IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 004416

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Mr ZJF
Date of birth:	[redacted]
Date of death:	5 August 2022
Cause of death:	1(a) Dextromethorphan toxicity
Place of death:	[redacted] Victoria, 3023

INTRODUCTION

1. On 5 August 2022, Mr ZJF was 27 years old when he was located deceased in his [redacted] home due to an apparent drug overdose.

2. Mr ZJF was born to parents Ms IWZ and Mr AJX and was raised alongside his brother in the St Albans area.

3. At 17 or 18 years of age, Mr ZJF stopped attending school. Ms IWZ observed he began smoking marijuana and drinking bottles of cough syrup, which contains the active ingredient dextromethorphan. She further recalled that became increasingly paranoid and was experiencing hallucinations.

4. Ms IWZ recalled of his personality:

> *'[Mr ZJF] had two personalities sometimes he was warm and would hug me and other times [he was] like someone who I don't know…he behaved suddenly, he switched into mental [instability] I could tell he wasn't in control [of] himself'.*

5. Mr ZJF's behaviour continued to deteriorate and around 2014, he attacked Ms IWZ with a knife. Ms IWZ contacted Victoria Police who attended and apprehended Mr ZJF. Despite that a Family Violence Intervention Orders (**FVIO**) was put in place, Ms IWZ recalled multiple instances where Mr ZJF nonetheless became abusive towards her.

6. Mr ZJF kept to himself and did not have many friends. His landlord, Calvin Chang (**Calvin**) recalls *'he was very, very, very lonely and isolated'.*

7. Around 2014, Mr ZJF was diagnosed with schizophrenia with a differential diagnosis of drug-induced psychosis and polysubstance use disorder. The same year, Mr ZJF first interacted with the criminal justice system and was charged with possession of cannabis. His criminal involvement continued throughout his life, involving a range of offences. He served multiple short periods of incarceration.

8. During the two years preceding his death, Ms IWZ recalls *'[Mr ZJF] was nicer to me, and the communication was better'.* However, she notes *'he was really upset and depressed, he would tell me he feels suicidal'* and further *'[he said] a few times he would kill himself'.* Mr ZJF told his mother that *'he loved drugs'* and did not want to cease use.

9. At the time of his death, Mr ZJF was subject to a Community Treatment Order under the *Mental Health Act 2014*, as then applied, which was overseen by the Royal Melbourne Hospital. He was most recently reviewed on 15 March 2022 where he appeared *'drowsy and possibly drug affected'* and admitted to ongoing heroin and benzodiazepine use. He reported that he experienced *'occasional suicidal ideation without any plan or intent'* and stated he *'[does not] feel anything anymore'.*

10. Mr ZJF was provided with renewed prescriptions for his anti-depressant and anti-psychotic medications, and clinicians planned to review him within a few weeks.

THE CORONIAL INVESTIGATION

11. Mr ZJF'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.

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

13. 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.

14. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr ZJF's death. The Coroner's Investigator conducted inquiries on the Court's behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

15. Coroner Audrey Jamieson initially held carriage of this investigation until it came under my purview in July 2023 for the purposes of obtaining additional material, finalising the matter and handing down findings.

16. This finding draws on the totality of the coronial investigation into the death of Mr ZJF 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.[1]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

17. On 2 August 2022, at 3:51am, one of Mr ZJF's neighbours, Daniel, contacted triple zero as Mr ZJF was *'having a breakdown'* and stated that he was *'stomping around the house and making weird sounds'.* At 8:18am, Victoria Police members arrived at the residence and after being unable to raise Mr ZJF, spoke with Daniel, who was noted to be *'extremely erratic and he possibly had some mental health issues'.*

18. The officers tried to locate Mr ZJF at the premises, however, he did not respond to the knock at the door, and so officers left the premises approximately 8 minutes after arrival.

19. Three days later, on 5 August 2022, the landlord was attempting to contact Mr ZJF as he had had not heard from him for over a month. At 5:52pm, the landlord contacted Victoria Police to conduct a welfare check. At 6:27pm, police arrived.

20. Attending members forced entry into Mr ZJF's residence and located him lying prone on his bedroom floor. Ambulance Victoria paramedics declared Mr ZJF deceased. Inside, members and the landlord noticed *'drug paraphernalia such as a spoon, needle, lighter and lots of light round pills on the ground'* and several empty bottles of cough syrup.

IDENTITY OF THE DECEASED

21. On 9 August 2022, scientist Dr Samantha Rowbotham (**Dr Rowbotham**) of the Victorian Institute of Forensic Medicine (**VIFM**) prepared an Identification Report noting that a fingerprint impression obtained from the deceased individual matched with fingerprint impressions previously obtained from Mr ZJF.

22. Coroner Audrey Jamieson reviewed the available evidence and determined that the cogency and consistency of all evidence relevant to identification supported a finding that the identity of the deceased was Mr ZJF, born 22 November 1994. Accordingly, her Honour signed a Determination by Coroner of Identity of Deceased (**Form 8**), dated 9 August 2022.

[1] 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.

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

MEDICAL CAUSE OF DEATH

24. Senior Forensic Pathologist Dr Brian Beer (**Dr Beer**) of the VIFM conducted an autopsy on the body of Mr ZJF on 15 August 2022. Dr Beer considered materials including the Victoria Police Report of Death for the Coroner (**Form 83**) and post-mortem computed tomography (**CT**) scan and provided a written report of his findings dated 25 November 2022.

25. The post-mortem examination revealed minor lacerations about the face including to the chin, inside the mouth, and to the hands and left hip. Dr Beer postulated these injuries were potentially due to Mr ZJF stumbling and falling in a confused and potentially psychotic state.

26. Toxicological analysis of post-mortem samples identified the presence of the following compounds:

Acetone	~ 21 mg/L
Dextromethorphan	~ 8.4 mg/L
Aripiprazole	~ 0.3 mg/L

27. Dr Beer commented that the presence of acetone is consistent with decompositional changes present and further the concentration of dextromethorphan was significantly elevated and within fatal ranges. Dextromethorphan is a synthetic form of codeine and is present in multiple over-the-counter cough syrups, tablets and capsules for its anti-tussive effects.

28. Dr Beer provided an opinion that the medical cause of death was 1(a) *dextromethorphan toxicity*.

29. I accept Dr Beer's opinion.

FURTHER INVESTIGATION

30. On the basis that Mr ZJF's death occurred proximate to contact with Victoria Police members, who had attended his residence three days prior to him being found deceased, the Court sought statements and materials from Victoria Police regarding its actions at the [redacted] residence on 2 August 2022 to assist in determining whether they complied with applicable Victoria Police policy and procedures.

Categorisation of the attendance to Mr ZJF and subsequent dispatch process

31. At 3:51am on 2 August 2022, Daniel placed a call to triple zero and requested an ambulance as:

> *'[Mr ZJF's] having a breakdown…[Mr ZJF] is next door is stomping around the house and making weird sounds…I think he needs to be triaged'.*

32. The triple zero call-taker asked Daniel whether he believed Mr ZJF to be attempting suicide and replied, *'I think so'* albeit he also conceded he was not with Mr ZJF at the time – given that he lived in the neighbouring property and did not have any direct observations.

33. At 3:51am, during a telephone call with an ambulance call-taker, Daniel started to exhibit paranoid behaviour and responders struggled to gather clear information, including Mr ZJF's last name, his precise location and his mental state at the time of the telephone call. When asked whether Mr ZJF was violent, Daniel responded '*mmm*'. When asked whether Mr ZJF had a weapon, Daniel responded '*mmm*' and then when further questioned '*what does he have?*', Daniel responded '*he's brought a couple of friends around and he goes and talks to people in the street then he brings them home and [indecipherable]*'. The ambulance call-taker redirected Daniel and again asked '*you said he has a weapon, what weapon would he have on him at the moment?*' with Daniel responding, '*oh I couldn't tell you*'.

34. During Daniel's telephone call, the ambulance call-taker selected the appropriate protocol *'Psychiatric/Abnormal Behaviour/Suicide Attempt'* and further entered Daniel's response in respect of the Structured Call Taking process. Due to Daniel's response that Mr ZJF may be violent, the corresponding Ambulance Event Type was generated indicating the possibility of violence, automatically generating *a 'multi-agency'* event that was simultaneously dispatched through to Victoria Police.

35. The priority of the event type was pre-determined by Ambulance Victoria (**AV**) and informed the required response that had been pre-assigned to the event in accordance with its Clinical Response Model (**CRM**). The priority assigned was '3' which under the ambulance dispatch process indicated a non-urgent event (most of which are sent through to Ambulance Victoria's Triage Service, REFCOMM,[2] for secondary triage by telephone). The priority of the event on

[2] REFCOMM is an AV service staffed by Triage Practitioners ('**TPs**') who are AV staff including paramedics, registered nurses and mental health triage nurses. Once an assessment has been completed by a TP, REFCOMM can update an event priority or response. REFCOMM can also provide self-care advice to the caller or refer them to alternative service

the Police system (not comparable to the ambulance system) was assigned a 'Priority 3' response, which is '*attend when able*'.

36. I am satisfied that the protocol selected by the ambulance call-taker and subsequent priority assigned was appropriate and in accordance with policy, given Daniel's disclosures in respect of what he knew of Mr ZJF's behaviour that morning, and noting the significant difficulties experienced by the ambulance call-taker in the Daniel's responses, which impeded their ability to comprehensively assess the situation.

37. At 3:54am, the event was accepted by the ambulance call-taker who presented the event to both the ambulance and police dispatchers. In respect of ambulance dispatch management, due to the event type and event priority assigned, the incident was deemed suitable for secondary triage by REFCOMM and therefore automatically held within Computer Assisted Dispatch (**CAD**) for 60 minutes to allow REFCOMM to further triage the event.

38. At 4:29am an AV Duty Manager (acting in the capacity of an AV Communications Support Paramedic) recorded in the event remarks 'AREA OF RESOURCE NEED' and that there was a 'CODE ORANGE' escalation in place, to communicate via CAD that there were no ambulance units available to attend the event. A 'Code Orange' is enacted by Ambulance Victoria when there are very limited or no ambulance resources available to attend to an event, which in this instance was in force from 6:09pm on 1 August to 7:30am on 2 August 2022.

39. At 4:55am, an AV Communications Support Paramedic instructed the ambulance dispatcher to hold the event to allow for ambulance resourcing to improve. The event was held until 5:41am during which time the ambulance dispatcher was not required to make efforts to dispatch (broadcast) the event.

40. At 5:41am, an AV Triage Practitioner called Daniel's telephone number with the intention of performing secondary triage. During that telephone call the Triage Practitioner asked, '*can you still hear him stomping around and yelling?'* to which Daniel replied '*He's been stomping around and … implying threats … towards my bambini … bambini is everything to me, yeah? … look, I don't want to talk any further. I've notified authorities about what is happening, and I won't compromise my bambini, mate … not for coin, not for nothing, I wouldn't compromise my bambini … but the bloke next door [indecipherable]*'.

providers, if after assessment, it has been identified that the event is suitable for such a response or than an emergency ambulance is not required.

41. Daniel then terminated the call. With no additional information forthcoming indicating a more urgent ambulance response was required, the event remained the same priority. Following this call, at 5:50am, the ambulance dispatcher was directed to hold the event pending allocation of day shift ambulance resources or for Victoria Police to attend the event.

42. At 6:41am, the ambulance dispatcher was directed to dispatch the event to the Albion-based ambulance day shift crew when they had logged on for their shift. The event was then held for twenty minutes.

43. At 6:48am, a different Triage Practitioner again called Daniel's phone to perform a welfare check call, as it had not been possible to dispatch an ambulance to the event within the requisite timeframe. Similar difficulties were encountered trying to obtain any further updates from Daniel in respect of whether Mr ZJF' behaviour was ongoing, and at 6:51am the TP recorded the following event remarks 'NEIGHBOUR HOSTILE AND ARGUMENTATIVE – NIL EXTRA INPUT RE: NEIGHBOURS BEHAVIOUR – EXPRESSING PARANOID THEMES HIMSELF'. Due to these ongoing and sustained difficulties elucidating a response from Daniel, I accept that REFCOMM was hindered in respect of effectively performing secondary triage in relation to this incident.

44. In respect of police dispatch management, at 4:02am, the Police event was dispatched to the Uniform Divisional Van Sunshine 309 however they were, at that time, occupied with other taskings and not in a position to immediately respond. At 5:35am, the Police dispatcher entered into CAD the notation 'NSS309 – PASS TO MORNING' indicating they had received an instruction that the Sunshine 309 unit did not have availability to attend prior to the conclusion of their shift, and the event would need to be allocated to the incoming 7:00am morning shift crew.

45. At 6:41am, this event was dispatched to the incoming morning shift crew, Sunshine 307, rostered that morning by Senior Constable (**SC**) Berny and First Constable (**FC**) Cook.

<u>Actions of Victoria Police during the Welfare Check on 2 August 2022</u>

46. At 7:00am, SC Berney telephoned Daniel to re-assess the situation. SC Berney stated that '*when I spoke with Daniel, he was non-sensical and stated multiple times that I should have heard of him and know him indicating prior involvement with police. Daniel could not answer the questions I posed to him about what he was hearing from his room-mate nor could he give me any information about his room-mate other than his name was Matthew. I asked Daniel*

multiple questions and each time he would go off on a tangent and speak about ASIO 'bugging' his apartment, that he currently had a Royal Commission investigation into Victoria Police and he was in contact with the Australian Federal Police about Italian organised crime'. SC Berney determined to *'attend a little later'* to allow Daniel time to *'settle down'.* At 7:08am SC Berney advised Police Communications with the following remark entered onto CAD, 'NSS307 – NONSENSICAL – WILL GO LATER IN DAY SO AS NOT TO DISTURB'.

47. At 7:23am, an ambulance dispatcher dispatched ambulance unit OP6136 to the event. This was a General Purpose Ambulance based in Oak Park and was 17.6km from the event location at the time of dispatch. At 7:25am, OP6136 marked themselves as *enroute* to the event on 'code 2' (i.e. no lights or sirens). At 7:57am, OP6136 marked themselves as on-scene and at 8.09am the ambulance dispatcher recorded a request for Victoria Police assistance from the on-scene paramedics due to there being an aggressive person on-scene (Daniel). Victoria Police were subsequently notified and immediately responded, with Sunshine 307 arriving on scene at 8.18am.

48. Records indicate that SC Berney and FC Cook spent approximately 8 minutes at the [redacted] residence during which time they spoke to Daniel and attempted to locate Mr ZJF. In respect of his interaction with Daniel, SC Berney states that '*Daniel was rambling and could not stay on topic bringing up his house is 'bugged' by ASIO and that his housemate was causing a lot of noise and that he recorded these interactions. When asked if he could provide the recordings Daniel became extremely evasive and had no recordings of what he was stating*'. Police members were also briefed by paramedics '*who informed that Daniel had approached them and was extremely erratic and he possibly had some mental health issues*'.

49. SC Berney then *' proceeded to the front door which was open and knocked on the door calling [Mr ZJF], Daniel became agitated and asked what I was doing. I could not hear any noise in the house, and no one made themselves known to me as I called out "[Mr ZJF]"'.*

50. SC Berney provided further evidence that he consulted the Law Enforcement Assistance Program **(LEAP)**, however it did not show anyone name 'Mr ZJF' or 'Matthew' being linked to the address. Upon further questioning, Daniel could not provide any other information about Mr ZJF other than his mother was living overseas, and he did not have a contact number for either Mr ZJF or his mother. FC Cook concluded:

> *'It did not appear anyone else was residing at the address'.*

Assessment of conduct of Victoria Police

Welfare check conducted on 2 August 2022

51. When assessing the conduct of Victoria Police and the adequacy of the welfare check conducted on the morning of 2 August 2022, I am conscious of the need to avoid hindsight bias (the tendency to perceive past events as more predictable or foreseeable than they actually were, based on the known outcome).

52. It is important to note that at the time, Victoria Police was aware of the 3:51am telephone call placed by Daniel reporting that his housemate, '*Mr ZJF'*, was '*stomping around'* but that Daniel was unable to provide any further relevant information that was relayed during the initial phone call.

53. The actions of Victoria Police officers are governed by Victoria Police Manuals (**VPM**), however, there is no VPM directly related to welfare checks or how they ought to be conducted. Nonetheless, officers receive training on duties including processes involved when responding to a request for a welfare check. Accordingly, Victoria Police officers are required to draw on experience and exercise professional discretion.

54. SC Berney and FC Cook had three options available to them that morning whilst conducting the welfare check, based on the information available to them, and that they were unable to raise anyone at Mr ZJF's premises:

    a) Force entry; or

    b) Continue knocking until someone could be raised (assuming a person was home); or

    c) Depart having satisfied themselves there did not appear to be any immediate concerns for welfare.

55. In considering whether SC Berney and FC Cook ought to have forced entry into the [redacted] residence to further their attempts to locate Mr ZJF, I note the following. Victoria Police have the power to forcibly enter a property derived from two sources.

56. Firstly, the VPM relating to 'Searches of Properties' provides:

'Police have a common law power to enter any premises to search for suspected ill, injured or deceased persons when they believe on reasonable grounds that entry is necessary to provide assistance'.

57. Alternatively, section 353 of the *Mental Health Act 2014*, as then applied, provided Victoria Police with the power to use reasonable force to enter a premises to apprehend a person. Prior to adopting reasonable force, officers had to be satisfied that the criteria for apprehension under section 351 would apply to that person. On the factual circumstances as they presented themselves, I do not consider that exercise of the power under section 353 was indicated.

58. Further, the common law power requires Police members *to believe on reasonable grounds that entry is necessary to provide assistance.* I accept that there was an insufficient basis to form the belief to the requisite standard, including:

    a) Absence of a specific threat of suicide or self-harm, noting at its highest all that was available was Daniel's assessment approximately 4:00am that Mr ZJF was '*having a breakdown*' and that he could hear him stomping around and yelling, which was a reported to be a frequent occurrence; and

    b) No evidence available that Mr ZJF was actually inside the premises at the relevant time, with Police members having exhausted all available enquiries to contact him.

59. I therefore accept that neither the common law power nor the *Mental Health Act* was available to the Police members on the basis of the information that they had available to them. Further, the Police members had no information in respect of Mr ZJF's surname, date of birth or contact details to make further enquiries or any evidence that there was a 'Mr ZJF' or 'Matthew' linked to that specific address.

<u>Collection and Storage of Body Worn Camera Footage from 2 August 2022</u>

60. During the attendance upon the [redacted] Residence on 2 August 2022, SC Berney and FC Cook activated their Body Worn Cameras (**BWC**) that captured their subsequent interaction with Daniel and Ambulance Victoria paramedics as well as their conduct in attempting to raise Mr ZJF. Upon returning to Sunshine Police Station and being uploaded, the footage was categorised as *'non-evidentiary'* and retained only for a 90-day period following recording. It had been deleted by the time I requested the footage from Victoria Police and was therefore not available to assist the coronial investigation.

61. SC Berney and FC Cook referred to their decision to categorise the BWC footage as *'non-evidentiary'*:

> *'No criminal offences [were] disclosed or identified by [Daniel] or neighbours. The most appropriate category I believed was non-evidentiary, I categorised the footage as such'.*

62. The relevant policies in force on 2 August 2022 were (i) VPM Body worn cameras (version date 17 February 2022); and (ii) Body Worn Camera Operational Guidelines v4.0 (8 December 2020).

63. The VPM stated that '*during the station evidence management process, members are responsible for reviewing, categorising and adding metadata to their BWC footage*' with subsequent reference being made to '*metadata, tagging and categorisation of footage are fully detailed in the BWC Operational guidelines*'.

64. The Body Worn Camera Operational Guidelines states the following of relevance with respect to categorising BWC footage:

    a) *'Members are required to categorise footage according to the guidelines outlined below. These categories drive the underlying retention periods for footage … …'*;

    b) The available categories were dependent on the nature of the attendance and activities captured and included:

        i. Fatality all types
        ii. Sex Offences
        iii. Professional Standards Command
        iv. Hazmat
        v. Major – Crime
        vi. Serious Injury Incident/Collision
        vii. Family Violence
        viii. Use of Force
        ix. Indictable Other
        x. Summary Brief
        xi. Other Summary
        xii. RSA Impairment Assessment
        xiii. Non-Evidentiary
        xiv. Pending Review

65. Assessing the available categories, it is understandable given the circumstances of their attendance the decision of the Police members to classify their BWC footage as *'non-evidentiary'* (given no other category at the time appeared to be applicable and the

accompanying instructions with respect to this classification included the notation '*none of the above'*).

66. What is also explicitly stated within the Operational Guidelines is that footage categorised as non-evidentiary would be permanently deleted after 90 days.

67. It is unclear however, whether BWC footage of Victoria Police attendance at incidents broadly referred to as *'welfare checks'* could be appropriately categorised as *'non-evidentiary'*. The activation of BWCs serves the twin purposes of collecting evidence and of providing transparency of Victoria Police interactions with the public.

68. Whether or not BWC footage holds evidentiary value is not always immediately apparent, as events can occur in the subsequent days or weeks which may render its contents probative in a multitude of ways. Indeed, these developments can occur far beyond 90 days following capture of the BWC footage.

69. At the time of downloading, there was nothing within either SC Berney or FC Cook's knowledge that would have caused them to classify their BWC any differently. It was not until three days later that Mr ZJF was located deceased within his residence following a concern for welfare being raised by his landlord who stated he had been unable to get in contact with him.

70. It is regrettable that the Police members who initially had carriage of this investigation did not turn their minds to the potential probative value of this BWC footage from three days earlier (noting the current Coroner's Investigator did not take carriage until 1 December 2022 when the matter was transferred to the Brimbank Criminal Investigation Unit). The responding police, when Mr ZJF was located deceased, were aware of this interaction three days earlier, with SC Sarwar stating in his evidence that '*also present at the scene was the male occupant who resided at [address] who stated that he had rung triple zero a few days ago after hearing commotion from [Mr ZJF's premises]. He further stated that Police had attended that day after he had made the triple zero phone call*'.

71. Regrettably, there appears to have been an oversight in terms of the Police member or members with initial carriage of the investigation, to turn their minds to the existence of BWC that may have captured recent police contact with Mr ZJF (or in this circumstance, Daniel), which was probative to the coronial investigation, yet which has been permanently lost due to the footage classification.

72. Since 2 August 2022, there has been a material change with respect to the relevant policies in force regarding categorisation and retention of BWC footage. The BWC Operational Guidelines have been superseded by the Victoria Police – Body Worn Camera Practice Guide (current version July 2023) which now includes the following additional category regarding categorisation of BWC footage:

Category	Notes	Retention period
Mental health event	All mental health events including: • s.351 and s.352 • VPeR • Welfare checks • AV assist • Voluntary attendance	7 years

73. Police members were responding to a telephone call where it had been stated Mr ZJF was '*having a breakdown*' and could be heard stomping around and yelling. In this context, their attendance, were it to repeat itself today in identical circumstances, would be classifiable as a 'mental health event' (welfare check) with the BWC footage retained for 7 years (and subsequently available to assist the coroner's investigation).

74. This will be contingent on members adopting the broad interpretation of 'mental health event' noted above, which is more expansive than, for example, simply transporting a person under section 232 of the *Mental Health and Wellbeing Act 2022*, the precursor of which was section 351 *Mental Health Act 2014* (still referred to in the current Practice Guide). In circumstances in which police attend for a welfare check that is potentially mental-health related, as for Mr ZJF, but where they did not ultimately sight the person in question, it is unclear whether BWC footage would be retained under this category.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Mr ZJF , born [redacted];

    b) the death occurred on 5 August 2022 at [redacted] Victoria, 3023, from dextromethorphan toxicity; and

    c) the death occurred in the circumstances described above.

76. I have considered all of the available evidence including that Mr ZJF had an extended history of substance use and of mental ill health. Despite that he had expressed suicidal ideation as recently as March 2022, the paucity of evidence relating to his mental state in the immediate lead-up to his death means that I am unable to make a finding as to whether Mr ZJF ingested the substance which led to his death with the intention to end his own life.

77. I have further considered the actions of Victoria Police officers who attended upon Mr ZJF's residence to conduct a welfare check on 2 August 2022. I note there was a scarcity of information available to attending officers and there were concerns as to the account provided by the person who had dialled '000'.

78. I find that, based on the information known to them at the time, police members responded appropriately and in accordance with the relevant Victoria Police procedures. While it is unfortunate that Mr ZJF was located deceased three days after police attendance, there was no basis upon which police ought to have escalated their intervention at the time of their initial attendance.

79. While I consider that no adverse comment is warranted, the circumstances in the lead-up to the death of Mr ZJF highlight a systems issue upon which I make comment below.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments on matters connected with the death:

1. I consider that the Body Worn Camera (**BWC**) Operational Guidelines were relatively basic in the guidance provided for police members regarding the categorisation of BWC footage obtained on 2 August 2022, which was marked as non-evidentiary and automatically deleted after a 90-day period. It is unfortunate indeed that the footage was not re-categorised, and thereby the retention period extended, by Victoria Police upon learning of Mr ZJF's death three days later. While statements collected during the course of the coronial investigation have provided context to Mr ZJF's life and death, that the footage was destroyed represents a lost opportunity to better understand the actions of police in attending upon the residence of Mr ZJF prior to him being located deceased.

2. To this end, a potential criminal investigation is not the only basis upon which BWC footage may be considered to have 'evidentiary' value. Such footage is often also critical to a coronial investigation, and police members, who are often tasked with investigating criminal matters but who may investigate only one or two coronial matters over the course of their careers, ought to be assisted in this task with appropriate guidance in relation to the same.

3. However, I note that since 2 August 2022, there has been a material change with respect to the relevant policies in force regarding categorisation of BWC footage and that 'mental health event' has been included in the relevant Practice Guide as an additional evidentiary category, entailing retention of BWC footage for 7 years. Reflecting on the circumstances that preceded Mr ZJF's death, I consider this to be a positive development and encourage Victoria Police to ensure its members adopt a broad interpretation of BWC footage that might fall within this category.

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

ORDERS AND DIRECTIONS

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:

Ms IWZ and Mr AJX, Senior Next of Kin

The Chief Commissioner of Police

Ambulance Victoria

Detective Senior Constable Shana Famularo, Coroner's Investigator

Signature:

Coroner Ingrid Giles

Date: 16 June 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.