant guidance concerning those functions resides in the VPM. Accordingly, it is not, as submitted on behalf of the Chief Commissioner, incongruous to hold the Chief Commissioner responsible for failures of its members in a coronial investigation that are inconsistent with the VPM and which undermine the Coroner's ability to appropriately discharge their statutory functions (such as failing to report a death to be a 'death in recent police contact', as occurred in Simon's case).

Were Ms Gaskill's costs reasonably incurred as a result of the unreasonable actions of the Chief Commissioner?

24. The first limb of section 74(2) of the Coroners Act being satisfied, I now turn to the second limb – that is – whether the claimed costs were reasonably incurred as a result of the unreasonable actions of the Chief Commissioner.

25. The history of the conduct of this matter is extensive and is detailed in the Finding into Death with Inquest. I do not propose to restate it here, save to note that Ms Gaskill was instrumental in providing the evidence concerning the circumstances of Simon's death that led to the re-opening of the investigation, and then drawing the Court's attention to significant deficiencies in the subsequent police investigation and preparation of the first coronial brief, that ultimately resulted in the Chief Commissioner appointing a homicide detective as the coronial investigator and commissioning two internal reviews of the investigation.

26. The inquest was conducted into Simon's death specifically to examine (amongst other matters):

    a) the adequacy of the police investigations into Simon's death;[16] and

    b) whether there are any systems improvements in respect of the management of police investigations of reportable deaths on behalf of a coroner.[17]

27. In light of these scope items, I determined that it was appropriate to call Ms Gaskill as a witness to give evidence at inquest concerning the family's interactions with police (together with other evidence about who Simon was as a person and her contact with Barwon Health during Simon's inpatient admission in December 2021). This assisted in ensuring that

[16] Scope of Inquest dated 5 February 2026, item 2.
[17] Scope of Inquest dated 5 February 2026, item 3(b).

relevant evidence was before me concerning the conduct of the police investigation, and to inform any recommendations to address systemic issues in the conduct of police investigations into reportable deaths.

28. Ms Gaskill subsequently engaged legal representation on 16 February 2026 (a week prior to inquest) to represent her interests at the inquest. Ms Gaskill was represented by counsel, Mr Lucien Richter, who – along with counsel representing the other interested parties – provided great assistance to my investigation through their participation in the inquest proceeding.

29. I am satisfied that – in circumstances where the inquest was examining issues of concern raised by Ms Gaskill, and where she had been called to give evidence at inquest – it was entirely reasonable for Ms Gaskill to engage legal representation for the inquest to represent her interests.[18]

30. I do not accept the submission on behalf of the Chief Commissioner that Victoria Police's approach after the first two phases of the investigation rendered the involvement of Ms Gaskill's legal representatives unnecessary.[19]

31. Ms Gaskill's involvement in the investigation and inquest – and the need to engage legal representation – was as a result of the successive identified failings of the delegates of the Chief Commissioner in the conduct of the initial investigations of Simon's death. But for these failings, Ms Gaskill would not have been required to retain and provide key evidence to Victoria Police that ought to have been seized at the scene (including Simon's laptop and personal documentation), nor to repeatedly advocate for a proper investigation to be conducted into Simon's death and to ultimately give evidence at inquest. The inquest was – as submitted by Counsel for Ms Gaskill – for the express purpose of ensuring that I could confidently rely upon the investigation conducted by DLSC Smyth for the purposes of making findings under s 67, following the initially deficient police investigation into Simon's death,[20] and to address any identified systemic failings in police investigations into reportable deaths.

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[18] While Counsel Assisting will typically ensure the interests of family members are addressed at Inquest where family members are not legally represented, it is not uncommon for a family member to engage their own legal representation where they are called to give evidence and/or have otherwise raised concerns of care throughout the coronial process.
[19] Chief Commissioner's Response, [7-8].
[20] Submissions in reply, filed on behalf of Ms Gaskill, 12 March 2026, [4]-[10].

32. Accordingly, I accept the submission of Counsel for Ms Gaskill that the costs were reasonably incurred as a result of the unreasonable actions of the Chief Commissioner (in respect of the initial investigations into Simon's death) and that they relate to her participation in the inquest into Simon's death.

33. As submitted by Ms Gaskill's Counsel, '*these circumstances are highly unusual*' and warrant departure from the default position that each party to an inquest bears their own costs.[21]

Other matters relevant to the assessment under s74 of the Coroners Act

34. In so determining, I acknowledge that an important pillar of the evidence at inquest was that of Professor Verma of Barwon Health, who gave evidence about Simon's care, in circumstances where Simon had been discharged from hospital to homelessness in late 2021, some months before he was found deceased. This was an issue of importance to my investigation having regard to my role in promoting public health and safety and identifying prevention opportunities and formed part of the inquest's scope. It did not relate in any way to the unreasonable conduct of the Chief Commissioner in the initial investigative stages of these proceedings.

35. Similarly, in the holding of the inquest, I also heard oral evidence directly from the Forensic Pathologist, Dr Fronczek, concerning the findings on autopsy and medical cause of death relevant to my statutory functions to make findings as to the cause of death.

36. I therefore accept the submission made on behalf of the Chief Commissioner that the inquest itself was not *solely* concerned with the conduct and role of Victoria Police in the investigation of Simon's death, albeit that this was a primary focus and purpose of the inquest, and for which I heard evidence from Ms Gaskill and DLSC Smyth across two days of evidence.

37. I also consider that, while the Chief Commissioner's conduct during inquest cannot necessarily 'offset' any unreasonable conduct during investigation for the purposes of a costs application, I was very much assisted by the Chief Commissioner's approach in the lead-up

[21] In this connection, it also bears commenting that, outside of the actions of certain police members in the present case, the majority of police members conducting coronial investigations approach their task with rigour and diligence, often in the context of being very busy with other daily duties. Investigations at the Coroners Court would grind to a halt without their assistance, skills and expertise. This underscores the highly unusual nature of the initial investigation into Simon's death and, in turn, the present ruling and order.

to inquest (including apparent concessions as to certain of the deficiencies outlined in the internal reviews) which negated the requirement to call certain key witnesses whose conduct was impugned in such reports. This meant that the inquest could be a relatively contained two-day affair, which was inclusive of closing submissions.

38. However, it remains that Ms Gaskill engaged counsel to appear at the entirety of the inquest. It would be artificial to consider that Ms Gaskill's participation in the inquest was only required for relevant portions of the inquest concerning the adequacy of the police investigation into Simon's death where her legal representatives were required to attend for the full two days (and preparation therefor).

39. Having weighed all of the circumstances outlined above, I determine that an award of costs against the Chief Commissioner in favour of Ms Gaskill is appropriate, and should be attributable to all of her legal expenses reasonably incurred in the inquest, and I so order.

ORDERS AND DIRECTIONS

40. Pursuant to section 74(2) of the *Coroners Act 2008* (Vic), I order the Chief Commissioner of Police pay the legal expenses reasonably incurred by Ms Gaskill in relation to the inquest into the death of Simon Christopher Gaskill.

41. I order that a copy of this ruling be published on the Coroners Court of Victoria website in accordance with rule 69 of the *Coroners Court Rules 2019* (Vic).

42. I direct that a copy of this determination be provided to the following:

    Ms Amanda Gaskill, c/Robinson Gill Lawyers

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

Signature:

INGRID GILES
CORONER

Date: 17 April 2026