IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 3104

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)
Section 67 of the Coroners Act 2008

Findings of:	**JOHN CAIN, STATE CORONER**
Deceased:	**MICHAEL GERALD ANTHONY**
Delivered on:	7 May 2021
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street, Southbank
Hearing date:	7 May 2021
Counsel assisting the Coroner:	Nicholas Ngai, Family Violence Senior Solicitor
Catchwords:	Suspected homicide, no person charged with an indictable offence in respect of a reportable death, mandatory inquest

TABLE OF CONTENTS

HIS HONOUR:

BACKGROUND

1. Michael Gerald Anthony (**Mr Anthony**) was born in Melbourne, on 30 October 1989. He was 26 years old at the time of his death and is survived by his parents, his younger brother, Trevor Anthony (**Trevor**), and his two children.

2. Mr Anthony completed his Year 12 secondary studies and was a keen martial artist in his youth, having attended several Karate dojos in his local area and competing in competitions at a young age.

3. Mr Anthony was reported to have started using illicit drugs at around 15 years of age. Mr Anthony's behaviour started becoming erratic and aggressive during this period and his family members noted that this behaviour continued every time Mr Anthony was reported to have used drugs.

4. Mr Anthony experienced a significant decline in his mental health with continual illicit drug use over the years in the lead up to the fatal incident. This affected his familial and personal relationships and his ability to retain gainful employment.

5. In September 2011, Mr Anthony was reported to have become aggressive and paranoid after using drugs and attending church, he stated that his mother was the devil and had cameras in her eyes. He then threatened family members with a large screwdriver before punching a hole in a plaster wall. The Police were called and arrested Mr Anthony whilst he was conveyed to Maroondah Hospital to get a psychiatric assessment. Mr Anthony was assessed as experiencing drug induced psychosis and was treated for depression with Olanzapine upon discharge to the care of his general practitioner.

6. In December 2011, Mr Anthony was admitted to Springvale Southern Health as an involuntary patient due to displays of paranoid behaviour and claiming that people could read his mind. Mr Anthony confirmed that he had ceased using Olanzapine to treat his depression as prescribed by his general practitioner and was instead using methylamphetamines.

7. In September 2013, Mr Anthony was admitted again as an involuntary patient at Monash Health in Clayton. He was reported to have displayed irrational and aggressive behaviour after consuming a number of illicit drug stimulants. Mr Anthony had fathered a daughter with

his then girlfriend, Kaylene, prior to his admission to Monash Health but was prevented from having contact with her due to his mental health and drug use.

8. In late 2013, after his admission to Monash Health, Mr Anthony formed a relationship with Geraldine Tourmentin (**Geraldine**) and they had a son together in 2014. Mr Anthony continued his relationship with Geraldine until October 2014 when he reportedly strangled her and Mr Anthony's father and brother, Trevor, intervened. Mr Anthony's relationship ended with Geraldine after this incident and he saw his son during supervised visits.

THE PURPOSE OF A CORONIAL INVESTIGATION

9. Mr Anthony's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria[1] and was violent, unexpected and not from natural causes[2].

10. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[3] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[4]

11. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[5] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[6] or to determine disciplinary matters.

12. The expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

13. For coronial purposes, the phrase "*circumstances in which death occurred*,"[7] refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

---

[1] Section 4 *Coroners Act 2008*
[2] Section 4(2)(a) *Coroners Act 2008*
[3] Section 89(4) *Coroners Act 2008*
[4] See Preamble and s 67, *Coroners Act 2008*
[5] *Keown v Khan* (1999) 1 VR 69
[6] Section 69 (1)
[7] Section 67(1)(c)

14. The broader purpose 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 the making of recommendations by coroners. This is generally referred to as the Court's "*prevention*" role.

15. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;[8]

    (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice;[9] and

    (c) 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.[10] These powers are the vehicles by which the prevention role may be advanced.

16. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[11] In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[12] 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 that they caused or contributed to the death.

17. 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 (and no person or persons have been charged with an indictable offence in respect of the death), or the deceased was immediately before the death, a person placed in custody or care, or the identity of the deceased is unknown.

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

Identity of the Deceased pursuant to section 67(1)(a) of the Act

18. On 6 July 2016, Roger Anthony identified the body of the deceased to be his son, Michael Anthony, born 30 October 1989.

---

[8] Section 72(1)
[9] Section 67(3)
[10] Section 72(2)
[11] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152
[12] (1938) 60 CLR 336

19. Identity is not in dispute in this matter and requires no further investigation.

Medical cause of death pursuant to section 67(1)(b) of the Act

20. On 8 July 2016, Dr Malcolm Dodd, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon the deceased's body. Dr Bouwer provided a written report, dated 21 December 2016, which concluded that Mr Anthony died from hypoxic ischaemic encephalopathy in the context of neck compression.

21. Dr Dodd made the following comments in his report:

    (a) Examination of the left side of the neck disclosed a distinct elongated ovoid pale region surrounded by erythema.

    (b) High power examination of the heart muscle fibres disclosed focal increased eosin uptake and scattered neutrophil polymorphs within the interstitium. These changes are consistent with the earliest alterations due to hypoxia and more than likely accompany the brain trauma rather than primary cardiac disease.

    (c) Hypoxia was most likely brought on by direct compression to the carotid arteries and/or compromise to the airway.

22. Dr Dodd also confirmed that there was no other significant injuries or natural diseases identified that could have caused or contributed to the death.

23. Toxicological analysis of postmortem specimens taken from the deceased identified the presence of alcohol at a concentration of 0.16 g/100mL and therapeutic medication likely to have been administered during Mr Anthony's admission to the intensive care unit. Dr Dodd noted that the level of alcohol toxicity was a contributing factor in the mechanism of death.

24. I accept the cause of death proposed by Dr Dodd.

Circumstances in which the death occurred pursuant to section 67(1)(c) of the Act

25. On 1 July 2016, Mr Anthony was invited to attend his son's second birthday party and was driven to the event by his father. Mr Anthony arrived with his father to the event at approximately 8.00pm.

26. Mr Anthony was reportedly drinking heavily during the event and spent most of his time in the driveway at the front of the property smoking cigarettes.

27. Mr Anthony refused to come inside the house for the cutting of his son's birthday cake and at approximately 10.25pm, Geraldine asked Mr Anthony to leave the premises after he made inappropriate sexual advances towards her.

28. Mr Anthony was very agitated at being asked to leave the premises and his brother, Trevor, attempted to escort him home. Trevor placed his arm around Mr Anthony's shoulders as they walked towards the front door. As they approached the door, Mr Anthony punched Trevor to the right side of his face and a physical altercation broke out between the two as they wrestled to the ground.

29. After a period of time, Trevor was able to restrain Mr Anthony on his back, with his right arm across the right side of Mr Anthony's neck and his right knee on Mr Anthony's right arm. The altercation lasted approximately ten minutes and Mr Anthony eventually stopping trying to fight back and became silent.

30. One of the bystanders pointed out that Mr Anthony's face was turning blue and they began resuscitation attempts whilst emergency services were contacted to attend the premises.

31. Ambulance paramedics arrived at approximate 11:15pm and took Mr Anthony to Dandenong Hospital. Mr Anthony was admitted to the intensive care unit at approximately 12.25am on 2 July 2016.

32. Unfortunately, medical services at the Dandenong Hospital were unable to revive Mr Anthony and life support was withdrawn at 6.30pm on 6 July 2016.

REQUIREMENT TO HOLD AN INQUEST

33. Section 52(2) of the Act provides for the circumstances under which it is mandatory for a coroner to hold an inquest into a death. One of those circumstances is where a coroner suspects the death was a homicide and no person or persons have been charged with an indictable offence in respect of the death.

34. The evidence suggests that Trevor was involved in a physical altercation with Mr Anthony on 1 July 2016 which resulted in Mr Anthony's death in circumstances of self-defence.[13] Members of the Victoria Police homicide squad conducted a thorough criminal investigation into the death of Mr Anthony and after receiving advice from the Office of Public Prosecutions, Trevor was not charged with an offence in relation to Mr Anthony's death. Section 52(2) of the Act mandates that I must hold an inquest into Mr Anthony's death, because I suspect that Mr Anthony's death was the result of a homicide.

35. A homicide is the killing of one person by another person. Section 69(1) of the Act prohibits me from making a finding that a person is or may be guilty of a criminal offence. In forming the suspicion that Mr Anthony's death was the result of a homicide, I make no finding as to Trevor's criminality, but I note simply that I am satisfied that Trevor's actions directly caused Mr Anthony's injuries, resulting in his death.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

Family Violence

36. For the purposes of the *Family Violence Protection Act 2008* (**the Act**), the relationship between Mr Anthony and his brother Trevor clearly fell within the definition of '*family member*[14] under that Act. Moreover, Trevor's actions causing Mr Anthony's death constitutes 'family violence.'[15]

37. Considering Mr Anthony's death occurred under circumstances of family violence, I requested that the Coroners' Prevention Unit (**CPU**)[16] examine the circumstances of Mr Anthony's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[17]

38. I confirm that a thorough review of all the available evidence did not reveal any missed opportunities for intervention or prevention in the circumstances of Mr Anthony's death.

---

[13] Section 322K(1) of the *Crimes Act 1958* states that a person is not guilty of an offence if the person carries out the conduct constituting the offence in self-defence.
[14] Family Violence Protection Act 2008, section 9(1)(b)
[15] Family Violence Protection Act 2008, section 5(1)(a)(i)
[16] 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
[17] 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

39. I am satisfied, having considered all the available evidence, that no further investigation is required.

FINDINGS AND CONCLUSION

40. Having investigated Mr Anthony's death and having held an inquest in relation to his death on 7 May 2021, at Melbourne, I make the following findings, pursuant to section 67(1) of the Act:

    (a) that the identity of the deceased was Michael Gerald Anthony, born 30 October 1989;

    (b) that Mr Anthony died on 6 July 2016, at Dandenong Hospital, from hypoxic ischaemic encephalopathy in the context of neck compression; and

    (c) that the death occurred in the circumstances set out above.

41. I convey my sincerest sympathy to Mr Anthony's family and friends.

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

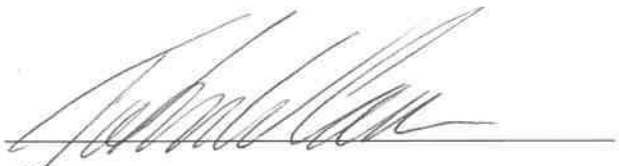
43. I direct that a copy of this finding be provided to the following:

    (a) Mr Roger Anthony, Senior Next of Kin;

    (b) Mrs Christiane Anthony, Senior Next of Kin; and

    (c) Detective Leading Senior Constable Rodney Andrew, Coroner's Investigator, Victoria Police.

Signature:



JOHN CAIN

STATE CORONER

Date: 7 May 2021