Rule 63(1)

IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2018 4194

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

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

Inquest into the death of: MICHAEL BRIAN SANDERS

Findings of:	AUDREY JAMIESON, CORONER
Delivered On:	3 March 2021
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street, Southbank, 3006
Hearing Dates:	3 March 2021
Counsel Assisting the Coroner:	*Hayley Challender*

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I, AUDREY JAMIESON, Coroner having investigated the presumed death of **MICHAEL BRIAN SANDERS**

AND having held an Inquest in relation to this death on 3 March 2021

at the Coroners Court of Victoria, FIND that

MICHAEL BRIAN SANDERS is deceased

was born on 8 February 1959

died on or about 25 May 2016

at the base of cliffs within approximately one-kilometre West North West of London Bridge Carpark, the Great Ocean Road, Peterborough, Victoria 3270

from:

1 (a) UNASCERTAINED CAUSES

In the following summary of circumstances:

On 23 May 2016, Gayle O'Connor, attended the Mornington Police Station to report her long-time partner, Michael Brian Sanders, as a missing person. Subsequently, Victoria Police officers ("police"), located Mr Sanders' vehicle and other personal items near cliffs adjacent to the London Bridge Carpark on the Great Ocean Road in Peterborough. Despite extensive investigations, police have not identified any evidence indicating that Mr Sanders is alive.

JURISDICTION

1. On 22 August 2018, Detective Leading Senior Constable (DLSC) Peter Butland of Mornington Criminal Investigation Unit, Victoria Police, notified the Coroners Court of Mr Sanders' suspected death. I accepted Michael Brian Sanders' death as a reportable death under section 4 of the Coroners Act 2008 ('the Act'); on the balance of probabilities, Mr Sanders died in Victoria in unexpected circumstances.

PURPOSE OF THE CORONIAL INVESTIGATION

2. The Coroners Court of Victoria is an inquisitorial jurisdiction.[1] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances

[1] Section 89(4) Coroners Act 2008.

in which death occurred.[2] The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances but is confined to those circumstances sufficiently proximate and causally relevant to the death and not merely all circumstances which might form part of a narrative culminating in death. [3]

3. The broader purpose of coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by Coroners, generally referred to as the 'prevention' role.[4] Coroners are also empowered to report to the Attorney-General on a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to 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.[5] These are effectively the vehicles by which the prevention role may be advanced.[6]

4. It is not the Coroner's role to determine criminal or civil liability arising from the death under investigation. Nor is it the Coroner's role to determine disciplinary matters.

5. Section 52(2) of the Act provides that it is mandatory for a Coroner to hold an Inquest into a death if the death or cause of death occurred in Victoria and a Coroner suspects the death was as a result of homicide, or the deceased was, immediately before death, a person placed in custody or care, or the identity of the deceased is unknown.

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[2] Section 67(1) of the *Coroners Act 2008*.

[3] See for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy v West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).

[4] The "prevention" role is explicitly articulated in the Preamble and Purposes of the Act.

[5] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations respectively.

[6] See also sections 73(1) and 72(5) of the Act which requires publication of Coronial Findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a Coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

STANDARD OF PROOF

6. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining whether a matter is proven to that standard, I should give effect to the principles enunciated in Briginshaw v Briginshaw. [7] These principles state that in deciding whether a matter is proven on the balance of probabilities, in considering the weight of the evidence, I should bear in mind:

    - the nature and consequence of the facts to be proved;
    - the seriousness of any allegations made;
    - the inherent unlikelihood of the occurrence alleged;
    - the gravity of the consequences flowing from an adverse finding; and
    - if the allegation involves conduct of a criminal nature, weight must be given to the presumption of innocence, and the court should not be satisfied by inexact proofs, indefinite testimony or indirect inferences.

7. The effect of the authorities is that Coroners should not make adverse findings against or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

INVESTIGATIONS PRECEDING THE INQUEST

Conduct of my Investigation

8. I directed DLSC Butland to prepare a coronial brief, including, *inter alia*: statements from relevant persons; a formal sworn statement from DLSC Butland; any other relevant documentation.

Background Circumstances

9. At the time of his disappearance, Michael Brian Sanders was 57 years of age. He was in a 35-year relationship with his partner Gayle O'Connor. They had no children together. Mr Sanders' immediate family lived in Queensland.

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[7] *Briginshaw v Briginshaw (1938) 60 C.L.R. 336 esp at 362-363. "The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences..."*

10. In about 1990, Mr Sanders and Ms O'Connor started a metal fabrication business called "Ironic Twist". The business successfully operated for approximately twenty years.

11. In 2000, the couple built their home in Mt Martha.

12. In 2010, Greg Fell contracted Ironic Twist to install various metal fences, gates, and balustrading at his home, at a cost of $60,000.00 ("the metal work"); Mr Fell had contracted work with Ironic Twist for his business "Aloha Pools" over the preceding 18 years.

13. Approximately six months later, Mr Fell requested that Mr Sanders repair and restore the metal work as it had begun to rust. Mr Fell stated that this occurred as the metal had not been correctly treated and that Mr Sanders agreed to do this work. However, the metal work repairs were not completed.

14. Shortly thereafter, Mr Sanders and Ms O'Connor sold Ironic Twist to an employee, David Last. Ms O'Connor retired, and Mr Sanders continued to work at Ironic Twist for about 6 – 12 months to facilitate the transition.

15. On 17 September 2010, Mr Sanders began working as a casual Engineering teacher at the Holmesglen Institute, a TAFE facility in Moorabbin.

16. In April 2014, Mr Sanders was promoted to "Senior Educator", overseeing teaching staff and course delivery in the Engineering Department.

17. In January 2015, Mr Fell made an application to the Victoria Civil and Administrative Tribunal (VCAT). Mr Fell stated that he and Mr Sanders had been unable to resolve the issue over the preceding years.

18. In late February 2015, Mr Sanders and Mr Fell met in mediation through VCAT. Mr Fell stated that Mr Sanders agreed to repair the metal work or pay for the repairs.

19. The repair work did not occur.

20. In July 2015, a VCAT hearing was held in relation to the metal work dispute. Mr Sanders did not attend, and a judgement was made against him for the amount of $60,000.00.

21. Mr Sanders did not make the payment. Mr Fell stated that he communicated with Mr Sanders and tried to convince him to seek legal advice so that their issue could be resolved.

22. In December 2015, Mr Fell applied for a bankruptcy notice against Mr Sanders based on the VCAT judgement. Mr Sanders did not pay the debt.

23. In February 2016, Mr Fell returned to the Federal Court and a trustee of bankruptcy was appointed. The Trustee of Bankruptcy arranged for Mr Sanders' home with Ms O'Connor to be sold, in order to pay the debt.

24. In March 2016, Mr Sanders' father died; he was in Queensland with his family during this period and acted as the executor of his father's Will.

25. On 3 May 2016, Mr Sanders received an influenza vaccine from General Practitioner (GP) Dr Arthur Kipouridis at a medical clinic co-located with the Holmesglen Institute. Dr Kipouridis stated that Mr Sanders had never attended an appointment in relation to his mental health and was confident that his patient did not consult GPs at other clinics.

Surrounding Circumstances

26. During the evening on 22 May 2016, Mr Sanders told Ms O'Connor that he was feeling concerned about a meeting with the Faculty Dean the following day. Ms O'Connor stated that Mr Sanders did not sleep well.

27. At about 6.30am on 23 May 2016, Mr Sanders left home for work: his usual departure time.

28. At approximately 9.00am, Ms O'Connor identified that she had a registered post notice by looking through the mailbox opening; Mr Sanders had placed a lock on their mailbox, ostensibly to prevent the wind from blowing it open. Ms O'Connor drove to the post office to collect her postage. She was shocked to discover that Mr Sanders was

engaged in a monetary dispute, he had been declared bankrupt, and their home was to be sold unless she was able pay the debt.

29. Ms O'Connor telephoned Mr Sanders to discuss her concerns. He initially denied the issue but ultimately said that he had *'received notification about this civil matter in February this year and he thought it would go away'*.[8] Mr Sanders was unable to explain this rationale and said that he could not come home to discuss it immediately, as he had an important meeting. However, he said that they would talk about it when he came home.

30. Shortly thereafter, Mr Sanders met with the Holmesglen Institute Faculty Dean Ross Digby and the Head of the Engineering & Electro-Technology Department Alexander Newman. Mr Newman stated that they discussed Mr Sanders' management of the Engineering Department, including:

    a. Employer communications,

    b. Student enrolments,

    c. Student resulting, and

    d. Course compliance.

31. Mr Newman said that Mr Sanders agreed that there were issues to address in relation to his management but did not offer any explanations. At the conclusion of the meeting, Mr Sanders was asked to complete some tasks to provide further information about the agreed issues. Mr Sanders was directed to present to the Faculty Dean and Mr Newman the following day.

32. After the meeting, Mr Sanders' approached colleague Marilou Fisher several times but she had indicated that she was not able to speak with him, as she was busy. Later, she approached Mr Sanders' desk, but he appeared occupied with his work and she did not get his attention. She was unable to speak with him after teaching her classes as he was not in his office. She stated that he had appeared stressed, pale and had messy hair.

[8] Coronial Brief, Statement of Gayle O'Connor, dated 5 September 2016, p 14.

Ms Fisher said that this was out of character and that he was normally talkative and friendly.

33. Ms Fisher said that Mr Sanders often spoke with her about personal, administrative issues; he seemed to appreciate her no-nonsense style of advice. He had not informed her about his debt to Mr Fell. However, he had raised concerns about his mortgage in the past. On those occasions, Ms Fisher had encouraged him to set aside his pride and ensure his future financial security by selling his home in Mt Martha and downsizing to something closer to his workplace.

34. Ms Fisher expressed immense regret at being unable to speak with Mr Sanders that day.

35. At approximately 4.50pm, Mr Sanders left the office and said goodbye to his colleague Sarah Keachie on the way out. Mr Newman said that Mr Sanders' tasks for the presentation were left, unfinished, on his desk. Mr Newman was surprised that Mr Sanders left his office at that time, in light of the amount of unfinished work.

36. Mr Sanders did not contact anyone from his personal or work mobile telephones.

37. At about 10.00pm, Ms O'Connor went to the Mornington Police Station as Mr Sanders had not come home and she was unable to get into contact with him.

Missing Persons Investigation

38. During the days following Mr Sanders' reported disappearance, Mornington uniformed police identified that Mr Sanders' work iPad was in Peterborough.

39. On 26 May 2016, police located a silver Volkswagen sedan parked approximately 200 metres west of London Bridge car park in Peterborough. The sedan was identified as the vehicle Mr Sanders had been driving on the date of his disappearance. The keys to the car were located on the front driver-side tyre. Mr Sanders' wallet, watch, personal phone, work phone, and work iPad were located within the vehicle.

40. Shortly thereafter, police spoke with two witnesses: Karen Gordon and Jenny Boydle.

a. On 24 May 2016 at about 8.15am, Ms Gordon drove in a westerly direction on the Great Ocean Road when she noticed a silver car parked off the road near to "The Grotto" and the London Bridge carpark. Ms Gordon said that she looked toward the nearby cliffs to admire the view. At that time, she noticed a figure standing on the precipice. She stated that it appeared to be a dangerous location.

b. On 25 May 2016 at about 1.15pm, Ms Boydle drove in an easterly direction on the Great Ocean Road between Peterborough and Port Campbell. As Ms Boydle passed "The Grotto", she observed a small silver car parked on the side of the road. Ms Boydle took notice of the vehicle as she thought it was a strange place to be parked, especially during the poor weather of the day. She also saw man on the ocean side of the road in the scrub. He was approximately 5.5 metres from the parked vehicle. Upon Ms Boydle's return trip about ninety minutes later, she observed the same man now on the opposite side of the road, approximately 2 metres from the verge. He was looking at the ground as though searching for something. Police showed a photograph of Mr Sanders to Ms Boydle and she identified him as the man she had seen on 25 May 2016.

41. Police commenced an air and land search along the coastline where Mr Sanders' car was found. The sea search had to be postponed for two days due to the rough seas. Neither search was successful. Mornington uniformed police conducted enquiries:

a. Taxi-Cab vehicles in the Port Campbell area had not picked up any persons fitting Mr Sanders' description;

b. Mr Sanders' had not contacted his family in Queensland nor any of his colleagues;

c. Mr Sanders had not accessed any of his bank accounts;

d. Mr Sanders' passport remained in his home and the Department of Immigration confirmed that he had not travelled overseas;

e. Mr Sanders' registered firearms remained in the designated locked cabinet in his home, and

f. Mr Sanders' mobile telephone, iPad and laptop remained in the vehicle on the verge adjacent to the Great Ocean Road and cliffs in Peterborough. These electronic devices were accessed for any indications as to Mr Sanders' whereabouts, to no avail.

Proof Of Life Checks

42. Mornington uniformed police exhausted their lines of enquiry; they were unable to identify any indication of Mr Sanders' whereabouts, beyond the parked silver Volkswagen sedan. The Investigation was referred to DLSC Butland for further investigations, proof of life checks and, ultimately, to assist in my Coronial Investigation into the death of Michael Brian Sanders.

43. DLSC Butland exhausted proof of life checks and was unable to identify any evidence that suggested Mr Sanders may be alive. DLSC Butland:

a. Took statements from relevant witnesses, including *inter alia*: Gayle O'Connor, Dr Arthur Kipouridis, Greg Fell, Alexander Newman, Marilou Fisher and David Last. These statements identified that Mr Sanders' faced multiple, severe stressors in period immediately prior to his disappearance. However, the statements did not identify any history of mental ill health nor that Mr Sanders' had given any indication of suicidality to those that knew him.

b. Confirmed with Centrelink and Medicare officers that Mr Sanders had not accessed their services since his disappearance.

c. Identified that Mr Sanders had not stayed in any accommodation centres in the Port Campbell area and had had not booked himself into any other accommodation using his own name.

d. Requested that the Victoria Police E-Crime Unit run their social media search capabilities to seek out any use of Mr Sanders' name, email address or phone number. There was no use of the same identified subsequent to his death.

e. Reconfirmed investigative work completed by the Mornington Uniformed police, including that:

i. Mr Sanders had not accessed any of his bank accounts, (an exhaustive list was provided by the Trustee of Bankruptcy);

ii. Mr Sanders' firearms remained in the locked cabinet and nothing else was missing from his home or garage;

iii. Mr Sanders' colleagues, immediate and extended family had not seen nor heard from him since 23 May 2016, and

iv. The Department of Immigration records indicated that Mr Sanders had not travelled overseas, and his passport remained at his home address.

Statement of Coroner's Investigator DLSC Peter Butland

44. DLSC Butland provided a formal sworn statement, detailing the investigations undertaken on my behalf which are detailed above.

45. DLSC Butland also spoke with Senior Accountant Andrew Ellemand who assisted Trustee of Michael Sanders' Bankruptcy, Alice Ruhe. Mr Ellemand expressed his surprise at Mr Sanders' bankruptcy, given his financial capacity to avoid that state of affairs over a relatively small debt. He also indicated that Mr Sanders had maintained the capacity to challenge or nullify the bankruptcy at the time of his disappearance. Mr Ellemand also explained that Mr Sanders had refused to participate in any part of the proceedings, even where he was legally obliged to participate. On that basis, Mr Ellemand considered Mr Sanders' behaviour strange and irrational.

46. DLSC Butland informed me that the terrain around the water's edge was rocky and treacherous; persons who entered the water from these types of sites were frequently never recovered, or otherwise their remains may be found many kilometres away. DLSC Butland concluded that the fact that Mr Sanders' body has never been recovered was not unusual.

INQUEST

47. Upon review of the Coronial Brief, I determined that there was sufficient evidence to make formal Findings in the investigation into the death of Michael Brian Sanders pursuant to section 67 of the Act.

48. In light of the circumstances surrounding Mr Sanders' disappearance and report of his death, I determined that this matter would be appropriately finalised by way of a Form 37 Finding into Death with Inquest and to hand-down my Findings at the conclusion of a Summary Inquest.

49. On 15 February 2021, interested parties were informed of my determination by way of a formal notice for a Summary Inquest to be held 3 March 2021. I indicated my intention to hand down my formal Findings on this date.

FINDINGS

1. I make my formal Findings on the civil standard of proof on balance of probabilities, with the *Briginshaw* gloss or explication.[9] A Finding that a missing person is deceased where there is no forensic evidence of their death is a serious matter that carries significant legal consequence.

2. Pursuant to section 67(1) of the *Coroners Act 2008* – in the absence of human remains and based on the weight of available, circumstantial evidence – I find:

    a. Michael Brian Sanders is deceased.

    b. Michael Brian Sanders was born 8 February 1959;

    c. Michael Brian Sanders died on or about 25 May 2016;

    d. Michael Brian Sanders' death occurred at the base of cliffs within approximately one-kilometre West North West of London Bridge Carpark, the Great Ocean Road, Peterborough, Victoria 3270

    e. I am unable to make any findings in relation to the medical cause of Michael Brian Sanders' death as his remains have never been located.

[9] Above n 7.

f. the death occurred in the circumstances described above.

3. I find that Michael Brian Sanders suffered stressors in the period proximate to his death, including:

   a. the death of his father;

   b. unresolved debt leading to Victorian Civil and Administration Tribunal proceedings, and bankruptcy;

   c. his de facto partner discovered his mismanagement of their shared finances, and

   d. work-related pressures including the fear of unemployment.

4. Having considered all of the circumstances, I find that Michael Brian Sanders intentionally ended his own life by jumping from cliffs above the Bass Strait in Peterborough.

If any further evidence in relation to the disappearance of Michael Brian Sanders should arise, an application under section 77 of the *Coroners Act 2008* (Vic) may be made to re-open the coronial investigation.

To enable compliance with section 73(1) of the *Coroners Act 2008* (Vic), I direct that the Findings will be published on the internet.

I direct that a copy of this Finding be provided to the following:

Gayle O'Connor

Detective Leading Senior Constable Peter Butland

Signature:

AUDREY JAMIESON

CORONER

Date: **3 March 2021**