IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 001606

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge John Cain, State Coroner
Deceased:	Jasmine Sara Thomas
Date of birth:	02 March 1985
Date of death:	24 March 2022
Cause of death:	1(a) EFFECTS OF FIRE
Place of death:	Breasley Road, Western Port Highway, Cranbourne West, Victoria, 3977
Keywords:	Death from effects of fire; no person charged with an indictable offence in respect of a reportable death; mandatory inquest

INTRODUCTION

1. On 24 March 2022, Jasmine Sara Thomas was 37 years old when she died. At the time of her death, Jasmine lived at 17 Funnel Court, Lyndhurst, Victoria, 3975 with her husband James Swan Palakamannil (James) and their two children Evelyn Kay James (Evelyn) and Carolyn Mary James (Carolyn).

2. Jasmine and James met in Kuwait and were married in India on 3 November 2012. Jasmine and James were granted permanent residency in Australia in May 2015 and moved to Melbourne in January 2016.[1]

3. Evelyn was born in 2016 and Carolyn in 2018.

THE CORONIAL INVESTIGATION

4. Jasmine'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.[2]

5. 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.

6. 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.

7. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Jasmine'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 from the Victoria Police Arson and explosives squad – and submitted a coronial brief of evidence.

[1] Coronial Brief, Statement of James Swan PALAKAMANNIL, p55
[2] *Coroners Act 2008* (Vic) s 4.

8. This finding draws on the totality of the coronial investigation into the death of Jasmine Sara Thomas 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.[3]

IDENTITY OF THE DECEASED

9. On 31 March 2022 Jasmine Sara Thomas, born 02 March 1985, was identified by DNA analysis comparison.

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

MEDICAL CAUSE OF DEATH

11. Forensic Pathologist Dr Henrich Bouwer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 29 March 2022 and provided a written report of his/ findings dated 6 July 2022.

12. The post-mortem examination revealed:

    a) extensive fire damage and evidence of inhalation of products of combustion, indicating that the deceased was alive in the fire prior to death. Apart from fire-related fractures, no other trauma was identified, although assessment was hampered by the degree of fire damage.

    b) Post-mortem toxicological analysis detected carboxyhaemoglobin in leg and extradural blood at 14% and 11% saturation respectively. This was in keeping with inhalation of products of combustion prior to death. Alcohol, common drugs and poisons were not detected.

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

14. Dr Bauer provided an opinion that the medical cause of death was 1 (a) EFFECTS OF FIRE.

[3] 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.

15. I accept Dr Bauer's opinion.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

16. On the evening of 24 March 2022 James arrived home from work at approximately 6.30 pm Jasmine was lying on the bed and Carolyn and Evelyn were playing on Jasmines mobile phone. James was annoyed by this as he did not like the children playing on the phone. He had called Jasmine on his way home and suggested to Jasmine that they do something outside when he got home as the weather was nice. He was surprised that Jasmine and the children were not ready to go and spoke to Jasmine about this and she said she needed to lay down for a bit longer.

17. A short time after that Jasmine asked Evelyn if she wanted to go to McDonalds. Evelyn said yes and Jasmine got into the car with both Evelyn and Carolyn. James had to move his car to allow Jasmine to move her car out of the driveway. James did not join Jasmine and the children, he stayed at home. James did not have any contact with Jasmine after she left in the car with Evelyn and Carolyn.

18. Jasmine was driving a red Toyota Hatchback and James recalls that she left the house at approximately 6.45 pm. CCTV footage from a house 1.2 kilometres from the family home recorded Jasmine's car travelling south at 7.01 pm. CCTV footage from the Liberty Service station in Thompsons Road Cranbourne West shows Jasmine arriving at the service station at 7.04 pm. At the Liberty Service station Jasmine purchases a 10-litre fuel container. Having purchased the container, she filled the container with 6.9 litres of petrol and places it in the boot of the car. She paid for the fuel and left the Service Station. Her movements at the service station are all captured on CCTV.

19. Upon leaving the Liberty service Station Jasmine drove to the Cranbourne West McDonalds restaurant which is nearby the Service Station.

20. The CCTV footage from the Cranbourne West McDonald Store shows Jasmine drive into the 'drive through' at the McDonald's, place her order before moving to the next window to collect her order. It appears from the available evidence that both Evelyn and Carolyn are in the back seat of the car at the time.

21. Jasmine leaves the 'drive through' area and parks in the Street in front of McDonalds. Jasmine is seen passing food over to the back seat and looking at her phone. Jasmine remained there

until 7.28 pm when she reverses out of the carpark and leaves. The CCTV footage from McDonalds also shows that nobody entered or exited the vehicle during that time.

22. At 7.37pm the first call to triple zero was made reporting an explosion and car fire on Western Port highway between Wedge Road, and Breasley Road. Numerous other calls followed this initial report. Fire Rescue Victoria arrive at the location at 7.45 pm. Leading Fire Fighter (LFF) Richard MCKAY stating that on arrival at the fire he "saw a car that was fully involved in fire and a grass fire was burning away from the car towards the north. [4] Fire Rescue Victoria teams extinguished the fire.

23. Inspection of the vehicle identified three occupants one in the driver's seat and two in the back seat of the burnt-out car. The bodies were later identified as Jasmine who was located in the driver's seat of the vehicle Evelyn and Carolyn both located in the back seat of the burnt-out vehicle.

Fire Investigation

24. The investigation of the fire was undertaken by John Desmond Kelleher (Mr Kelleher) and he provided a statement to the court following his examination and investigation. Mr Kelleher holds a Bachelor of Applied Science and Bachelor of Arts and is a member of the Royal Australian Chemical Institute and a Chartered Chemist. He is also a member of the Australian Institute of Physics and is employed by Victoria Police Forensic Services Centre. Mr Kelleher conducted an extensive and thorough examination of the vehicle to determine the mechanism and cause of the fire. His report has greatly assisted this investigation.

25. In his statement Mr Kelleher concludes

The cause of the fire was the ignition of combustible material in the passenger compartment, such as seat covers, seat padding, trim and clothing, assisted by the presence of petrol. A child seat and possibly a booster seat would have increased the amount of combustible material present.

There was evidence of a significant explosion, which caused structural damage to the vehicle. The windows remained intact, but were bent outwards, the door skins were partly blown off, and the frame was distorted.

There was a relatively low level of petrol detected in the rear of the vehicle, and the fuel-air mixture in the rear may have been lean, which would tend to cause more explosion damage.

There were two children in the rear seat, both of whom were very severely burnt.

[4] Coronial Brief, Statement of Richard MCKAY, pg151

Higher levels of petrol were detected in the front passenger foot well, and the highest level was detected on the driver's seat base cover and padding.

There was an adult female person in the driver's seat, who was also very severely burnt.

The majority of the fuel appeared to have been on and around the driver, particularly on the driver's seat, leading to severe burning to the driver. The driver was seated correctly in the driver's seat, with her seatbelt undone, but with her door closed and probably locked.

There was a small amount of melted red plastic found on the passenger seat. This may have been the remains of a fuel container, but the amount present was so small this could not be confirmed.

There were low levels of petrol detected on material from the rear seat. It was not clear whether petrol was poured in this area or whether it spread to the rear as a result of firefighting.

The source of ignition was not determined. Matches may not have survived the fire, and a cigarette lighter may have been embedded in the debris. While the circumstances suggested that ignition by match or a cigarette was probable, the electrical equipment of the car also presented several possible ignition sources, such as the ignition switch and the various light switches[5]

26. In his statement James told police that there had been a green 'bic lighter' that was usually in the drawer of the kitchen but that it could not be located in the days after the fire[6]. It is possible that Jasmine took this lighter when she left the house and used it to ignite the fuel.

FURTHER INVESTIGATIONS AND CPU REVIEW

Family Violence Investigation

27. The relationship between Jasmine and her children met the definition of *'family member'*[7] as defined by the *Family Violence Protection Act 2008* (Vic) (**FVPA**). Evidence available to the court suggests that Jasmine perpetrated *'family violence'*[8] in setting fire to the car leading to the death of both children and herself.

28. In these circumstances, I requested that the Coroners Prevention Unit (**CPU**)[9] examine the circumstances of her death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[10]

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[5] Coronial Brief, Statement of John KELLEHER, pg215
[6] Coronial Brief, Statement of James Swan PALAKAMANNIL, p70
[7] Family Violence Protection Act 2008, section 8(1)(a)
[8] Family Violence Protection Act 2008, section 5
[9] 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.
[10] 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.

29. There is one incident of family violence reported to police which I will briefly summarise. On 29th September 2021, James contacted police following a dispute with Jasmine. James reported that Jasmine had become aggressive and was causing damage to property, including clothing and kitchen appliances. Evelyn and Carolyn were at home at the time. Police attended the home and spoke with James. Jasmine had left by the time police arrived.

30. James did not support any criminal action being taken against Jasmine and signed a 'Statement of no complaint'. Police attempted to contact Jasmine that same day but were unsuccessful. They applied to the Magistrates Court for an Intervention Order to protect James, Evelyn and Carolyn.

31. On 8th November 2021, Jasmine attended the Dandenong Police Station and was interviewed. On 18 November 2021 an Interim Intervention Order was granted by the Dandenong Magistrates Court, which included conditions that Jasmine could not have any contact with James, Evelyn and Carolyn, and that she could not attend the family home.

32. Jasmine was worried that the Intervention Order might affect her work and that she might lose custody of the children. She did not have alternative accommodation and spent some nights sleeping in her car. At other times, she would stay at the family home, even though Jasmine and James, both knew it was against the conditions of the order. No further incidents were reported to police and James stated that it was peaceful between them after the September incident.

33. On 23 February 2022, the Intervention Order application was heard at the Dandenong Magistrates Court. James asked the Court to remove the exclusion condition so that he and Jasmine could live together. A final Intervention Order was issued with the condition that Jasmine must not commit family violence against James, Evelyn or Carolyn, or intentionally damage any of their property. The order was issued for a period of 12 months. James stated that once the Intervention Order was varied, Jasmine was happier. Jasmine continued working three days a week at the Dandenong Hospital and lived in the family home with James, Evelyn and Carolyn.

34. A thorough review of the available material found no other family violence incidents and I am satisfied that other than this incident there does not appear to be any other reported incident of family violence and that there are no prevention opportunities that have been missed

Mental Health Investigation

35. As part of my investigation, I obtained Jasmine's medical history and statements from treating doctors. Dr Sarita Kotur from the Union Medical Centre was Jasmine's usual doctor. She had attended the clinic on multiple occasions from March 2019 to November 2021. Jasmine had attended Dr Kotur with issues ranging from backpain, fatigue and concerns about not coping at work. Dr Kotur reports that on 21 June 2021 Jasmine attended the clinic complaining she was feeling low and not sleeping. She was assessed as suffering mild depression and was prescribed Cipramil which is an anti-depressant and melatonin to treat her insomnia. In October she returned to the clinic stating that although the was taking the medication it was not assisting. Dr Kotur referred Jasmine to a psychologist for further treatment.

36. This referral resulted in a telehealth appointment with Psychologist Sangeeta Sutharsanan. In that consultation Jasmine denied having any suicidal thoughts or intent. Jasmine described how the lack of family support as well as the stressors of juggling her work and caring responsibilities was contributing to an increase in arguments between herself and James. Sangeeta Sutharsanan states that she did not identify any risk of self-harm or harm to others posed by Jasmine. A follow up appointment was scheduled for 31 January 2022, but Jasmine did not attend this appointment.

37. The medical assessments of Jasmine did not identify a risk of harm to herself or others and having reviewed the material I am satisfied that the care provided to Jasmine was reasonable and appropriate in light of the history provided by Jasmine and the absence of any other identified issues.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

38. A thorough review of the family violence history, management of the complaint and follow up reveals only the one incident of family violence that was dealt with. There are no further reports or issues raised. Similarly, the medical care and treatment for Jasmine appears to be appropriately managed with initial assessment by the Doctor and later a referral and appointment with a psychologist with no indication that self-harm or harm to others was likely or a risk. The investigation has not revealed any explanation or understanding of the precise events or circumstances that led to Jasmine killing herself and her two children. In the circumstances I can only conclude that Jasmine had an episode of psychosis and whilst in this psychotic sate she killed both her children and herself.

FINDINGS AND CONCLUSION

1. Having held an inquest into the death of Evelyn Kay James and Carolyn Mary James I make the following findings, pursuant to section 67(1) of the Act:

    a. the identity of the deceased are Evelyn Kay James born 15 March 2016 and her sister Carolyn Mary James born 23 November 2018;

    b. the deaths occurred on 24 March 2022 at Western Port Highway Cranbourne West, Victoria;

    c. the cause of death was Evelyn Kay James (1)(a) Effects of Fire; and Carolyn Mary James (1)(a) Effects of Fire

    d. the death occurred in the circumstances described above.

2. I have been unable to determine the contributing factors that lead to Jasmine take her own life and the lives of her children Evelyn and Carolyn, and in the absence of any other intervening event, I have concluded that Jasmine suffered an episode of psychosis and while in this psychotic state she caused the death of both her children and herself in the circumstances described above.

3. Having considered all the available evidence, I am satisfied that no further investigation is required in this case.

4. I convey my sincere condolences to Mr James Swan Lapakamannil and his family for their loss.

5. 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.

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

    Mr James Swan Lapakamannil, Senior Next of Kin

    Detective Senior Constable Jarrod Westlake, Coroner's Investigator

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.

Signature:

Judge John Cain
STATE CORONER
Date:

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