2020

THE LEGISLATIVE ASSEMBLY FOR THE

AUSTRALIAN CAPITAL TERRITORY

CORONER'S REPORT INTO THE DEATH OF JANDY RENIA SHEA

Presented by

Yvette Berry MLA

Minister for the Prevention of Domestic and Family Violence

CORONERS COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	**AN INQUEST INTO THE DEATH OF JANDY RENIA SHEA**
Citation:	**[2019] ACTCD 12**
Date of Findings:	23 September 2019
Before:	B C Boss
Decision:	1 Jandy Renia Shea (nee Ferguson) died on 4 March 2018 at 3A Charlton Crescent, Gordon in the Australian Capital Territory; 2 The manner and cause of death of Ms Shea are sufficiently disclosed and a hearing is unnecessary; 3 The manner and cause of Ms Shea's death is suicide by hanging; and 4 Pursuant to s 52(4)(a)(i) of the *Coroners Act 1997*, no matter of public safety is found to arise in connection with this inquest.
File Number:	CD 60 of 2018

1. The death of Jandy Renia Shea, a 27 year old woman at the date of her death, was reported to then ACT Chief Coroner Walker as she was thought to have died unnaturally in unknown circumstances. Jandy was located by her husband Christopher (Chris) in the early morning of 4 March 2018 hanging from a bathroom door handle by a tie-down strap.

2. Shortly after Jandy's death was reported, her parents, Renia and David Ferguson, contacted Police to suggest that Jandy might have died as the result of the actions of another person. Accordingly Chief Coroner Walker directed a police investigation into the events of Ms Shea's death occur.

3. On her appointment to the Supreme Court on 1 August 2019, Her Honour acting Justice Walker no longer holds commission as a Coroner. This matter then fell to me to decide.

4. The then Chief Coroner had prepared draft findings in this matter, and caused a section 55 notice to be forwarded before her appointment as an acting Judge. I have had an

opportunity to review all of the evidence that was before the then Chief Coroner. I have had an opportunity to consider that evidence, the submissions made, and the findings drafted for publication by the then Chief Coroner. I find no reason to alter the conclusions drawn from the evidence and the proposed findings and recommendation articulated by the then Chief Coroner.

5. I am satisfied on review of the available evidence that there is no utility in a public hearing. I make the following factual findings.

Background

6. Jandy was born in Canberra to Renia and David Ferguson on 23 March 1990. She met Chris Shea in Canberra in 2007. On 13 September 2009 their first son Aiden was born. On 26 September 2009 Jandy and Chris were married at the Lanyon Homestead in Tharwa. On 20 November 2011 their second son Flynn was born.

7. Jandy was the victim of sexual assault when she was 16. This incident triggered lifelong episodic anxiety and depression in Jandy, including ante-natal and post-natal depression in relation to the births of her children. Jandy undertook some counselling in the immediate aftermath of the sexual assault. She had taken anti-depressants for post-natal depression. However, in the years prior to her death she was not receiving any treatment for her mental health. Jandy's family described her as being in good physical health.

Domestic Violence Incident

8. In late 2014 the relationship between Jandy and Chris broke down. In September 2014 Chris moved out of the family residence in Gordon and Jandy remained in the house with Aiden and Flynn. Jandy commenced a relationship with another person. Chris retained keys to the residence but was not supposed to go to the house without prior arrangement with Jandy.

9. In the early hours of 15 November 2015 Jandy received a number of messages from Chris that she decided not to return at the time. At about 6am that day Chris began to knock on Jandy's bedroom window. Jandy went outside to speak with Chris. Chris started to choke Jandy and drag her back into the house. Jandy lost consciousness during the assault.

10. Chris was arrested by Police for this assault on Jandy. He pleaded guilty in the ACT Magistrates Court, and was sentenced as follows:

a. On two counts of common assault, 9 months imprisonment, 3 months of which were to be served as periodic detention; and

b. On one count of act of indecency, 9 months imprisonment, fully suspended upon entering into a good behaviour order for 2 years.

11. On 17 November 2014 Jandy applied for and was granted an interim domestic violence order against Chris. Ultimately a final order was made prohibiting Chris from engaging in family violence against Jandy, and from attending the family residence in Gordon, for a period of 2 years.

12. On 2 September 2015 Chris successfully completed the ACT Corrections Domestic Abuse Program.

Reconciliation

13. About July 2017, Jandy and Chris recommenced contact. Shortly after recommencing contact they made a decision to recommence their relationship. Chris moved back into the Gordon family residence with Jandy, Aiden and Flynn.

14. However, the relationship between Jandy and Chris remained tumultuous at times. Jandy's parents and many of her friends reported to Police after her death that Jandy was in fear of Chris at times. Jandy's sister Kelly told Police after Jandy's death that Jandy had feared that Chris would kill her. One of Jandy's friends told Police that Jandy had referred to herself as "the next Tara Costigan"[1].

15. On 17 February 2018 Jandy and Chris entertained some friends at their residence. One of those friends took surreptitious videos of Chris's behaviour towards Jandy, specifically of Chris berating and belittling Jandy.

16. Investigation of Jandy's phone by Police after her death located a number of text messages dated 27 and 28 February 2018 in which Jandy reported that Chris "has started getting physical again" and evidence of an argument between them. Police also located a photograph taken at 9:28pm on 27 February 2018 which showed a large bruise on Jandy's thigh. Additionally, one of Jandy's friends volunteered a number of messages dated 27 February 2018 in which Jandy described violence towards her by Chris and stated that she felt scared of Chris but unable to leave the relationship.

[1] Tara Costigan was murdered in her ACT residence by her ex-partner on 28 February 2015: see *An inquest into the death of Tara Maree Costigan* [2018] ACTCD 4 (Coroner Morrison).

17. Jandy visited a friend on 1 March 2018. That friend reported to Police after Jandy's death that Jandy had not seemed herself, looked dishevelled, and reported that she and Chris had had a big fight.

The night before Jandy's death

18. At 7:38pm on 3 March 2019 Jandy, Chris, Aiden and Flynn went to Rose Cottage, Gilmore, for Chris's sister Jessica's 18th birthday party. CCTV footage suggests that Chris bought eight schooners of beer; he told Police after Jandy's death that Jandy had three schooners and he had five. Attendees at the party told Police later that Jandy seemed good, bright, and discussed future events. The family left Rose Cottage at around 9:30pm with Jandy driving the family car.

19. At 9:45pm Jandy and Flynn entered the Coles Supermarket in Chisholm. There they bought a case of beer. The family returned home at about 10pm. Aiden and Flynn were put to bed.

20. I discuss in futher detail what occurred after Jandy and Chris returned home in considering the manner of Jandy's death.

21. At about 2:25am on 4 March 2018, Jandy messaged a friend on Facebook as follows:

> *"I fucking hate my life. I had nightmares every night about this. Why did I not listen to my psychi* (sic). *Im the biggest fucking fuckhead you will ever meet."* (response from friend followed)
>
> *"Im so sorry"*

22. At 5:50am Chris rang 000 and asked for the ambulance service. During that call he advised that he had woken up in bed and saw Jandy hanging in the bathroom. He said that he had got her down and she was cold and blue. He located a note from Jandy while on the phone.

Report of Death

23. At 5:59am an officer of the ACT Ambulance Service (ACTAS) contacted ACT Policing to advise of receipt of the 000 call from Chris, and that paramedics were en route. Police officers were dispatched.

24. ACTAS officers arrived at about 6:05am. They spoke with Chris who took them into the ensuite bathroom. They located Jandy lying on the floor of the ensuite with a cable tie-

down strap around her neck. She showed no signs of life. Jandy was cool to the touch, but not cold, and there were no signs of rigor mortis.

25. An ACT Police patrol arrived at about 6:08am. After conducting an initial assessment, they requested that AFP Forensics and Investigators attend to conduct the scene and death examination. In the meantime, the attending officer commenced a conversation with Chris which was recorded on a hand held digital recorder.

26. First Constable Joel Williams from the On-Call Investigations team was tasked to conduct the investigation of Jandy's death. He arrived at the scene at about 7:31am. A Forensic Medical Officer and scientific officers also arrived shortly after and conducted a thorough examination of Jandy and the death scene. Jandy's phone and an A4 sized exercise book on the dining room table which appeared to contain suicide notes written by Jandy were seized.

27. Police spoke later that day with Jandy's parents. They could not accept that Jandy would have committed suicide and suggested that she may have died at the hands of another person. Renia and David sent an email to Police two days after Jandy died suggesting that Jandy displayed "no signs of mental illness or depression" and requesting a full forensic investigation into her death.

28. The Police later interviewed Aiden and Flynn. Flynn suggested that prior to attending the birthday party at Rose Cottage, Jandy and Chris may have had a fight in the bedroom in which no one was hurt. Aiden said that every morning Jandy and Chris would yell at each other, and Jandy was upset when she did not feel welcome at the party.

Post-Mortem Examination

29. At the direction of the then Chief Coroner, Professor Johan Duflou conducted a post-mortem examination of Jandy and opined that she died as the result of neck compression. He noted that the ligature mark around Jandy's neck was not a "standard" mark but opined that the forensic evidence was consistent with a suicide in unusual circumstances. He observed that there were some injuries to Jandy's neck consistent with her placing her hands around the ligature. He suggested that follow up investigations be undertaken to attempt to verify the death scene and the suicide note. I discuss those follow-up investigations below in relation to the manner of Jandy's death.

30. Jandy was found to have a blood alcohol level after death of 0.240g of alcohol per 100mL of blood, nearly five times the legal driving limit. No other drugs or poisons were detected.

Statutory Findings

31. I am required by section 52(1) of the *Coroners Act 1997* (the Act) to make findings as to the identity of the deceased person, when and where they died, and the manner and cause of their death. I am also required by section 52(4)(a) of the Act to state whether a matter of public safety is found to arise in connection with the inquest, and if I find such a matter, may comment upon it.

32. I find that:

> Jandy Shea (nee Ferguson) died on 4 March 2018 at 3A Charlton Crescent, Gordon. The physical cause of her death is neck compression.
>
> Pursuant to s 52(4)(a)(i) of the *Coroners Act 1997*, no matter of public safety is found to arise in connection with this inquest.

Manner of Death

33. The key issue I am asked to decide in this case is the manner of Jandy's death: did she die as a result of suicide (which is to say, hanging herself with the intention of ending her life) or was another person involved in her death?

34. Chris is the main source of information for events proximate to Jandy's death. He said:

    a. After returning home and putting the kids to bed at about 11pm, he and Jandy each had two more beers while sitting on the lounge. Music was playing from a Bluetooth speaker.

    b. Between the first and second beers he and Jandy had sex on the lounge. He was not very interested in sexual contact and after about 10 minutes he ceased the activity. Jandy seemed ok with that.

    c. He wanted to go to bed after the two beers as the family had planned a push bike ride all together the next morning and he did not want to be hungover for that activity. Jandy said that she was going to stay up and finish her beer, and perhaps have another beer, but she would not be too far behind him. He went to bed at about 1am and left Jandy on the lounge.

d. He woke up at 5:50am wondering where Jandy was. The music was still playing on the speaker. He sat up in bed and saw her hanging from the neck upright from the ensuite bedroom door handle, facing back to the door with her knees bent. There was a chair next to Jandy that had been knocked over. He tried to get the ligature from around her neck but initially could not. He lifted Jandy and unhooked the ligature from the back of the door handle. He sat on the floor holding Jandy and called for an ambulance.

e. After they had reconciled in 2017 Jandy told him that she had attempted suicide by hanging a few months prior to their reconciliation. Chris inferred that there may have been multiple suicide attempts in the period of his and Jandy's separation.

f. Jandy had problems with excessive alcohol consumption in the period before her death. She would drink three or four nights a week up to eight or ten drinks in a sitting, and she would finish whatever alcohol was in the house in a sitting. He challenged Jandy to limit her drinking and to seek help for her mental health but she was not willing to do so.

35. The evidence from the first responders at the death scene is equivocal. First Constable Williams examined the death scene on the day of Jandy's death and considered at that time that there were no signs of a disturbance in the bathroom. The Forensic Medical Officer who conducted an examination of Jandy at the death scene observed that in her opinion, the cause of death was consistent with suicide by ligature asphyxiation. Similarly, the AFP Forensics officer identified no suspicious circumstances at the death scene. However, the ACTAS officer who first attended the scene reported concerns to police with how he had found Jandy, noting that the scene did not appear typical of other death by hanging scenes he had attended.

36. For these reasons, and in light of Jandy's parents' concerns, the then Chief Coroner directed that an expert mechanical assessment of the ligature take place to determine its placement and use on Jandy, and that further post-mortem examination of Jandy take place to determine if strangulation was a possible cause of Jandy's death. The then Chief Coroner also directed that a handwriting analysis be undertaken of the alleged suicide note. The then Chief Coroner granted a coronial investigation scene order to the Police to enable them to re-attend the residence for these purposes and re-examine the death

scene for possible disturbance, DNA, fingerprints and semen. Police also later executed search warrants.

37. The outcome of the Forensic re-examination of the death scene was equivocal: the examination "did not shift the investigation towards either theories of suicide vs homicide vs misadventure".

38. A re-creation of the death scene with a mannequin was conducted by Police with the assistance of Dr Andrew McIntosh, an expert biomechanist. That re-creation confirmed that the ensuite bathroom door handle was capable of sustaining Jandy's weight, that the ligatures found on Jandy were capable of sustaining Jandy's weight and were capable of producing a significant force on her neck. Chris's account of lifting Jandy up and unhooking the ligature was also re-created and found to be possible. The ultimate conclusion by Police after the re-creation was that it was possible that Jandy died by way of suicide: the ligature length was consistent with what Chris had described, the marks on Jandy's neck were consistent with the positions of the ligature arranged during the re-creations, and Chris's account of events was plausible.

39. Professor Duflou undertook a second autopsy of Jandy which included a full dissection of the structures of her neck. There was evidence to suggest that Jandy's hands were entrapped between the ligature and the surface of her neck. He stated that Jandy's blood alcohol level suggested that she would have been significantly intoxicated but likely not to a level where she would be unable to physically perform an act of hanging. The absence of extensive liver damage suggested that Jandy was not a very regular heavy drinker, and as such she may have been more prone to the effects of alcohol as compared to a regular heavy drinker. Professor Duflou was unable to conclusively identify which of the three possible means of neck compression caused Jandy's death, being hanging, ligature strangulation, or manual strangulation. He commented that Jandy's injuries are not typical of any of these methods, but the features most favour those of a self-inflicted hanging, although the other possibilities cannot be excluded.

40. The then Chief Coroner also directed that an expert review of the evidence surrounding Jandy's death be undertaken by Dr Michael Burke, a specialist forensic pathologist practising at the Victorian Institute of Forensic Medicine. Dr Burke's opinion was that the examination of Jandy did not show overt evidence of an assault. He stated that the evidence suggested that Jandy's fingers were beneath the ligature, and while this is

uncommon it is occasionally seen in cases of death by hanging and has been reported in scientific literature. He said that this is believed by some to be evidence of a change of mind during the process of hanging, but it is impossible to certain of this, and a degree of alcohol intoxication also clouds the issue. Ultimately Dr Burke concluded there was no pathological evidence of foul play.

41. The suicide note was also examined by an AFP Forensic Document Examiner. The Examiner was provided with specimen notes written by Jandy, as well as a pen, that had been seized by Police from the residence. The expert expressed qualified support that the author of the specimen notes was also the author of the suicide note, meaning that there were similarities and a lack of fundamental differences between the compared material. Additionally, the pen seized by Police was likely the same pen, or of the same type, as the pen used to write the suicide note. The expert also found indentations in the book suggesting that other suicide notes had been written and removed, that had not been found. One of Jandy's friends was also shown the alleged suicide note by Police, and she said that in her opinion the note reflected the way Jandy felt.

42. The ultimate conclusion by First Constable Williams expressed to me after a thorough investigation was that there were no suspicious circumstances to Jandy's death, and that Chris did not kill Jandy.

43. Despite the suggestion in Renia and David's correspondence to Police that Jandy displayed "no signs of mental illness or depression", I find that there is evidence to suggest that Jandy did have a history of mental illness and depression. She was distressed in the hours immediately before completing suicide.

44. There is also evidence that Jandy had in the past attempted self-harm up to the point of suicide. Renia Ferguson, Jandy's mother, reported to Police on the day of Jandy's death that in the year prior to her death Jandy had on occasion engaged in self-harm by cutting her arms. Police examination of Jandy's phone located a text message sent by her to a friend on 4 May 2017 in which she makes reference to a failed suicide attempt by hanging. Another of Jandy's friends confirmed that in May 2017 Jandy had discussed suicide by hanging.

45. Of particular note, one of Jandy's friends told Police that she believed Jandy took her own life to take the power away from Chris, that Jandy believed Chris would one day kill her and Jandy could not stand waiting any longer for it.

46. Having regard to all the matters described above, I am satisfied, in all the circumstances, that Jandy died as a result of suicide by hanging.

Adverse Comments and Findings

47. Subsection 55(1) of the Act provides as follows:

> A coroner must not include in a finding or report under this Act (including an annual report) a comment adverse to a person identifiable from the finding or report unless the coroner has, making the finding or report, taken all reasonable steps to give to the person a copy of the proposed comment and a written notice advising the person that, within a specified period (being not more than 28 days and not less than 14 days after the date of the notice), the person may—
>
> (a) make a submission to the coroner in relation to the proposed comment; or
>
> (b) give to the coroner a written statement in relation to it.

48. In making findings and comments of this type, I have regard to the principle laid down in in *Briginshaw v Briginshaw* (1938) 60 CLR 336 as stated by Dixon J at 361-3:

> *"The truth is that, when the law requires the proof of any fact, the tribunal must feel an actual persuasion of its occurrence or existence before it can be found. ... Except upon criminal issues to be proven by the prosecution, it is enough that the affirmative of an allegation is made out to the reasonable satisfaction of the tribunal. But reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. 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 issue has 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. It is often said that such an issue as fraud must be proved "clearly", "unequivocally", "strictly" or "with certainty"* (case references omitted). *This does not mean that some standard of persuasion is fixed intermediate between the satisfaction beyond reasonable doubt required upon a criminal inquest and the reasonable satisfaction which in a civil issue may, not must, be based on a preponderance of probability. It means that the nature of the issue necessarily affects the process by which reasonable satisfaction is attained. When, in a civil proceeding, a question arises whether a crime has been committed, the standard of persuasion is,*

according to the better opinion, the same as upon other civil issues (case references omitted). *But, consistently with this opinion, weight is given to the presumption of innocence and exactness of proof is expected."*

49. As I noted above, while she still had carriage of the matter, the then Chief Coroner had prepared draft findings in this matter, and caused a section 55 notice to be forwarded to Christopher Shea in relation to a proposed adverse comment and finding. Mr Shea, through his legal representatives, made submissions that the adverse comment and finding should not be made. It was suggested that much of the evidence relied upon by the then Chief Coroner was opinion information provided to Police after Jandy's death, and possibly influenced by her passing. It was also submitted that there was no psychological evidence before the then Chief Coroner about Jandy's mental state immediately prior to her death and that in circumstances where there were multiple stressors in Jandy's life, it would not be appropriate to single out Chris. References were made to *Briginshaw* and particularly the quote in relation to *"inexact proofs, indefinite testimony, or indirect inferences".*

50. I have carefully considered the submissions put forward on behalf of Chris, and revisited the evidence in light of those submissions. I accept that the childhood sexual assault was a significant stressor and contributor to Jandy's mental health. But the proposed adverse comment was put in terms of a contribution towards Jandy's decision to end her own life, not as the sole or primary contribution. I have had regard to the passage in *Briginishaw* I was taken to and its context. I am satisfied that the evidence relied on to support the adverse comment and finding are not *"inexact proofs, indefinite testimony, or indirect inferences".* I note that the evidence before me includes contemporaneous videos, text messages and Facebook messages involving Jandy or including Jandy. I am satisfied in my own right, and to a level of reasonable satisfaction, that it is appropriate to make the proposed adverse comment and finding contemplated by the then Chief Coroner.

51. I therefore find that there is no evidence that Chris directly caused Jandy's death or was otherwise involved in her hanging. However, I am satisfied that Chris's conduct towards her contributed to Jandy's decision to end her own life, and I so find.

<u>Conclusion</u>

52. In all the circumstances, in my view, there is no utility in holding a public hearing in relation to Jandy's death.

53. I recommend that the ACT Government create a register of family violence perpetrators on which those convicted of a serious criminal offence against a family member shall be recorded. I direct that copies of my findings and recommendation be forwarded to the Attorney-General, the Minister for the Prevention of Domestic and Family Violence, and the Office of the Coordinator-General for Family Safety for their consideration.

54. I direct that these findings be published in due course on the Coroner's Court website.

55. I thank First Constable Joel Williams for the thorough investigation he undertook of Jandy's death.

56. I extend my condolences to Jandy's family and friends.

DATED 23 September 2019

B C BOSS
CORONER