IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 003155

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner John Olle
Deceased:	Jack William Allen
Date of birth:	25 September 2002
Date of death:	17 June 2021
Cause of death:	1(a) NECK COMPRESSION 1(b) HANGING
Place of death:	15 Paynes Road, Seville, Victoria, 3139

INTRODUCTION

1. On 17 June 2021, Jack William Allen was 18 years old when he was found deceased at home. At the time of his death, Jack lived at 15 Paynes Road, Seville with his mother, Jenny Allen (**Ms Allen**).

THE CORONIAL INVESTIGATION

2. Jack's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

3. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

4. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

5. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Jack's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

6. This finding draws on the totality of the coronial investigation into the death of Jack William Allen including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. 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 as to those matters taking into account the consequences of such findings or comments.

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

Circumstances in which the death occurred

7. Jack was a happy child but as a young man, the available evidence suggests that he increasingly struggled with his mental health and general wellbeing.

8. In 2014 Jack's parents, Jenny and Paul Allen (**Mr Allen**), initially became separated and he experienced this as fundamentally destabilising event in his life.

9. In 2015, as part of an acrimonious separation, Family Court proceedings between his parents resulted in Jack being placed primarily with his mother with his father having supervised visits. Jack began acting out at school and fell out with his mother, eventually ending in him living with the families of various friends, including Ky Supple's (**Mr Supple**) family at one point.

10. On 7 September 2017 Ms Allen was served with an Intervention Order which listed Jack as the Affected Family Member and herself as the Respondent. Jack then began living with his father in Mansfield.

11. There is some evidence to suggest that Jack attended a psychologist contracted to his school in Mansfield to a limited extent, however Mr Allen states that he distrusted the profession and disengaged with any professional support.

12. In early 2020, after falling behind due to behavioural problems, drug use and non-attendance at school, Mr Allen agreed to support in leaving school to embark on a plastering apprenticeship. Mr Allen noticed Jack beginning to challenge the rules in his home as he (Jack) experienced more independence.

13. After turning 18, Jack made several attempts to move out of home with friends but ultimately returned home each time following disagreements with his housemates.

14. Mr Allen learned that Jack's apprenticeship had been terminated due to non-attendance and behavioural concerns.

15. Jack then moved to Wodonga to work in a plastering business with his cousin, although the available evidence suggests that he became involved in drug use and trafficking cocaine and MDMA.

16. Jack also began a relationship with Isabella Kennedy (**Ms Kennedy**) whom he lived with and who financially supported him. Following the end of this relationship, Jack was homeless and relied on friends to 'couch-surf'.

17. Ms Kennedy states that it became apparent Jack was struggling with his mental health.

18. On 17 May 2021, Ms Kennedy notes that Jack sent a suicidal message via Snapchat. Ms Kennedy also notes that she was aware for some time that Jack was harbouring such thoughts.

19. In the period prior to his death Jack was involved in a motor vehicle collision, causing significant damage to his treasured car. He later disclosed to a friend that this was an abandoned attempt to take his own life.

20. In the days before Jack's death, Victoria Police also began executing drug warrants on his associates pursuant to an investigation by detectives in Mansfield. Ms Allen believes this was stressor for Jack.

21. On 17 June 2021, sent a text message thanking his family and friends for their support but expressing his decision to end his life. Jack sent a Snapchat of his feet on a chair on what appeared to be his mother's back porch which Mr Supple received and immediately attended the Seville house, though Jack was deceased on his arrival.

Identity of the deceased

22. On 17 June 2021, Jack William Allen, born 25 September 2002, was visually identified by his mother, Jenny Allen.

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

Medical cause of death

24. Forensic Pathologist Dr Joanna Glengarry from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 18 June 2021 and provided a written report of her findings dated 21 June 2021.

25. The post-mortem examination revealed injuries consistent with the circumstances, including a hyoid fracture and ligature abrasion of the neck.

26. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or any commons drugs or poisons.

27. Dr Glengarry provided an opinion that the medical cause of death was 1 (a) NECK COMPRESSION.

28. I accept Dr Glengarry's opinion.

FINDINGS AND CONCLUSION

29. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Jack William Allen, born 25 September 2002;

    b) the death occurred on 17 June 2021 at 15 Paynes Road, Seville, Victoria, 3139, from NECK COMPRESSION; and

    c) the death occurred in the circumstances described above.

30. Having considered all of the circumstances, I am satisfied that Jack intentionally took his own life.

31. It is often difficult to determine what may have precipitated a person's decision to end their own life. There are sometimes issues known only to the deceased person. It is clear that Jack was experiencing a number of stressors in his life, including his mental health, drug use and trying to establish his own independence in life. Though family and friends were cognisant to some extent of Jack's struggles, he appears to have internalised these and resisted attempts to engage him with professional support. In such circumstances, no one bears responsibility for this tragedy.

32. I convey my sincere condolences to Jack's family for their loss.

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

Jenny Allen, Senior Next of Kin

Paul Allen, father of the deceased

Senior Constable Jayden Coulson, Victoria Police, Coroner's Investigator

Signature:

Coroner John Olle

Date : 13 May 2022

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 investigation. 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.