IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 000704

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Deceased:	Jake Anthony Kinkela
Delivered on:	13 November 2026
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street, Southbank
Hearing date:	12 November 2026
Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Assisting the coroner:	Olivia Vella, Coroners Court of Victoria
Representation:	No appearances
Key words:	Uncharged homicide, self-defence, defence of others

INTRODUCTION

1. On 5 February 2024, Jake Anthony Kinela (**Mr Kinkela**) was 37 years old when he died in hospital five days after he was restrained by being placed in a chokehold by a member of the public. At the time of his death, Mr Kinkela was single and lived on his own in Hastings. He is survived by his parents, Peter and Julie, his sister, Jessie, and his four children.

2. Mr Kinkela was described as a very outgoing, happy type of person with a wicked sense of humour. He was a roof plumber by trade but at the time of his death was employed installing bridge balustrades. He was skilled at his trade.

3. Mr Kinkela spent four months incarcerated in late 2023 on charges of contravention of a family violence order, unlawful assault and intentional property damage.

INVESTIGATION AND SOURCES OF EVIDENCE

4. This finding draws on the totality of the coronial investigation into the death of Mr Kinkela including evidence contained in the coronial file comprising the coronial brief compiled by the Coronial Investigator Detective Sergeant Shaun O'Connell, Mr Kinkela's medical records, the e-medical deposition from Frankston Hospital and the autopsy report, neuropathology report and toxicology report from the Victorian Institute of Forensic Medicine (**VIFM**).

5. All of this material, together with the inquest transcript, will remain on the coronial file.[1] In writing this finding, I do not purport to summarise all the material and evidence but will only refer to it in such detail as is warranted by its forensic significance and the interests of narrative clarity.

[1] From the commencement of the *Coroners Act 2008* (Vic) (**the Act**), that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act. Unless otherwise stipulated, all references to legislation that follow are to provisions of the Act.

CORONIAL INVESTIGATION AND INQUEST

6. The purpose of a coronial investigation of a *reportable death*[2] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[3] Mr Kinkela's death clearly falls within the definition of reportable death, specifically section 4(2)(a) which includes (relevantly) a death that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury.

7. 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 all those circumstances which might form part of a narrative culminating in death.[4]

8. The broader purpose of any coronial investigation 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.[5]

9. Coroners are empowered to report to the Attorney-General in relation to 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,

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[2] The term is exhaustively defined in section 4. Apart from a jurisdictional nexus with the State of Victoria a reportable death includes deaths that appear to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury; and, deaths that occur during or following a medical procedure where the death is or may be causally related to the medical procedure and a registered medical practitioner would not, immediately before the procedure, have reasonably expected the death (section 4(2)(a) and (b)). Some deaths fall within the definition irrespective of the section 4(2)(a) characterisation of the 'type of death' and turn solely on the status of the deceased immediately before they died – section 4(2)(c) to (f) inclusive.

[3] Section 67(1).

[4] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).

[5] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, compared with the *Coroners Act 1985* (Vic) where this role was generally accepted as 'implicit'.

including public health or safety or the administration of justice.[6] These are effectively the vehicles by which the coroner's prevention role can be advanced.[7]

10. Coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.[8]

MANDATORY INQUESTS

11. Sections 52(2)(a) and 52(3)(b) requires me to hold an inquest into a death if the death or cause of death occurred in Victoria and I suspect the death was the result of homicide, and no person has been charged with an indictable offence in respect of the death.

12. In this context, the word homicide, is a broad term referring to the killing of one person by another and captures deaths resulting from dangerous or negligent acts, including acts of self-defence, as well as what is more commonly referred to in public discourse as homicide in the sense of the crimes of manslaughter and murder.

13. An inquest was heard on 12 November 2026. At the inquest, the Coronial Investigator Detective Sergeant Shaun O'Connell was examined and a summary of the evidence and circumstances surrounding Mr Kinkela's death was provided.

IDENTITY OF THE DECEASED

14. On 5 February 2024, Jake Anthony Kinkela, born 9 May 1986, was visually identified by his mother, Julie Bateman, who signed a formal Statement of Identification to this effect.

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

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[6] See sections 72(1), 67(3) and 72(2) regarding reports, comments, and recommendations respectively.
[7] See also sections 73(1) and 72(5) 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.
[8] Section 69(1). However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69(2) and 49(1).

MEDICAL CAUSE OF DEATH

16. Senior Forensic Pathologist, Dr Matthew Lynch (**Dr Lynch**), from the VIFM, conducted an examination on 8 February 2024 and provided a written report of his findings dated 16 September 2024.

17. Neuropathological examination confirmed the presence of hypoxic ischaemic encephalopathy with sinus thrombosis. There was also evidence of bronchopneumonia, a sequela of hypoxic brain injury. Some non-specific injuries were noted in the form of an abrasion on the under surface of the chin and some scattered bruises and abrasions on the limbs, but no injuries were noted to the torso including chest and back. There was no laryngeal injury. The heart was unavailable for examination as it had been donated.

18. A post-mortem computed tomography (**CT**) scan showed cerebral oedema, a left pneumothorax, pleural effusions and evidence of organ donation.

19. Dr Lynch commented that the only evidence of any compressive force being applied to the neck region was an abrasion on the under-surface of the chin. He stated that in cases where pressure is applied to the neck by an arm in a chokehold, there can be little or nothing to identify at post-mortem examination. It is possible that the chokehold resulted in pressure to the carotid sinus region of the neck resulting in cardiac arrhythmia or vascular obstruction. The autopsy findings could neither confirm nor refute the fact of significant compression of the neck having occurred.

20. Dr Lynch further commented that the circumstances suggested that Mr Kinkela had been drinking and was intoxicated. An intoxicated individual placed in a prone position with pressure applied to their back is at risk of airway compromise and mechanical asphyxia, and it is possible that this contributed to the development of the hypoxic ischaemic brain injury to which Mr Kinkela succumbed.

21. On their own, the autopsy findings did not allow a determination of the respective contribution (if any) of the neck compression, mechanical asphyxia and intoxication to the development of the hypoxic brain injury.

22. Routine toxicological analysis of post-mortem samples detected fentanyl,[9] methylprednisolone,[10] and metoclopramide[11] which were medications administered to Mr Kinkela by medical staff. Cannabis metabolites[12] were also detected. No ethanol (alcohol) was detected post-mortem.

23. No suitable ante-mortem samples were available for analysis. These would have been useful in providing evidence of Mr Kinkela's level of intoxication closer to the time of the incident that led to his death. Unfortunately, Mr Kinkela's blood ethanol level at the time he was admitted to hospital was not documented.

24. Dr Lynch provided an opinion that the medical cause of death was *"1(a) Hypoxic ischaemic encephalopathy complicating out of hospital cardiac arrest in the setting of compression of the neck and trunk, and intoxication"*.

25. I accept Dr Lynch's opinion.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

26. Mr Kinkela worked in Sunbury on the day of 31 January 2024. His friend and colleague Corie-Jaye Whateley (**Mr Whateley**) drove to and from the site in Mr Kinkela's utility vehicle (**the ute**), as Mr Kinkela did not hold a driver's licence.

27. At about 1.30pm, as the pair were leaving Sunbury, Mr Kinkela asked Mr Whateley to stop at a bottle shop where he purchased a 750mL bottle of Jack Daniel's bourbon. He drank at least two thirds of the bottle during the trip to his house in Hastings.

28. When they returned to Mr Kinkela's house, Mr Kinkela told Mr Whateley he would drive the ute back to Mr Whateley's house as he wanted to leave it there. Mr Whateley told him not to as he was, as he described as *"off his rocker"* and did not have a driver's licence.

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[9] Fentanyl is a synthetic opioid used in surgical anaesthesia and chronic pain.
[10] Methylprednisolone is a corticosteroid indicated for a wide range of autoimmune and inflammatory diseases, acute asthma, acute exacerbation of multiple sclerosis, and acute transplant rejection.
[11] Metoclopramide is an anti-emetic drug used for the treatment of nausea and vomiting.
[12] Delta-9-tetrahydrocannabinol (**THC**) is the active form of cannabis (marijuana). Persons under the influence of cannabis will experience impaired cognition (reasoning and thought), poor vigilance, and impaired reaction times and coordination.

However, Mr Kinkela jumped in the ute and drove off with Mr Whateley following in his own car.

29. He drove to Mr Whateley's house at 137 Palmerston Avenue in Dromana and arrived at about 4.45pm where he proceeded to do 'burnouts' in Mr Whateley's driveway, causing gravel to be flicked onto nearby cars, including that of Mason Paynter (**Mr Paynter**). Mr Paynter was visiting his friends, Robert Pattison (**Mr Pattison**) and Coral Long (**Ms Long**), who lived at the neighbouring house. Mr Kinkela and Mr Paynter then had a short conversation with Mr Kinkela offering to pay for the damage, but Mr Paynter told him to forget about it.

30. Mr Kinkela then walked to another neighbour's house and attempted to hit their pet dog with the Jack Daniel's bottle, before entering Mr Whateley's house. Mr Whateley's brother was inside the house and told Mr Whateley to get Mr Kinkela to leave due to his behaviour. Mr Whateley noted that there was *"no calming him down, he was pretty much out of control, there was no reasoning with him".*

31. Mr Kinkela then *"took off like a rocket"* at about 5.10pm and drove to Mr Whateley's father's house in Rye, where he stayed until about 8.30pm.

32. At about 8.43pm, Mr Kinkela returned to Dromana and pulled up in front of 139 Palmerston Avenue, home to Mr Pattison and Ms Long. Mr Paynter was still at their property cleaning his car in the driveway. Mr Kinkela then reversed away at speed before performing several burnouts on Palmerston Avenue. He subsequently drove back to 139 Palmerston Avenue, driving directly at Mr Paynter who had stood outside to see what was happening.

33. Mr Kinkela yelled through the passenger window at Mr Paynter *"in a rage"* before exiting his vehicle, with the Jack Daniel's bottle in hand, and chased Mr Paynter a short distance. They had a verbal altercation in which Mr Kinkela threatened to shoot Mr Paynter and smash him with the bottle, with Mr Paynter attempting to diffuse the situation.

34. At about 8.47pm, Mr Kinkela, still in a rage, walked towards Mr Pattison who was standing on his front porch. Mr Pattison stated that Mr Kinkela was mentioning Mr Whateley's car. Mr Kinkela tripped and fell over on the porch but then grabbed Mr Pattison by the shirt and

headbutted him to the mouth. Ms Long attempted to intervene, at which time Mr Kinkela struck both her and Mr Pattison to the head with the Jack Daniel's bottle. After he struck Mr Pattison and Ms Long, Mr Kinkela was still acting erratically and in a threatening manner whilst holding the Jack Daniel's bottle and grappling with Mr Pattison who then called out to Mr Paynter to help.

35. At about this time, a neighbour called Triple Zero to report the altercation.

36. Mr Paynter stepped in to intervene and grabbed Mr Kinkela's arms. They grappled for a short time before Mr Paynter forced Mr Kinkela face down onto a couch on the porch, with his right arm around Mr Kinkela's neck in a chokehold. Once he felt Mr Kinkela *"go to sleep"*, he loosened the pressure around his neck but continued to lay on top of him.

37. At 8.49pm, Mr Pattison called Triple Zero and advised he had been assaulted, and the 'offender' was currently detained.

38. At 8.51pm, Ms Long used Mr Paynter's phone to call Mr Paynter's brother and asked him to attend to help restrain Mr Kinkela.

39. Mr Paynter's brother arrived shortly after and used cable ties to restrain Mr Kinkela's ankles. Mr Paynter let go of Mr Kinkela but remained at the scene.

40. Victoria Police members arrived at 8.58pm and spoke to Mr Paynter who gave a brief account of what had occurred. They observed Mr Kinkela slumped forward on the couch with his knees on the decking.

41. At about 9.01pm, the police members handcuffed Mr Kinkela at which time they realised he was not breathing. They immediately removed the handcuffs and commenced cardiopulmonary resuscitation (**CPR**) until the arrival of Ambulance Victoria paramedics at 9.09pm.

42. Mr Kinkela was found to be unconscious, not breathing and in asystole (no electrical heart activity). He was intubated and a return of spontaneous circulation (**ROSC**) was achieved at 9.31pm.

43. Mr Kinkela was conveyed to Frankston Hospital where an initial CT scan showed global hypoxic ischaemic brain injury. He subsequently developed a suspected aspiration pneumonia. Repeat CT imaging showed no perfusion to the brain.

44. On 5 February 2024, Mr Kinkela was declared braindead with no brainstem reflexes. His family kindly consented to the donation of his organs.

VICTORIA POLICE INVESTIGATION

45. Mr Paynter was arrested at the scene for Recklessly Causing Serious Injury and conveyed to the Rosebud Police Station. He was interviewed and provided an account of the incident and was subsequently released pending further enquiries.

46. The available evidence is that Mr Kinkela was extremely alcohol affected at the time of the incident and was *"in such a rage"*, causing those involved in the altercation to fear for their safety.

47. Investigating police members submitted a criminal brief of evidence against Mr Paynter in relation to the death of Mr Kinkela and sought advice from the Detective Inspector of the Victoria Police Homicide Squad as to whether a charge of manslaughter or any other charges would be authorised. Ultimately, no charges against Mr Paynter were authorised to proceed on the following bases:

    (a) In his interview on the night of the incident, Mr Paynter raised the lawful defence of self-defence of himself or defence of another.

    (b) Statements contained within the brief of evidence corroborated the fact that Mr Paynter was acting in self-defence of himself and others.

    (c) Closed circuit television (**CCTV**) footage corroborated the account provided by Mr Paynter and other witnesses.

    (d) There was no reasonable prospect of conviction.

FINDINGS AND CONCLUSION

48. The applicable standard of proof for coronial findings is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[13]

49. Adverse findings or comments against individuals or institutions are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and in so doing caused or contributed to the death under investigation.

50. Having applied the applicable standard of proof to the available evidence, I find that:

    (a) the identity of the deceased was Jake Anthony Kinkela, born 9 May 1986;

    (b) the death occurred on 5 February 2024 at Frankston Hospital, 2 Hastings Road, Frankston, Victoria;

    (c) the medical cause of Mr Kinkela's death was hypoxic ischaemic encephalopathy complicating out of hospital cardiac arrest in the setting of compression of the neck and trunk, and intoxication; and

    (d) the death occurred in the circumstances described above.

51. Further, the available evidence supports the following findings:

    (a) At about 4.45pm on 31 January 2024, Mr Kinkela arrived at Palmerston Avenue in Dromana intoxicated and behaving in a disorderly manner.

    (b) Later, at about 8.43pm, Mr Kinkela returned to Palmerston Avenue where he performed several burnouts before pulling up at the home of Mr Pattison and Ms

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[13] *Briginshaw v Briginshaw* (1938) 60 CLR 336 especially 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…".*

Long, driving directly at Mr Paynter who had stood outside to see what was happening.

(c) Mr Kinkela exited his vehicle holding a 750mL Jack Daniel's bottle and chased Mr Paynter down the road.

(d) Mr Paynter tried to calm Mr Kinkela down, but he returned to the property, still with the bottle in hand, and physically assaulted Mr Pattison and Ms Long and continued to grapple with Mr Pattison at which point Mr Paynter restrained him in a chokehold until he stopped resisting.

(e) When Mr Kinkela was restrained, he was intoxicated, acting in an uncontrollable manner, had already physically harmed Mr Pattison and Mr Long and continued to pose a risk of serious injury or death to Mr Pattison, Mr Long and Mr Paynter.

(f) Mr Paynter restrained Mr Kinkela in circumstances where he was acting in self-defence and in defence of others.

(g) Although Mr Pattison, Ms Long and Mr Paynter were unsure why Mr Kinkela was behaving in a threatening and violent manner towards them, Mr Pattison's statement refers to an incident about a year earlier involving Mr Pattison damaging his neighbour Mr Whateley's car. However, they resolved the issue and continued to speak to each other occasionally. Given Mr Kinkela mentioned Mr Whateley's car at the time of the assault, the previous incident may have been the reason he targeted Mr Pattison and Ms Long. In any event, it is likely that Mr Kinkela's judgement and reasoning at the time of the assault were significantly impaired by the effects of alcohol.

52. I acknowledge the Coronial Impact Statement submitted by Julie Bateman, Mr Kinkela's mother and disappointment that no criminal charges were laid as a result of her son's death. I also convey my sincere condolences to her and to the rest of Mr Kinkela's family and his friends for their loss.

PUBLICATION OF FINDING

Pursuant to section 73(1) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

DISTRIBUTION OF FINDING

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

Peter Kinkela and Julie Bateman, Senior Next of Kin
Peninsula Health
DonateLife Victoria
Detective Sergeant Shaun O'Connell, Victoria Police, Coronial Investigator

Signature:



Deputy State Coroner Paresa Antoniadis Spanos

Date: 12 November 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 inquest. 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.