IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 4333

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**Coroner Darren J. Bracken**
Deceased:	**Anthony Sean Jenkins**
Date of birth:	4 June 1968
Date of death:	30 August 2017
Cause of death:	Hypoxic ischaemic brain injury complicating neck compression in the circumstances of hanging
Place of death:	University Hospital Geelong, 322 Ryrie Street, Geelong, VIC 3220

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HIS HONOUR:

BACKGROUND

1. On 30 August 2017 Anthony Sean Jenkins was 49 years old when he was pronounced deceased at University Hospital Geelong. Mr Jenkins worked at Civil Force in Newtown and was living in a house owned by his brother Nicholas in St Albans Park. Mr Jenkins had been in a de facto relationship with Ms Ruth McClure for approximately seven years and had two children from that relationship, a son, Clinton, and a daughter, Shiloh.

2. Mr Jenkins separated from Ms McClure in approximately 2012 and Ms McClure moved to Deer Park, Victoria with their two children. Mr Jenkins spent time with his children when they visited him once a month.[1]

3. Mr Jenkins regularly socialised with friends, in particular Matthew O'Brien and Hilton Henderson. He also saw his brother Nicholas, two to three times a week. Mr Jenkins was known by his family and friends to be a "*functioning alcoholic*".[2]

4. On 3 August 2017, Shiloh alleged to Ms McClure that between the ages of three and eight years of age, Mr Jenkins had committed a number of indecent acts on her during visits to his home in Newtown. On 11 August 2017, Ms McClure reported these allegations to the Victoria Police Sexual Offences and Child Abuse Investigation Team (**SOCIT**) based in Brimbank who then notified Detective Senior Constable Amanda Evans (**DSC Evans**) of the Geelong SOCIT.[3]

5. DSC Evans met with Ms McClure on 22 August 2017 to obtain a statement and more details regarding the nature of allegations.[4]

6. On 23 August 2017 at approximately 6.55pm, DSC Evans and Detective Sergeant Young attended Mr Jenkins' home in St Albans Park to interview him in relation to these allegations. Mr Jenkins invited the detectives into the shed at the rear of his property where he was watching television and drinking beer.[5]

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[1] Statement of Nicholas Andrew Jenkins dated 5 September 2017, Coronial Brief, 16.
[2] Statement of Nicholas Andrew Jenkins dated 5 September 2017, Coronial Brief, 17.
[3] Statement of Detective Senior Constable Amanda Evans dated 5 September 2017, Coronial Brief, 13.
[4] Statement of Detective Senior Constable Amanda Evans dated 5 September 2017, Coronial Brief, 13.
[5] Statement of Detective Senior Constable Amanda Evans dated 5 September 2017, Coronial Brief, 13.

7. DSC Evans told Mr Jenkins of Shiloh's allegations. Mr Jenkins was calm and composed and told DSC Evans that he believed that his former partner, Ms McClure, was "*behind this*".[6]

8. Mr Jenkins told DSC Evans that he was an alcoholic and that he had been drinking that day since arriving home at approximately 5pm. DSC Evans noted that while he did not appear to be intoxicated, he was possibly affected by his consumption of alcohol and made arrangements for him to go to the Geelong Police station on the following Saturday, at 3.00pm on the 26th to be interviewed about the allegations. Mr Jenkins told DSC Evans that he would cooperate with the investigation and DSC Evans gave him information regarding where he could obtain legal advice. DSC Evans and DS Young left Mr Jenkins home at approximately 7.10pm.[7]

THE PURPOSE OF A CORONIAL INVESTIGATION

9. Mr Jenkins' death constituted a '*reportable death*' pursuant to section 4 of the *Coroners Act* (2008) (Vic) (the **Act**); the death occurred in Victoria, was unexpected and was not from natural causes.[8]

10. The Act requires a Coroner to investigate reportable deaths such as Mr Jenkins' and, if possible, to find the:

    (a) identity of the deceased.

    (b) the cause of death and

    (c) the circumstances in which death occurred.[9]

11. For coronial purposes, '*circumstances in which death occurred*'[10] refers to the context and background the death including the surrounding circumstances. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, required findings in relation to circumstances are limited to those circumstances which are sufficiently proximate to be considered relevant to the death.

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[6] Statement of Detective Senior Constable Amanda Evans dated 5 September 2017, Coronial Brief, 14.
[7] Statement of Detective Senior Constable Amanda Evans dated 5 September 2017, Coronial Brief, 14.
[8] *Coroners Act 2008* (Vic) s 4.
[9] *Coroners Act 2008* (Vic) preamble and s 67.
[10] *Coroners Act 2008* (Vic) s 67(1)(c).

12. The Coroner's role is to establish facts, rather than to attribute or apportion blame for the death.[11] Neither is it the Coroner's role to determine criminal or civil liability,[12] nor to determine disciplinary matters.

13. One of the broader purposes 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 making recommendations.

14. Coroners are also empowered to:

    (a) report to the Attorney-General on a death;[13]

    (b) comment on any matter connected with the death investigated, including matters of public health or safety and the administration of justice;[14] and

    (c) make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[15]

15. Coronial findings must be underpinned by proof of relevant facts on the balance of probabilities.[16] The strength of evidence necessary to so prove facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[17]

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 demand a weight of evidence commensurate with the gravity of the facts sought to be proved.[18] Facts should not be considered to have been proved on the balance of probabilities by inexact proofs, indefinite

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[11] *Keown v Khan* (1999) 1 VR 69.
[12] *Coroners Act 2008* (Vic) s 69 (1).
[13] *Coroners Act 2008* (Vic) s 72(1).
[14] *Coroners Act 2008* (Vic) s 67(3).
[15] *Coroners Act 2008* (Vic) s 72(2).
[16] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[17] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J but I note that His Honour was referring to the correct approach to the standard of proof in a civil proceeding in a federal court with reference to section 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at 170-171 per Mason CJ, Brenna, Deane and Gaudron JJ.
[18] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336, referring to *Barten v Williams* (1978) 20 ACTR 10; *Cuming Smith & Co Ltd v Western Farmers Co-operative Ltd* [1979] VR 129; *Mahon v Air New Zealand Ltd* [1984] AC 808 and *Annetts v McCann* (1990) 170 CLR 596.

testimony, or indirect inferences,[19] rather such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[20]

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

Identity of the Deceased - Section 67(1)(a) of the Act

17. On 30 August 2017, Lynette Jenkins identified the body of the deceased as her son Anthony Sean Jenkins born 4 June 1968.

18. Mr Jenkins' identity is not disputed and requires no further investigation.

Cause of death - Section 67(1)(b) of the Act

19. On 31 August 2017 Dr Victoria Francis, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an external examination upon Mr Jenkins' body and provided a written report, dated 4 September 2017, in which she opined that a reasonable cause of death was "*hypoxic ischaemic brain injury complicating neck compression in the circumstances of hanging*". I accept Dr Francis' opinion.

20. Toxicological analysis of ante mortem specimens detected significant levels of ethanol (alcohol) (0.20 g/100ml) and Midazolam[21] (0.07 mg/L). Post mortem specimens also detected Midazolam[22] (0.7 mg/L), Clonazepam[23] (0.01 mg/L) and its metabolite 7-Aminoclonazaepam (0.1 mg/L), Morphine[24] (0.1 mg/L), Levetiracetam[25] (1.2 mg/L) and Paracetamol[26] (16 mg/L).

21. Dr Francis commented that blood alcohol concentrations in excess of 0.15g/100ml can cause considerable depression of the central nervous system affecting cognition and capable of producing adverse behavioural changes.

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[19] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.
[20] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.; *Cuming Smith & CO Ltd v Western Farmers Co-operative Ltd* [1979] VR 129, at p. 147; *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at 170-171 per Mason CJ, Brenna, Deane and Gaudron JJ.
[21] Midazolam is a short acting benzodiazepine used intravenously in intensive care patients.
[22] Midazolam was administered at University Hospital Geelong as part of palliative care treatment.
[23] Clonazepam is a benzodiazepine related to diazepam possessing sedative and anticonvulsant properties.
[24] Morphine was administered at University Hospital Geelong as part of palliative care treatment
[25] This is an anticonvulsant medication and is administered to treat possible seizures or myoclonic activity.
[26] This is a pain relief medication

22. Dr Francis also commented that it is likely that most of the above drugs were administered as part of medical treatment Mr Jenkins received after his body was discovered, and this has been confirmed by the treating medical practitioners from University Hospital Geelong.[27]

Circumstances in which the death occurred - Section 67(1)(c) of the Act

23. On Friday 25 August 2017 at approximately 3.30pm, Mr Jenkins' close friend and work colleague Mr O'Brien visited Mr Jenkins at his home. Mr Jenkins told Mr O'Brien that the police had been around to see him earlier in the week about allegations made by his daughter and that he needed to speak with the police. Mr O'Brien observed Mr Jenkins to be upset about having to go and see the police and blamed Ms McClure for the police investigation.[28]

24. At approximately 1.00pm the next day Mr O'Brien went to Mr Jenkins' home to drink with him. Mr O'Brien queried Mr Jenkins on how his call to the police went and Mr Jenkins said that the police officer he had spoken to didn't start work until 2pm. At around 2pm, Mr Jenkins called DSC Evans and said that he wanted to re-schedule the appointment to 9.00am on Sunday 27 August 2017.[29] Mr O'Brien was unaware that Mr Jenkins had made that telephone call to the police and left at around 3.00pm to 3.30pm.[30]

25. At approximately 4.27pm on the same day, Mr Jenkins rang his brother Nicholas to arrange to go to Nicholas' house and drink a few beers. Mr Jenkins arrived at his brother's home at around 5.30pm and Mr Jenkins' brother observed that Mr Jenkins was "*quieter than usual but nothing else stood out*".[31] Messrs Jenkins drank beer together until around 6.15pm when Mr Jenkins left returning home.[32]

26. Between 6.44 pm to 6.45pm, Mr Jenkins took a series of photographs of notes that he had apparently written and arranged on a table in the rear shed of his home. These notes were addressed to his friends and family. In particular, in his note to his parents, Mr Jenkins wrote *"I can't handle the latest shit, I haven't slept for 3 days"*.[33]

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[27] Dr Paul Mestitz medical report dated 3 November 2017, Coronial Brief, 44.
[28] Statement of Matthew Michael O'Brien dated 7 September 2017, Coronial Brief, 19.
[29] Statement of Detective Senior Constable Amanda Evans dated 5 September 2017, Coronial Brief, 14.
[30] Statement of Matthew Michael O'Brien dated 7 September 2017, Coronial Brief, 20.
[31] Statement of Nicholas Andrew Jenkins dated 5 September 2017, Coronial Brief, 17.
[32] Statement of Nicholas Andrew Jenkins dated 5 September 2017, Coronial Brief, 17.
[33] Anthony Sean Jenkins suicide note addressed to his parents and dated 26 August 2017, Coronial Brief, 80; Photographs extracted from Anthony Sean Jenkins mobile phone, Coronial Brief, 86-89.

27. Analysis of Mr Jenkins' mobile phone showed that Mr Jenkins took photos of himself and his dog in his rear shed between 8.15am and 8.16am on 27 August 2017.[34]

28. Mr Jenkins had a standing arrangement with a close friend, Hilton Henderson, to attend the Sunday morning market. At approximately 8.42am on Sunday 27 August 2017, Mr Henderson arrived at Mr Jenkins' home to collect him. Not finding Mr Jenkins in the rear shed where they normally drank beer, Mr Henderson noticed the handwritten notes on a table and began to search for Mr Jenkins whom he shortly found hanging from a beam in the garage.[35] Mr Jenkins was unconscious.

29. Mr Henderson cut the rope holding Mr Jenkins and lowered him to the floor. He rang emergency services and was instructed to commence cardiopulmonary resuscitation (**CPR**). At approximately 8.55am police arrived at the scene and assisted Mr Henderson with CPR.[36]

30. Paramedics arrived at approximately 9.00am and continued CPR. About 15 minutes later, a pulse was detected in Mr Jenkins' body and he was transported to the University Hospital Geelong where he was admitted into the intensive care unit.[37]

31. Mr Jenkins did not regain consciousness and life support was withdrawn in consultation with his family at 4.00pm on 30 August 2017. He was pronounced deceased at 4.17 pm. Police were notified attended the hospital and took photographs of Mr Jenkins including of ligature marks on the right side and front of his neck.[38]

32. I find that Mr Jenkins died on 30 August 2017 in circumstances where he intended to take his own life.

33. I am satisfied, having considered all of the available evidence, that no further investigation into Mr Jenkins' death is required.

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[34] Photographs extracted from Anthony Sean Jenkins mobile phone, Coronial Brief, 86-88.
[35] Statement of Hilton John Henderson dated 27 August 2017, Coronial Brief, 24.
[36] Statement of Hilton John Henderson dated 27 August 2017, Coronial Brief, 24; Statement of Senior Constable Rodan Smith dated 8 September 2017, Coronial Brief, 26.
[37] Statement of Senior Constable Rodan Smith dated 8 September 2017, Coronial Brief, 27; Statement of Detective Sergeant Craig Dooley dated 19 October 2017, 46.
[38] Statement of Detective Sergeant Craig Dooley dated 19 October 2017, 46; Dr Paul Mestitz medical report dated 3 November 2017, Coronial Brief, 43.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

34. A finding of suicide can impact upon the memory of a deceased person and can reverberate throughout a family for generations. Such a finding should only be made on compelling evidence, not indirect inferences or speculation.

35. It is often difficult to determine what may have precipitated a decision to end one's own life. There are sometimes issues known only to the deceased person; sometimes events in the person's life suggest a reason.

36. On the available evidence, Mr Jenkins was at least anxious in the days leading up to his death and his drinking continued to be significant. This anxiety is likely to have been the result of police telling him that they wanted to interview him of allegations of sexual assault that his daughter Shiloh had made against him. Mr Jenkins commented in the note left to his parents that he had not slept for three days because he was unable to deal with the events that occurred just prior to his death, probably a reference to police investigating the allegations by Shiloh.[39]

37. For the purposes of the Family Violence Protection Act 2008, Shiloh was a 'family member' of Mr Jenkins and vice-versa.[40] Moreover, the allegations of sex offences made by Shiloh against Mr Jenkins constitute 'family violence as defined in that Act.'[41]

38. In light of a possible connection between Mr Jenkins' death and his alleged family violence against his daughter, I requested that the Coroners' Prevention Unit (**CPU**)[42] examine Mr Jenkins' death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[43]

39. The Victoria Police *Code of Practice for the Investigation of Sexual Crime 2016* (**Code of Practice**), in place at the time of Mr Jenkins death provides guidance to Victoria Police members in their investigation of and response to alleged sexual crimes, including sexual crimes against children.[44] This document incorporates information about the psychological

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[39] Anthony Sean Jenkins suicide note addressed to his parents and dated 26 August 2017, Coronial Brief, 80.
[40] Family Violence Protection Act 2008, section 8(1)(d)
[41] Family Violence Protection Act 2008, section 5(1)(a)(i)
[42] The Coroners Prevention Unit is a specialist service for Coroners established to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety
[43] The VSRFVD provides assistance to Victorian Coroners to examine the circumstances in which family violence deaths occur. In addition the VSRFVD collects and analyses information on family violence-related deaths. Together this information assists with the identification of systemic prevention-focused recommendations aimed at reducing the incidence of family violence in the Victorian Community
[44] Victoria Police, *The Code of Practice for the Investigation of Sexual Crime 2016* (2016).

and social consequences that allegations of child sexual offences can have on suspects and the potential risk for self-harm among them post notification.[45]

40. The Victoria Police *Manual - Procedures and Guidelines, Sexual offence investigations* (**Procedures and Guidelines**), provides further guidance to investigating police and stipulates that:

> "*Members intending to interview a person in relation to allegations of sexual offences involving children need to be aware of the suspect's welfare. They are considered to be at a higher risk of suicide and/or self-harm.*"[46]

41. Research suggests that once a suspect becomes aware that allegations of sexual offences have been made against a person there is a heightened risk of self-harm and suicide. Such an elevated risk can be contributed to by shame, loss of reputation, and the collapse of relationships with family and friends.[47]

42. In April 2015, Coroner English published her finding in the matter of the death of James Tomlinson (2011/2865) and commented that:

> "*All suspects should be provided with a welfare referral or information upon first contact with police*".[48]

43. Coroner English recommended that the *Information and Support Referral Brochure* (**ISR Brochure**),[49] a document that police are required to provide to those they inform of allegations of sexual offences against them, be updated to include information about the police investigation, the judicial process regarding police charges, the potential involvement of other agencies, and how to seek appropriate assistance for wellbeing and mental health.

44. Following Coroner English's recommendations, the Victoria Police adopted changes to the ISR Brochure which currently sets out information about the police investigation process, legal advice and support service referrals.

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[45] Victoria Police, *The Code of Practice for the Investigation of Sexual Crime 2016* (2016), 31.

[46] Victoria Police, *Sexual Offences and Child Abuse Team- Practice Note: Suspect Welfare Management* (20 October 2015), 1; Victoria Police, *Victoria Police Manual – Procedures and Guidelines: Sexual offence investigations* (27 April 2016), 6.

[47] Brophy, Justin. *"Suicide outside of prison settings among males under investigation for sex offenses in Ireland during 1990 to 1999."* The Journal of Crisis Intervention and Suicide Prevention 24, no. 4 (2003): 155-159

[48] Finding without inquest into the death of James Tomlinson (COR 2011 2865), 5.

[49] The ISR Brochure was first introduced following recommendations by Her Honour, Coroner Armour in her finding without inquest into the death of Terence Russell Bennett (COR 2010 4056), following on from this finding, Coroner English in her finding without inquest into the death of James Tomlinson (COR 2011 2865) recommended updating the ISR Brochure to include more extensive referrals.

45. Current Victoria Police practice, policy and procedure in the investigation of sexual offences dictates that the ISR Brochure be provided after a suspect has been interviewed by the police.[50]

RECOMMENDATIONS PURSUANT TO SECTION 72(2) OF THE ACT

46. In this case, DS Young and DSC Evans acted in accordance with the Code of Practice and the Procedures and Guidelines in relation to their requirements to respond to the welfare of a suspect. Upon first contact with Mr Jenkins on 23 August 2017, DSC Evans observed Mr Jenkins to be calm and did not disclose any concerns for his wellbeing. Furthermore, DSC Evans provided Mr Jenkins with information regarding legal representation.

47. Speculating on whether Mr Jenkins would have suicided had he been given the ISR Brochure when DS Young and DSC Evans spoke to him on 23 August is inutile. It is, none-the-less, at least reasonable to surmise that a suspect may benefit from the provision of the information in the ISR Brochure when police initially contact them about allegations of sexual assault rather than waiting for them to be interviewed. It is not uncommon for there to be a delay between initial contact and interview, and given the nature of the allegations that period is likely to be a particularly stressful interval during which people may be at an increased risk of self harm.[51]

48. Mr Jenkins' death is one of several cases identified by the Coroners Court of Victoria that involved deceased who, at the time of their death, were under investigation by the police for alleged child related sex offences. In these cases the deceased suicided after initial contact with the police but prior to a formal interview with police.

49. For that purpose, I recommend that the Victoria Police consider updating the *Code of Practice for the Investigation of Sexual Crime* and relevant policies procedures and protocols, to explicate the increased risk of suspects engaging in self harm, between notification that allegations have been made against them and the intended interview date and to emphasise the significance of suspect welfare management at the first point of Victoria Police contact.

50. I also recommend that the Victoria Police consider updating the *Code of Practice for the Investigation of Sexual Crime* and relevant policies, to require that investigating police provide the ISR Brochure to suspects at the first point of contact.

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[50] Victoria Police, *Sexual Offences and Child Abuse Team- Practice Note: Suspect Welfare Management* (20 October 2015), pages 2 and 5; Victoria Police, *Victoria Police Manual – Procedures and Guidelines: Sexual offence investigations* (27 April 2016), 7.

[51] Victoria Police, *Sexual Offences and Child Abuse Team- Practice Note: Suspect Welfare Management* (20 October 2015), 1; Victoria Police, *Victoria Police Manual – Procedures and Guidelines: Sexual offence investigations* (27 April 2016), 6.

FINDINGS AND CONCLUSION

51. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) The identity of the deceased was Anthony Sean Jenkins, born 4 June 1968;

    (b) Mr Jenkins' death occurred;

        i. on 30 August 2017 at University Hospital Geelong, 322 Ryrie Street, Geelong, VIC 3220;

        ii. from hypoxic ischaemic brain injury complicating neck compression in the circumstances of hanging; and

        iii. in the circumstances described in paragraphs 23 – 33 above.

52. Pursuant to section 73(1A) of the Act I order that this Finding be published on the internet.

53. I direct that a copy of this finding be provided to the following for their action:

    (a) Mr Graham Ashton, Chief Commissioner, Victoria Police.

54. I direct that a copy of this finding be provided to the following for their information only:

    (a) Ms Lynette Jenkins, Senior Next of Kin;

    (b) Detective Sergeant Craig Dooley, Coroner's Investigator, Victoria Police;

    (c) Ms Ruth McClure; and

    (d) Ms Lorraine Judd, Barwon Health, Geelong Hospital.

Signature:

DARREN J. BRACKEN

CORONER

Date: 14 December 2018.