IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2023 001604
Related matter: COR 2023 001605
COR 2023 001606

**FINDING INTO DEATH FOLLOWING INQUEST**

*Form 37 Rule 63(1)*

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

**Inquest into the Death of: CAROLYN JAMES**

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| Findings of: | JUDGE CAIN, State Coroner |
| Delivered On: | 23 April 2024 |
| Delivered At: | Coroners Court of Victoria<br>65 Kavanagh Street, Southbank, Victoria, 3006 |
| Hearing Dates: | 23 April 2024 |
| Counsel Assisting: | Nicholas Ngai<br>Coroners Court of Victoria |
| Keywords | Filicide; Family violence; Mandatory Inquest |

I, JUDGE JOHN CAIN, State Coroner, having investigated the death of CAROLYN JAMES

AND having held an inquest in relation to this death on 23 April 2024

at the Coroners Court of Victoria, 65 Kavanagh Street, Southbank, Victoria

find that the identity of the deceased was CAROLYN JAMES

born on 23 November 2018;

and the death occurred on 24 March 2022

at the Western Port Highway, Cranbourne West, Victoria. 3977

from:

1(a) Effects of fire

**In the following summary of circumstances:**

Carolyn James suffered from the fatal effects of fire that was set by her mother, Jasmine Thomas whilst sitting in a motor vehicle parked along the Western Port Highway in Cranbourne West. Despite Fire Rescue Victoria fire fighters successfully controlling the motor vehicle fire, Carolyn, her sister, Evlyn and mother, Jasmine were declared deceased on site.

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## BACKGROUND CIRCUMSTANCES

1. Carolyn James was born on 23 November 2018 and was 3 years old at the time of her death. She lived with her parents, Jasmine Thomas and James Palakamannil, and her older sister, Evlyn James in Dandenong North, Victoria.

2. Ms Thomas was of Indian background,[1] born in Kuwait on 2 March 1985.[2] She completed her education in India then returned to Kuwait to work as a nurse when she was 25 years old. In 2012, Ms Thomas met Mr Palakamannil who was also of Indian descent and born in Kuwait, through a website for arranged marriages.[3]

3. Ms Thomas and Mr Palakamannil were married in India in November 2012, and were granted permanent residency in Australia in 2015.[4]

4. Ms Thomas reportedly told her mother she wanted to divorce Mr Palakamannil while they were living in Kuwait, however remained married on the basis that he would relocate to Australia with her, which is something she really wanted.[5]

5. In 2016, Ms Thomas and Mr Palakamannil moved to Melbourne. Ms Thomas completed a course so she could get her local registration as a nurse and began working in late 2017 at various hospitals.[6]

6. In August 2019, Ms Thomas, Carolyn and Evlyn visited family in India.[7] It is unclear from the evidence reviewed as to why Mr Palakamannil did not go. Carolyn stayed in India for a period as the family had limited supports in Melbourne, and Mr Palakamannil's parents were able to care for her before Ms Thomas returned to collect her in December 2019.[8]

[1] Coronial brief, Statement of James Swan Palakamannil dated 14 April 2022, 55.
[2] Coronial brief, Summary, 4.
[3] Above n 1, 55.
[4] Ibid.
[5] Coronial brief, Statement of DSC J Westlake dated 25 July 2022, 263.
[6] Above n 1, 56.
[7] Ibid.
[8] Ibid.

## SURROUNDING CIRCUMSTANCES

7. Mr Palakamannil reported that Ms Thomas may have had post-natal depression, and during COVID became paranoid.[9] He also reported that in their community it is a big shame to acknowledge such problems.[10]

8. In April 2021, Ms Thomas resigned from her role as a nurse at Mulgrave Private Hospital abruptly, after which they offered to meet with her and offered Employee Assistance Program (**EAP**), both of which she declined.[11] There had been no disciplinary nor work related issues raised with Ms Thomas.[12] Ms Thomas subsequently increased her (already established) casual employment at Dandenong Hospital to an ongoing role,[13] which continued until the fatal incident.

9. In June 2021, Ms Thomas told her mother that she was upset about '*issues in her marriage*,'[14] and was diagnosed by her GP with mild depression.[15]

10. In January 2022, Ms Thomas again told her mother she wanted a divorce.[16] Ms Thomas gained Australian citizenship in February 2022.[17]

## IMMEDIATE SURROUNDING CIRCUMSTANCES

11. On 24 March 2022, Mr Palakamannil recalled that he went to work in the morning and Ms Thomas dropped the children at school and childcare.[18] In the evening, Mr Palakamannil called Ms Thomas to suggest the family do something outdoors when he got home as the weather was nice.[19]

12. When Mr Palakamannil arrived home at 6.30pm, he noticed that Evlyn and Carolyn were

[9] Ibid, 57-58.
[10] Ibid, 57.
[11] Coronial brief, Statement of K Hotker dated 25 May 2022, 87.
[12] Coronial brief, Statement of R Whyte dated 25 May 2022, 90.
[13] Coronial brief, Statement of James Swan Palakamannil dated 14 April 2022, 62.
[14] Coronial brief, Statement of DSC J Westlake dated 25 July 2022, 263.
[15] Coronial brief, Statement of Dr S Kotur dated 30 May 2022, 77.
[16] Coronial brief, Statement of DSC J Westlake dated 25 July 2022, 262.
[17] Coronial brief, Statement of James Swan Palakamannil dated 14 April 2022, 60.
[18] Ibid, 66
[19] Ibid.

playing on a mobile phone.[20] Ms Thomas was lying on her bed, saying that she needed to lay down for a bit. Ms Thomas then came into the lounge room and asked the children if they wanted to go to McDonalds, after which she and the two children left in her car.[21]

13. The available evidence indicates that at approximately 7.04pm, Ms Thomas drove to a service station along Thompson Road in Cranbourne West and purchased a fuel container which she filled with petrol.[22] She then drove to McDonalds along Thompson Road in Cranbourne West. Available CCTV footage shows that Ms Thomas remained in the McDonalds carpark until 7.28pm.

14. At 7.37 pm, a car was reported on fire parked in an area off Western Port Highway, Cranbourne West and opposite KCC Park.[23]

15. At 7.45pm, Fire Rescue Victoria fire fighters arrived at the scene of the fire and attempted to control the fire. Ms Thomas and her two children were found deceased in the car once the fire was extinguished.[24]

16. Victoria Police Fire and Explosion Unit members attended the scene shortly after the fire was extinguished and commenced an investigation.[25] The investigation noted that there had been an explosion in the passenger compartment of the vehicle and the exterior panels were all severely damaged by fire and the explosion.[26]

17. The investigation concluded that the cause of the fire was the ignition of combustible material in the passenger compartment and was assisted by the presence of petrol. The highest level of petrol was detected on the driver's seat base cover and padding which lead to severe burning to the driver. There were low levels of petrol detected on material from the rear seat. The available evidence suggests that it was possible that petrol was poured in the rear area but also that it could have spread to the rear as a result of firefighting.

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[20] Ibid.
[21] Ibid, 66-67
[22] Coronial brief, Exhibit 3 – CCTV footage from Liberty Service Station
[23] Coronial Brief, various witness statements, 106-116
[24] Coronial brief, Statement of Richard McKay dated 20 May 2022, 151-152
[25] Coronial brief, Statement of John Kelleher dated 4 April 2022, 215-217
[26] Ibid, 220-221

## THE PURPOSE OF A CORONIAL INVESTIGATION

18. Carolyn's death constitutes a "*reportable death*" under the *Coroners Act 2008* (Vic) (the Act), as Carolyn was ordinarily resided in Victoria[27] and the death appears to have been unexpected and violent.[28]

19. Pursuant to section 52(2) of the Act, it is mandatory for a coroner to hold an inquest if the 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.

20. Section 52(1) of the Act further provides that a coroner may hold an inquest into any death that the coroner is investigating. This discretion must be exercised in a manner consistent with the preamble and purposes of the Act.

21. It was apparent, upon reading the coronial brief of evidence, that the events leading up to the fatal incident gave rise to community concern about issues of public health and safety. Consequently, I determined that these issues warranted further investigation to:

    a. Ascertain what services had contact with Jasmine Thomas, Carolyn James and Evlyn James in the lead up to the fatal incident; and

    b. Learn from the deaths of Carolyn James, Evlyn James and Jasmine Thomas to potentially reduce the risk of such an event occurring again and to ensure that key services are better able to support individuals receiving relevant services and respond to similar circumstances.

22. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[29] 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.[30]

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[27] Section 4 *Coroners Act 2008*
[28] Section 4(2)(a) *Coroners Act 2008*
[29] *Coroners Act 2008* (Vic) s 89(4),
[30] *Coroners Act 2008* (Vic) preamble and s 67.

23. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[31] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[32] or to determine disciplinary matters.

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

25. For coronial purposes, the phrase "*circumstances in which death occurred*,"[33] 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.

26. 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.

27. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;[34]

    (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;[35] 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.[36] These powers are the vehicles by which the prevention role may be advanced.

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[31] *Keown v Khan* (1999) 1 VR 69.
[32] *Coroners Act 2008* (Vic) s 69 (1).
[33] *Coroners Act 2008* (Vic) s 67(1)(c).
[34] *Coroners Act 2008* (Vic) s 72(1).
[35] *Coroners Act 2008* (Vic) s 67(3).
[36] *Coroners Act 2008* (Vic) s 72(2).

## SOURCES OF EVIDENCE

## STANDARD OF PROOF

28. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[37] In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*.[38] 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.

## INVESTIGATIONS PRECEDING THE INQUEST

### Identity

29. Carolyn James was identified through DNA sample comparisons of the deceased's blood and buccal swab samples from her father, James Palakamannil.

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

### Medical cause of death

31. On 29 March 2022, Dr Heinrich Bouwer, Forensic Pathologist at the Victorian Institute of Forensic Medicine (**VIFM**) performed an autopsy upon the body of Carolyn James.

Post-mortem examination

32. Dr Bouwer reported that there was evidence of extensive fire damage which limited his examination. There was evidence of inhalation of products of combustion.

Toxicology

[37] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[38] (1938) 60 CLR 336.

33. Toxicological analysis of Carolyn's postmortem blood detected carboxyhaemoglobin at 8% saturation, indicating inhalation of products of combustion prior to death. No ethanol (alcohol) was detected.

Forensic pathology opinion

34. Dr Bouwer ascribed the cause of Carolyn's death to the effects of fire.

**Coroners Prevention Unit – Family Violence investigations**

35. For the purposes of the Family Violence Protection Act 2008, the relationship between Ms Thomas and her children was one that fell within the definition of "*family member*"[39] under that Act. Moreover, Jasmine's actions in fatally setting herself and her children on fire constitutes "*family violence*".[40]

36. In light of Carolyn's death occurring during a family violence incident I requested that the Victorian Systemic Review of Family Violence Deaths (**VSRFVD)**[41] examine the circumstances of Jasmine and her children's deaths and any recent services that had contact with Ms Thomas and her children in the lead up to the fatal incident.

37. There was one instance of family violence reported to Victoria Police for this family prior to the fatal incident. In September 2021, Mr Palakamannil called Victoria Police due to Ms Thomas' damage to property.[42] Mr Palakamannil reported to police he was not in fear, but that Ms Thomas had been increasingly physically and verbally abusive since January 2021.[43] Mr Palakamannil further reported that Ms Thomas' previous violence included threatening him with a knife and cutting up his suits, however he did not report this to police previously as he wanted to manage this within the family.[44] Mr Palakamannil reported much of what he

[39] Family Violence Protection Act 2008, section8(1)(e)
[40] Family Violence Protection Act 2008, section 5
[41] 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.
[42] Victoria Police, LEAP records for CCOV, 15.
[43] Ibid.
[44] Ibid.

described as Ms Thomas' paranoia, was that he was contacting people and speaking badly about her.[45]

38. In November 2021, an interim Family Violence Intervention Order (**FVIO**) was issued, excluding Ms Thomas from the home.[46]

39. Between November 2021 and the Court hearing date on 23 February 2022, Ms Thomas sometimes slept in her car and sometimes stayed at the home in breach of the FVIO, as *'she had nowhere else to go'*.[47] Whilst Ms Thomas did have extended family in Melbourne whom they had stayed with previously, she had cut off contact with them.[48]

40. On 23 February 2022, a final FVIO was issued by the Magistrates Court with consent, with limited conditions and no exclusion.[49]

41. Whilst it appears that professional services identified Ms Thomas as the alleged perpetrator of family violence, the available evidence suggests that this was not an accurate depiction of the relationship. Notably, while engaged with Department of Families, Fairness and Housing (**DFFH)** Child Protection after the reported incident in September 2021, Ms Thomas reported that her husband was '*making her look crazy*,'[50] and she made further reports of coercive control and financial abuse (by Mr Palakamannil).[51] Ms Thomas also advised Child Protection that her husband threatens to call the police whenever she gets angry because he knows she will '*get in trouble'*.[52]

42. The available evidence also suggests that in a phone consultation with her GP in October 2021, Ms Thomas reported her husband was verbally abusive and was referred to Relationships Australia for support to separate, as Ms Thomas advised she could not afford a lawyer.[53] Also, in a telehealth appointment with Psychology for Change in January 2022,

[45] Above n1, 58.
[46] Coronial brief, Exhibit 28, Certified Extract of Interim Intervention order, 345-347.
[47] Coronial brief, Statement of James Swan Palakamannil dated 14 April 2022, 59.
[48] Ibid, 64.
[49] Coronial brief, Exhibit 29, Certified Extract of Final Intervention order, 348-349.
[50] Department of Families, Fairness and Housing, UNREDACTED CP File – Carolyn James, 21.
[51] Department of Families, Fairness and Housing, UNREDACTED CP File – Evlyn James, 104-107.
[52] Above n50, 84.
[53] Coronial brief, Statement of Dr S Kotur dated 30 May 2022, 77.

Ms Thomas disclosed that her husband threatened to report her to the nursing board during the incident in September 2021, and Ms Thomas refused to answer when asked about physical violence from her husband. She was subsequently offered contact details for family violence support services.[54]

43. The available evidence further suggests that Mr Palakamannil advised that he could see where Ms Thomas was when she left the house during an argument in 2021 because he had her iPhone log in and could track her.[55] His evidence also included that he would force her onto the bed in the room and not let her leave the home if she was angry and screaming, due to the shame it would bring.[56]

## THE INQUEST

44. Pursuant to section 52(2) of the Act, it is mandatory for a coroner to hold an inquest if the 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.

45. Whilst Ms Thomas died from an apparent suicide, her children died in circumstances indicating possible homicide. Section 52(1) of the Act further provides that a coroner may hold an inquest into any death that the coroner is investigating. This discretion must be exercised in a manner consistent with the preamble and purposes of the Act.

46. I considered it appropriate to use my discretion to hold a Summary Inquest on 23 April 2024. However, I did not deem it necessary to hear from any witnesses as coronial investigation had thoroughly examined the circumstances of each death and there was no prevention opportunity identified.

## COMMENTS

I make the following comment(s) connected with the death under section 67(3) of the Act:

[54] Coronial brief, Statement of S Sutharsanan dated 21 June 2022, 80.
[55] Above n1, 61.
[56] Ibid, 61.

*Family violence risk factors relevant to this investigation*

47. I note that a coronial inquiry is by its very nature a wholly retrospective endeavour and this carries with it an implicit danger in prospectively evaluating events through the '*the potentially distorting prism of hindsight'*.[57] I make the following observations about professional services that had contact with the deceased to assist in identifying any areas of practice improvement and to ensure that any future prevention opportunities are appropriately identified and addressed.

48. The available evidence indicates that there were a number of relevant family violence risk factors evidence in this case, this included potential social isolation of Ms Thomas due to her belief that her husband was '*speaking bad about her to everyone'*,[58] emotional abuse including '*it was about him emotionally putting me down'*,[59] and potential systems abuse including '*my husband is very clever, he will not let me go'* indicating her perception that her husband may have a better knowledge of how authorities operate in Australia.[60] These indicators could have been explored in the cultural context of the family and their lack of support networks, but appear to have been largely disregarded in light of the allegations of physical violence by Ms Thomas.

49. Despite both Child Protection and Victoria Police holding concerns about Ms Thomas' mental health, as she was not assessed as acutely unwell and did not wish to engage with services, she did not receive any formal assessment nor diagnosis beyond mild depression. Ms Thomas' hesitation in seeking mental health support may indicate a potential gap between communities in Australia and connectedness to services that can assist them.

50. Since the final report of the **Royal Commission into Mental Health** (2021), the Victorian Government has:

[57] *Adamczak v Alsco Pty Ltd (No 4*) [2019] FCCA 7, [80]
[58] Department of Families, Fairness and Housing, UNREDACTED CP File – Evlyn James, 105.
[59] Ibid.
[60] Above n33, 106.

a. Provided grants for community-led organisations to support the mental health and wellbeing of culturally and linguistically diverse communities, LGBTIQ+ people and people with disability;

b. Established a Diverse Communities' Working Group, which advises on the mental health and wellbeing needs of diverse communities and how best to respond to these needs;

c. Progressed a Diverse Communities Mental Health and Wellbeing Framework and Blueprint guided by the Working Group and feedback from people from diverse communities;

d. Begun improving data recording and collection system to better record and understand the experiences of diverse communities; and

e. Partnered with community organisations and peak bodies to support their communities to engage with the reforms.[61]

51. From the available evidence, it is difficult to accurately determine what was occurring for this family in the lead up to the fatal incident, however we note that there may have been issues of misidentification in context of family violence. There is insufficient engagement with services however to conclusively make a determination on this point.

52. I note that if this was a case of misidentification, a specialist family violence worker may have been able to engage with Ms Thomas around her support needs and reasons for her reported use of violence.

53. I note that **CO-Responder (cooperative frontline response) programs** have been suggested as an alternative method to provide victims of family violence with the support they require. The presence of a family violence specialist worker during police attendance at an incident of family violence could assist in '*identifying the dynamics and meanings*

[61] Victorian Government, Department of Health, Recommendation 34; Working in partnership with and improving accessibility for diverse communities <https://www.health.vic.gov.au/mental-health-reform/recommendation-34>.

*attached to the violence'*[62], and aid the victim to consider the '*options and consequences in her specific circumstances'*.[63] It has been suggested that this model of intervention could '*assist police in distinguishing between coercive control, violent resistance and fights'*.[64]

54. While Ms Thomas was not present when police attended the initial incident, they then engaged with her to be interviewed for criminal damage and served an interim intervention order. Had a co-responder model been in place, this would have been a key opportunity for a specialist family violence worker to be able to work with Ms Thomas to identify her support needs and determine if family violence or mental health supports would be more appropriate.

## FINDINGS

1. I find that Carolyn James born 23 November 2018 died on 24 March 2022 at along the Western Port Highway, Cranbourne West, Victoria.

2. I accept and adopt the cause of death as ascribed by Forensic Pathologist, Dr Heinrich Bouwer and I find that Carolyn James died from the effects of fire and circumstances where her mother had deliberately set fire to the motor vehicle Carolyn was sitting in with her sister and mother.

3. I am not able to determine all of the contributing factors leading Jasmine Thomas to end her own life and that of her children. However, in the absence of any other intervening significant event, I find that Jasmine Thomas was experiencing significant stress in her relationship and there was evidence of a number of family violence risk factors in the lead up to the fatal incident.

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[62] Nancarrow, H. (2016). Legal responses to intimate partner violence: Gendered aspirations and racialised realities. Unpublished doctoral dissertation). Griffith University, Australia, 180.
[63] Ibid.
[64] Nancarrow, H., Thomas, K., Ringland, V., & Modini, T. (2020). Accurately identifying the "person most in need of protection" in domestic and family violence law (No. ANROWS Research Report 23). Australia's National Research Organisation for Women's Safety, 21.

4. I find no causal link between services who had contact with Jasmine Thomas and her children and Jasmine's decision to take her own life and that of her children.

**PUBLICATION OF FINDING**

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

**DISTRIBUTION OF FINDING**

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

Mr James Palakamannil, Senior next of kin

Assistant Commissioner Lauren Callaway, Family Violence Command, Victoria Police

Eleri Butler, CEO, Family Safety Victoria

Liana Buchanan, Principal Commissioner, Commission for Children and Young People

Emma Pistritto, Civil Litigation Manager, Victoria Police

Detective Senior Constable Heather Whitehead, Coroner's Investigator, Victoria Police

Signature:

_____

JUDGE JOHN CAIN
STATE CORONER
Date: 23 April 2024


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.