IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 001628

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Daniel James Mayes
Date of birth:	18 September 1985
Date of death:	30 March 2021
cause of death:	1(a) Neck compression 1(b) Hanging
Place of death:	5 Brindalee Place, Cranbourne East, Victoria, 3977
Keywords:	Suicide, bullying, mental health

INTRODUCTION

1. On 30 March 2021, Daniel James Mayes was 35 years old when he was found deceased at his home. At the time of his death, Daniel lived at 5 Brindalee Place, Cranbourne East as a carer for his grandmother.

2. Daniel grew up in the Belgrave South area surrounded by his family. His mother, Jennifer, described him as a happy child. While going through puberty, Daniel was diagnosed with Type 1 diabetes and struggled with becoming insulin dependent.[1]

3. As a teenager, Daniel attended Emerald Secondary College but was expelled when he was about 16 years old for drinking alcohol and chose not to return to school. Whilst he had struggled academically, Daniel was always good with his hands and willing to work and learn new skills. He had a particular interest in motor mechanics.[2]

4. Daniel left home at the age of 15 to avoid conflict with his mother's then partner and went to live with his maternal grandmother. He later became his grandmother's carer when she developed dementia, a role which he found increasingly difficult as her illness progressed over the last two or three years of his life, but he remained devoted to giving her the best care he could and maintained a good relationship with her until his passing.[3]

5. As Daniel got older, his attitude hardened and he started to get into trouble with police. In addition to drug-related matters,[4] Daniel became known for stealing cars and driving them around, then ultimately returning them to where he had found them.

6. Aside from his diabetes, Daniel's health was otherwise good. At the time of his passing, he was unemployed and single.[5]

THE CORONIAL INVESTIGATION

7. Daniel'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.

[1] Statement of Jennifer Sporton, Coronial Brief.
[2] Ibid.
[3] Ibid.
[4] Daniel's mother was aware that he consumed alcohol, cannabis and amphetamines. Ibid.
[5] Ibid.

8. 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.

9. 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.

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

11. This finding draws on the totality of the coronial investigation into the death of Daniel James Mayes 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.[6]

12. In considering the issues associated with this finding, I have been mindful of Daniel's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

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

Circumstances in which the death occurred

13. A few years prior to his passing, Daniel formed a romantic attachment with a young woman. The relationship ended when Daniel found out that she was sleeping with a long-term male acquaintance of his. When Daniel confronted the pair about this, he was initially physically

[6] 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.

abused and then sent harassing electronic messages. He shared some of these with his mother, and admitted he was struggling with his mental health as a result.

14. Approximately three weeks before his death, Daniel sent his mother a screenshot of one of these abusive messages, which Jennifer recalled were words to the effect of, 'Your first attempt didn't work, you're weak, make sure you get it right next time'.[7]

15. His mother was not aware whether Daniel had made a previous suicide attempt, but she nonetheless tried to engage him with mental health support or medication. Daniel declined, however, explaining that he knew that his problem was his former romantic relationship and that things would be better once she was out of his life.

16. On 29 March 2021, Daniel sent his family text messages saying, 'I've had enough and can't deal with everything anymore'.

17. The next morning, 30 March 2021, Daniel's grandmother called Jennifer and said that Daniel was sitting outside and ignoring his dog, who was pawing and nudging him. Given her dementia background, Jennifer suspected there might be something wrong and arranged to meet Daniel's sister at the house as soon as possible.

18. When Jennifer arrived at Daniel's address, police and ambulance members were already present, having arrived at around 8:40 am after receiving a 000 call. Daniel was found hanging from a red rope attached to a rafter of the outdoor patio area. His body was already cold and stiff, and police cut the ligature to release Daniel to the ground. He was formally pronounced deceased at 9:02 am. Police found no suspicious circumstances.

19. At the request of the family, police removed a cannabis plant found growing inside the house for destruction.[8]

Identity of the deceased

20. On 30 March 2021, Daniel James Mayes, born 18 September 1985, was visually identified by his grandmother, Janet Burrows.

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

[7] *Ibid*. Copies of the messages have not survived.
[8] Statement of Senior Constable Thomas Lewis & Exhibit 1 Ambulance Victoria Verification of Death Form, Coronial Brief.

Medical cause of death

22. Forensic Pathologist Dr Brian Beer from the Victorian Institute of Forensic Medicine conducted an external examination on 31 March 2021 and provided a written report of his findings dated 7 April 2021.

23. The external examination revealed ligature marks around the neck consistent with the red nylon rope separately provided. There were no other marks or injuries to the remainder of the body, and no other independent causes of death were identified.

24. Toxicological analysis of post-mortem blood samples identified the presence of a significant but not fatal amount of alcohol (0.12 g/100mL), but did not identify the presence of any other common drugs or poisons.

25. Dr Beer provided an opinion that the medical cause of death was 1(a) neck compression secondary to 1(b) hanging. I accept Dr Beer's opinion.

FURTHER INVESTIGATION

26. During the course of my investigation, I formed the view that although copies of the abusive messages sent to Daniel by his former partner and male acquaintance had not survived, an indictable offence may have been committed by the act of sending of them.[9]

27. Accordingly, on 18 July 2022, I referred the matter to the Director of Public Prosecutions for her consideration.[10] This led to Victoria Police being given legal advice, the contents of which are rightly privileged and do not form part of my brief, however, after being allowed sufficient time to complete their investigations, I have confirmed that no charges were ultimately laid.

FINDINGS AND CONCLUSION

28. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[11] With respect to adverse comments or findings, the effect of the authorities is that they should not be made unless the

[9] See for instance, the stalking offence set out at section 21A of the *Crimes Act 1958* (Vic) and its reference to electronic publication intentionally causing physical or mental harm, including self-harm. Section 474.17 of the *Criminal Code* (Cth) also makes it an offence to use a carriage service to menace, harass or cause offence.

[10] Pursuant to section 49(1) of the *Coroners Act 2008* (Vic).

[11] *Briginshaw v Briginshaw* (1938) 60 CLR 336 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…'.

evidence provides a comfortable level of satisfaction that an individual (or institution) caused or contributed to the death, and in the case of individuals acting in a professional capacity, that they departed materially from the standards of their profession.

29. A coronial investigation is a fact-finding exercise rather than a vehicle for the apportionment of blame. Further, a finding that a person is, or may be, guilty of an offence is specifically prohibited by s 69(1) of the Act.[12] However, that is not to say that individuals or other entities will not be criticised in a coronial finding. It is sometimes necessary to identify fault to devise a means of correction through a coronial recommendation, or fault may be implied in the description of the circumstances in which the death occurred.

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

    a) the identity of the deceased was Daniel James Mayes, born 18 September 1985;

    b) the death occurred on 30 March 2021 at 5 Brindalee Place, Cranbourne East, Victoria, 3977, from neck compression secondary to hanging; and

    c) the death occurred in the circumstances described above.

31. Having considered all of the circumstances, I am satisfied that Daniel intentionally took his own life. The weight of the available evidence suggests that Daniel's mental health had deteriorated in the face of significant distress occasioned by the breakdown of his relationship and the subsequent online bullying and abuse perpetrated by his former partner and a male acquaintance.

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

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

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

Jennifer Sporton, Senior Next of Kin

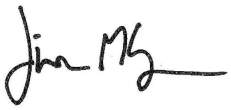
Peter Sporton, Senior Next of Kin

[12] Subsection (1) does not apply to prevent the inclusion in a comment of a statement relating to a notification to the Director of Public Prosecutions under section 49: s 69(2) *Coroners Act 2008* (Vic).

The Director of Public Prosecutions

Senior Constable Thomas Lewis, Coroner's Investigator

Signature:



Coroner Simon McGregor

Date : 07 November 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 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.