IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 003594

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Mr ZS
Date of birth:	[redacted] 1966
Date of death:	On or between 12 March 2025 and 26 June 2025
Cause of death:	1a: ISCHAEMIC HEART DISEASE 1b: CORONARY ARTERY ATHEROSCLEROSIS
Place of death:	87/180 Mills Street Albert Park Victoria 3206
Keywords:	DFFH housing, public housing, natural causes, welfare check, rental arrears, social isolation

INTRODUCTION

1. On 26 June 2025, Mr ZS was 58 years old when he was found deceased on a welfare check performed by members of Victoria Police. At the time of his death, Mr ZS lived alone in housing owned and managed by the Department of Families, Fairness and Housing (**DFFH**) in Albert Park, a suburb of Melbourne, Victoria.

2. Mr ZS had been residing as a tenant of the DFFH property since 14 January 2024 and had not previously been a resident in government-managed public housing.

3. Mr ZS had last been seen alive by a DFFH worker on 1 February 2025. Sadly, by the time he was found deceased on 26 June 2025, he was heavily decomposed, and it appeared to first responders that he had been deceased for some time.

THE CORONIAL INVESTIGATION

4. Mr ZS'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 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 an officer to be the Coronial Investigator for the investigation of Mr ZS's death – Senior Constable Harley Bruem (**SC Bruem**). The Coronial Investigator conducted inquiries on my behalf, including providing a helpful chronology of Mr ZS's last known movements and an outline of the investigation conducted by police following his death.

8. This finding draws on the totality of the coronial investigation into the death of Mr ZS. 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]

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

Circumstances in which the death occurred

9. On 26 June 2025, police members attended Mr ZS's Albert Park address for a welfare check with his DFFH worker, who was in possession of an Eviction Notice from the Victorian Civil and Administrative Tribunal (**VCAT**). Police members entered using the master keys provided by the DFFH worker.

10. Police members located a person at the property who was clearly deceased, and heavily decomposed. The apartment itself was observed to be neat and orderly.

11. Police members noted that, due to decomposition, the deceased's identity could not immediately be confirmed.

12. They conducted an investigation of the apartment and found a bank statement located on table inside, displaying a date of last transaction of 28 February 2025, and yoghurt in fridge with the expiry date as 11 March 2025. A calendar in the lounge room was flipped to March 2025.

13. Police did not identify any suspicious circumstances.

Identity of the deceased

14. On 11 July 2025, Mr ZS, born [redacted] 1966, was formally identified via fingerprint comparison.

15. Identity is not in dispute and requires no further investigation, aside from the commentary below under 'Issue Two'.

[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.

Medical cause of death

16. Forensic Pathologist Dr Brian Beer (**Dr Beer**) from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 1 July 2025 and provided a written report of his findings dated 14 August 2025.

17. The post-mortem examination revealed marked decomposition changes with the only significant finding being of severe left descending coronary artery atherosclerotic stenosis.

18. There were no injuries found at autopsy that may have caused or contributed to the death.

19. Toxicological analysis of post-mortem samples identified the presence of ethanol (alcohol) at 0.12 g/100mL, but Dr Beer noted that, in a decomposed body, this should not be regarded as significant. Prescription drugs were also detected at non-toxic levels, and there was evidence of cannabis use.

20. Noting the extent of decomposition, and on the balance of probabilities, Dr Beer provided an opinion that the medical cause of death was *1(a) ischaemic heart disease, 1(b) coronary artery atherosclerosis*.

21. Dr Beer opined that the death was due to natural causes.

22. I accept Dr Beer's opinion.

FURTHER INVESTIGATIONS

23. As Mr ZS's death was due to natural causes, I initially considered the investigation I would undertake would be fairly circumscribed. However, two issues arose during the course of the proceedings that required additional investigation and clarification.

Issue One – Contact with DFFH in lead-up to Mr ZS's death

24. Given that Mr ZS was in a DFFH-managed property at the time of his death, and his body was not found for some months, I considered it appropriate to investigate what contact and supports Mr ZS had been provided by DFFH in the lead-up to being found deceased, if any.

25. A very comprehensive and considered statement dated 12 June 2026 was provided by Ms Taanya Gounas (**Ms Gounas**), Executive Director, Bayside Peninsula Area, South Division of DFFH.

26. Therein, Ms Gounas noted that Mr ZS had resided in his DFFH-managed flat pursuant to a public housing tenancy only, which relates to the provision of accommodation and does not give rise to the provision of any health or other services.

27. Upon commencement of his tenancy in January 2024, Mr ZS made a payment of two weeks' rent at the post office. Ms Gounas explained that renters are requested to make this one-off payment to ensure accounts are always paid on time and do not fall into arrears. Mr ZS entered into an arrangement thereafter by which his fortnightly rental payments would be automatically debited from his Centrelink account.

28. Unfortunately, due to an administrative error that was no fault of Mr ZS's, his first fortnightly automatic payment from Centrelink was not received by the DFFH until three Sundays had passed, placing him in a small amount of rental arrears, a situation which unfortunately persisted during his entire tenancy.

29. Mr ZS's last direct debit to DFFH in relation to his usual rental payment was received on 13 March 2025, with no monies paid thereafter.

30. Given that Mr ZS's rent was deducted via Centrelink, I conducted further investigations with Services Australia as to activity on his account. I was advised that as a JobSeeker recipient, Mr ZS had an obligation to report earnings on a fortnightly basis, and he had last reported earnings on 12 March 2025. Following this date, his rental payments appear to have ceased, and he fell into further arrears.

31. On 16 April 2025, a DFFH housing services officer sent Mr ZS a letter and rental statement in relation to the arrears on his account.

32. On 23 April 2025, a DFFH housing services officer sent Mr ZS another rental statement in relation to arrears after an attempt was made to telephone him to discuss his arrears, however his phone had been disconnected.

33. On 30 April 2025, a DFFH Housing Services Officer sent a Notice to Vacate for arrears as Mr ZS had not been contactable.

34. No direct contact (such as via a visit or welfare check) occurred during this time, which DFFH has acknowledged is contrary to its 'Home visits and inspection in public housing operational guidelines' (**guidelines**) in "*making or establishing contact with tenants regarding an identified issue or concern*".

35. Given that Mr ZS had consistently paid his rent from January 2024 up until March 2025, it is concerning that the Housing Services Officer did not consider that there might be issues regarding Mr ZS's welfare, and that he was in fact sought to be evicted from his home without any contact from DFFH, in contravention of its guidelines. While it is possible that earlier contact with Mr ZS (including via forced entry on a welfare check) may have led to a different outcome for him, I consider this to be speculative and unable to be established on the evidence.

36. However, it would invariably have resulted in Mr ZS's death being detected earlier and may have reduced the distress of his sister, as well as that of the DFFH worker and police members in attendance.

Issue Two – Delay in Notifying Senior Next of Kin

37. Per the usual Victoria Police process, following a deceased person being located, efforts were made to identify next of kin in order to deliver a death message. For reasons that are beyond the scope of my inquiry, and which have been dealt with by way of a separate process, there was a significant delay in Mr ZS's sister being notified of his death.

38. Indeed, while Mr ZS was formally identified on 11 July 2025, Mr ZS's sister was not notified of Mr ZS's death until 14 November 2025, by which time his personal possessions had already been removed from his property, as there was no next of kin known to DFFH. The totality of this state of affairs understandably caused her great distress.

39. While I note that these issues have appropriately been dealt with through a parallel process, it is of concern that this is not the first time such a delay has occurred – to the great distress of family – and that there remains scope for clarification of processes that attend upon the discovery of a deceased person who cannot be identified at the scene, and the subsequent notification to family where the next of kin is not immediately apparent.

40. On 17 April 2026, following an Inquest in an unrelated matter,[2] I made the following recommendation:

> *That the Chief Commissioner of Victoria Police, in consultation with the Coroners Court of Victoria, the Coronial Support Unit (formerly known as the Police Coronial Support Unit), and the Coronial Admissions and Enquiries Office of the Victorian Institute of Forensic Medicine, review guidance materials provided to police members on unidentified human remains to clarify the processes to be followed where the identity of the*

[2] Finding into the death with Inquest of Simon Gaskill, 17 April 2026, Coroner Ingrid Giles, p. 105, available here.

> *deceased is suspected, but cannot be formally identified at the scene, and where forensic identification tests are required to be undertaken. This should include information about the steps to be taken for notifying family members of the suspected death where the identity of the deceased is believed to be ('BTB') a particular person (including requests for DNA samples) […].*

41. The Court received a response today to the recommendation from the Chief Commissioner of Police, which will be published on the Court's website, noting that the recommendation is supported in-principle though there are unresolved issues to address that will require a 12-month timeframe for resolution.

42. I consider this recommendation to be apposite as it relates to the circumstances of Mr ZS's death and post-death investigations, and consider that clarification of identification processes in the manner contemplated in this recommendation will be of great benefit to families and also better assist coroners in the discharge of their statutory duties, including as to make timely determinations regarding identity. I have elected to notify the present finding to the Chief Commissioner of Police in order to inform its further consideration of the relevant issues over the next 12 months.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Mr ZS, born [redacted] 1966;

    b) the death occurred on or between 12 March 2025 and 26 June 2025 at Albert Park Victoria 3206, from *1(a) ischaemic heart disease, 1(b) coronary artery atherosclerosis*.

    c) the death occurred in the circumstances described above.

44. Having considered all of the evidence, I cannot make a finding with any certitude as to the precise date upon which Mr ZS died, nor the details of what occurred in the lead-up up to his death. However, following an investigation into Mr ZS's last known movements and transactions on his various accounts, I find that the evidence supports that the appropriate date range for Mr ZS's death, on the balance of probabilities, is a date on or between 12 March 2025 (when he last reported his income to Centrelink) and 26 June 2025 (the date he was found deceased).

45. Having considered all of the circumstances, I am satisfied that Mr ZS's death was due to natural causes, and that there are no suspicious circumstances or direct prevention opportunities.

46. However, my investigation has highlighted the importance of adherence to processes regarding contact with residents of government-managed public housing where an issue has been identified with their tenancy, as occurred with Mr ZS's.

47. While I find that the contents of the very considered statement provided on behalf of the Department of Families, Fairness and Housing (**DFFH**) obviate the need for any coronial recommendations (noting the processes in place for contact with renters when there is an apparent tenancy issue, and strengthened processes in place for terminations of residential tenancy agreements), I remain concerned and saddened that a member of our community died alone in circumstances where there ought to have been systems in place to, at the very least, trigger contact with him to ascertain any reasons why there might have been difficulties paying rent. In Mr ZS's case, he was falling further and further behind on his rental payments because he was, sadly, deceased.

48. To this end, and while not casting blame on any person involved, I urge DFFH to remind its staff of the importance of strict adherence to its current set of policies and procedures, noting that residents of public housing are, at times, vulnerable members of our community and that robust processes for checking in on them when something has gone awry with a tenancy can be critical to their wellbeing, and reflects their dignity and worth.

I offer my most sincere condolences to Mr ZS's sister and acknowledge the distressing journey she has faced following the death of her brother.

ORDERS AND DIRECTIONS

I direct that a de-identified copy of 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:

Mr ZS's sister, Senior Next of Kin

Department of Families, Fairness and Housing

Centrelink (Services Australia)

Chief Commissioner of Police

Senior Constable Harley Bruem, Coronial Investigator

Signature:

INGRID GILES

CORONER

Date: 10 August 2026

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.