Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref No: 17/18

I, Barry Paul King, Coroner, having investigated the suspected death of ***Shane Christopher Flanders*** *with an inquest held at the* ***Perth Coroner's Court*** *on* ***10 April 2018****, find that the death has been established beyond all reasonable doubt and that the identity of the deceased person was* ***Shane Christopher Flanders*** *and that death occurred on or about* ***28 January 2016*** *in the* ***Indian Ocean off City Beach*** *from* ***an unknown cause*** *in the following circumstances:*

Counsel Appearing:

Sergeant L Housiaux assisting the Coroner

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INTRODUCTION

1. Shane Christopher Flanders (the deceased) was a 29 year old man with a history of drug and alcohol abuse and mental illness who was last known to be alive at about 1.15 pm on 28 January 2016. He was not seen again and has not contacted family or associates.

2. At about 5.50 pm on 28 January 2016, a Town of Cambridge ranger saw the deceased's car parked on a reserve on the west side of West Coast Highway in City Beach about 200 metres from the Indian Ocean. The deceased's car remained there for about a week, and was then towed to a holding area.

3. On 16 February 2016, the deceased's father, Stephen Flanders, reported to police that the deceased was missing.

4. By way of a letter dated 22 June 2016, Mr Flanders contacted the Office of the State Coroner to request that the deceased's disappearance be investigated. The State Coroner requested the Missing Persons Unit of the Western Australia Police to provide any relevant information.[1]

5. On 14 September 2016, an officer from the Missing Persons Unit sent a report to the State Coroner indicating that all efforts had been exhausted in the attempt to locate the deceased, and that the evidence obtained indicated that he was probably dead.

6. Under section 23 of the *Coroners Act 1996* (the Act), where a person is missing and the State Coroner has reasonable cause to suspect that the person has died and that the death was a reportable death, the State Coroner may direct that the suspected death of the person be investigated. Where the State Coroner has given such a direction, a coroner must hold an inquest into the circumstances of the suspected death of the person and, if the coroner finds that the death of the person has been established beyond all reasonable doubt, into how the death occurred and the cause of death.

[1] Exhibit 1, Tab 3

7. A reportable death is relevantly defined in section 3 of the Act to mean a Western Australian death that appears to have been unexpected, unnatural or violent.

8. On 16 September 2016 the State Coroner directed that the suspected death of the deceased be investigated. An inquest was therefore mandatory under the Act.

9. I held an inquest into the deceased's suspected death on 10 April 2018 at the Perth Coroner's Court.

10. The documentary evidence adduced at the inquest comprised a report, including attachments, compiled by Detective Senior Constable A Baker from the Missing Persons Team, together with medical documents obtained by this court.[2]

11. Detective Senior Constable Baker provided oral evidence.[3]

12. I have found that the death of the deceased has been proved beyond all reasonable doubt. I have found that the cause of his death is unknown, but was probably immersion.

13. Given that I have not been able to find the cause of death, I have made an open finding as to how death occurred.

THE DECEASED

14. The deceased was born on 26 September 1986 in Perth. He had an older brother and a younger brother.[4]

15. As a boy, the deceased lived in Roleystone with his parents and brothers. He attended the local primary school and in 1999 went on to attend Roleystone Senior High School where he completed year 10.[5]

16. When the deceased was about 13 years old, he was struck by a car while riding his bicycle to school and sustained a

[2] Exhibit 1
[3] ts 4 – 17 per Baker, A
[4] Exhibit 1, Tab 4
[5] Exhibit 1, Tab 4

broken leg. After that accident he appeared to become withdrawn.[6]

17. In 2001 the deceased's mother separated from Mr Flanders and moved out of the family home. The deceased did not speak to her again for several years as he blamed her for the separation.[7]

18. When the deceased left school, he worked with Mr Flanders doing fibreglass work, but Mr Flanders then sold the family home and moved to Leeman with the deceased's youngest brother. The deceased moved in with a female cousin in Bentley.[8]

19. When the deceased was about 17 years old, he was caught by police selling drugs. His mother went to the Armadale Police Station to deal with the situation and, afterwards, the deceased went to Leeman to live with his father and brother.[9]

20. When the deceased was about 19 years old, he got a job as a plant operator on a mining site. For the next six years or so he lived between his father's house and mine sites.[10]

21. In 2010, the mining company which employed the deceased closed down, so he returned to the Perth area to do a course, and in early 2011 he began working on a fly-in/fly-out basis in the northwest of WA.[11]

THE DECEASED'S MENTAL HEALTH

22. From 2001 the deceased attended a doctor in Kelmscott, at first for prescriptions for asthma medications or antibiotics. He also had recurrent genital herpes and headaches. His doctor felt that he was obsessed about infection, oral and elsewhere, and had a sex and love addiction which led him to pay regularly for sex with prostitutes. The doctor

[6] Exhibit 1, Tab 4
[7] Exhibit 1, Tab 4
[8] Exhibit 1, Tab 4
[9] Exhibit 1, Tab 4
[10] Exhibit 1, Tab 4
[11] Exhibit 1, Tab 4

suspected a borderline personality disorder with schizoid traits and narcissism.[12]

23. In 2011 the deceased developed recurrent frontal headaches. He was reviewed by several specialists and underwent CT scans and MRI scans, but no pathological cause was identified. His doctor diagnosed him with depression and prescribed duloxetine.[13]

24. On 25 July 2011 the deceased attended the Mead Centre at the Armadale Mental Health Clinic with long-standing problems of low frustration level, impulsivity, attention and concentration impairment, mood disorder and risk-taking behaviour. When assessed, he displayed no clear evidence of depression, hypomania, mania or psychosis, and he denied any ongoing suicidal or homicidal thoughts. He reported having used cannabis and ecstasy heavily in the past, and was drinking up to 12 cans of beer or mixed drinks a day. The impression was of cluster B personality structure (mostly anti-social personality traits) and polysubstance abuse.[14]

25. The deceased was referred to a psychiatrist for further assessment. The psychiatrist diagnosed him with attention deficit hyperactivity disorder (ADHD) and anxiety. She prescribed methylphenidate.[15]

26. On 20 December 2011 the deceased presented at the emergency department at Royal Perth Hospital (RPH) after taking an overdose of propranolol because of his headaches. He said that he had wanted to die and had intended to take 100 tablets but had only taken 50. He was intubated and admitted to the intensive care unit until 22 December 2011, when he was referred to the mental health team.[16]

27. From 2012 the deceased did not appear to have a regular doctor. When his psychiatrist reviewed him on 24 January 2012, he described anger and frustration about his

[12] Exhibit 1, Tab 30
[13] Exhibit 1, Tab 23
[14] Kelvale Medical Group patient notes
[15] Exhibit 1, Tab 31
[16] Royal Perth Hospital medical notes

headaches but denied suicidal ideation. She referred him to a psychologist to deal with his anger and impulsivity.[17]

28. On 18 April 2012 the psychiatrist changed his medication to dexamphetamine because of concerns that the methylphenidate was causing swelling of his hands. By 30 May 2012 he was back at work and feeling more like himself. He saw the psychiatrist for the last time on 30 November 2012, at which time he said that his job was going ok. She gave him another prescription for dexamphetamine.[18]

29. On 23 January 2013 the deceased's work mates took him to the emergency department at RPH after he had misused his dexamphetamine and was acting strangely, including expressing suicidal ideation. He was diagnosed with acute stress reaction with suppressed memories of childhood abuse. The dexamphetamine was ceased and he was referred back to his psychiatrist.[19]

30. On 10 February 2013 the deceased was staying at his mother's home with his mother and her partner. His younger brother was also living there. That night, the deceased went into his brother's room and attacked his brother while he was sleeping. His brother shouted and their mother went into the room. The deceased went into the kitchen, picked up a knife and walked towards his mother. She and the deceased's brother ran out the back door and called the police; the deceased stayed in the house and used the knife to kill one of the family dogs. Police officers attended and tasered the deceased without effect, then eventually shot him in the leg.[20]

31. After he was shot, the deceased was taken to RPH where he was diagnosed with drug-induced psychosis from dexamphetamine use. He spent three months in hospital before being transferred to Shenton Park Hospital for rehabilitation.[21]

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[17] Exhibit 1, Tabs 31.A and 31.C
[18] Exhibit 1, Tab 31; Inspire Psychotherapy patient notes
[19] Exhibit 1, Tab 29
[20] Exhibit 1, Tabs 4 and 4A
[21] Exhibit 1, Tab 29

32. There is little information available about the deceased's mental health between July 2013 and September 2015. He did manage to get short term jobs on mine sites during that period.

33. In October or November 2014 the deceased moved into the home of Ian Ross, a friend of his father, in Pickering Brook. Mr Ross found the deceased very reclusive and strange. While he stayed with Mr Ross, the deceased never drank alcohol, but Mr Ross later noticed empty alcohol containers in the deceased's room.[22]

34. On 30 September 2015 the deceased went to a pathology lab with a referral from a doctor for fine needle aspirations to be taken from an unusual body area due to infestations. Staff at the lab called Armadale Adult Mental Health Services and an alert was placed on PSOLIS, the Health Department's mental health clinical information system.[23]

35. On 17 October 2015 the deceased presented to the emergency department at RPH with a 2 cm laceration to his scrotum after he had tried to perform a vasectomy on himself. The wound was stitched and a psychiatrist diagnosed him with anti-social and possible schizotypal/schizoid personality features or a possible psychotic illness. There were no grounds to detain him involuntarily.[24]

36. In late 2015 the deceased finished working on the mines. Mr Ross returned home one day and noticed that the deceased was also there when he would usually be on his work rotation. The deceased said that he had been to Mexico, which caught Mr Ross by surprise. Mr Ross encouraged the deceased to speak to a local orchard owner, who hired him until early January to work in the orchards.[25]

37. On one occasion Mr Ross noticed that the deceased had a large concrete tub with a hole in it in his car. Mr Ross

[22] Exhibit 1, Tab 5
[23] Royal Perth Hospital medical notes
[24] Exhibit 1, Tab 29
[25] Exhibit 1, Tab 5

thought it really strange. The tub was so heavy that Mr Ross could barely lift it.[26]

EVENTS LEADING UP THE DISAPPEARANCE

38. On 8 January 2016 the deceased's mother spoke to him to ask him to visit his grandfather, who was aged and unwell. The deceased was a bit vague and did not say much at the time. She and the deceased's younger brother called the deceased on 10 January 2016 briefly about his grandfather. That was the last time she had any contact with him. She tried to contact him over the following few weeks, but he did not reply. She assumed that he had obtained another job.[27]

39. On 27 January 2016 the deceased went to Perth International Airport for an unknown reason. While he was there, he approached two Australian Federal Police officers from behind and verbally abused them before walking past them. They tried to stop him to check his identification and to establish why he had abused them, but he refused to stop or to show his identification. He acted aggressively and yelled obscenities at them, so they placed him under arrest, but he struggled and his head hit the floor, causing him a gash above his left eyebrow.[28]

40. The police officers called for assistance, and two further officers attended to help to arrest the deceased. Three officers took the deceased to the emergency department at RPH for treatment of his injury. He refused treatment and told medical staff that he would do his own sutures.[29]

41. The doctor on duty decided to sedate the deceased so that he could be treated. The three police officers and three hospital security staff were required to control him so that he could be sedated.[30]

[26] Exhibit 1, Tab 5
[27] Exhibit 1, Tab 4
[28] Exhibit 1, Tabs 10 and 11
[29] Exhibit 1, Tabs 10 and 11
[30] Exhibit 1, Tabs 10 and 11

42. The doctor then treated the injury and the deceased remained unconscious for about two hours. During that time, a police officer searched the deceased's belongings and found documents relating to self-harm and suicide. The officer notified the doctor.[31]

43. When the deceased regained consciousness, he was assessed by the psychiatric liaison nurse who cleared him for any acute psychiatric illness requiring hospital admission.[32] The police officers transferred him to the Perth Watch House late that night and charged him with disorderly behaviour and obstructing public officers.[33]

44. On the morning of 28 January 2016, the deceased attended the Perth Magistrates Court and was granted bail at about 11.15 am.[34] It appears that he then went back to the Perth Airport by taxi to pick up his car.[35] At about 12.40 pm, he called the RAC to arrange for a tow truck to recover his car from the median strip on the Tonkin Highway near Horrie Miller Drive. It seems that he had missed the exit to Horrie Miller Drive and had tried to drive through a ditch to get to the road when he bogged his car.[36]

45. After the tow truck driver had pulled out the deceased's car, the deceased paid with his credit card and drove off.[37]

46. The tow truck driver and his boss, who had also attended the scene, were the last known people to have seen the deceased.

47. At about 6.00 pm that evening, a Town of Cambridge ranger noticed the deceased's car parked in a reserve off West Coast Highway in City Beach about 200 metres from the ocean. Nearby was a carpark and a path leading from the carpark to the beach.[38]

[31] Exhibit 1, Tab 11
[32] Exhibit 1, Tab 29
[33] Exhibit 1, Tabs 11 and 27
[34] Exhibit 1, Tab 26
[35] Exhibit 1, Tab 20
[36] Exhibit 1, Tabs 20 and 6
[37] Exhibit 1, Tab 6
[38] Exhibit 1, Tabs 2 and 8

48. The next day, another ranger noticed the deceased's car parked in the same spot, so he took photographs of it and attempted to contact the deceased as owner, but without success. On 5 February 2016 he arranged for the car to be towed to a holding area in Bibra Lake.[39]

49. On 16 February 2016, Mr Flanders notified police that the deceased was missing.

POLICE INVESTIGATIONS

50. Police investigators spoke to Mr Ross and to the deceased's parents, and they searched the deceased's bedroom at Mr Ross' house in Pickering Brook.[40]

51. The deceased was listed on the National Missing Persons Coordination website. On 3 August 2016 the deceased was featured on the Western Australia Police Facebook page as part of Missing Persons Week. No useful information was forthcoming.[41]

52. The investigators did not become aware of the fact that the deceased's car had been seized by rangers and stored at Bibra Lake until 20 April 2016. They searched the car and in it found the deceased's wallet, mobile phone, laptops, hard-drives, documentation and other personal items.[42]

53. Two of the documents found by police in the deceased's car were:

    a. a handwritten note of items in a 'to do' list, which included '- BUY A SMALL KYAK/PADDLE TO END MYSELF WITH DEATH! ON CHRISTMAS DAY' ; and

    b. a handwritten note: 'CHAIN & BLOCK AROUND MY FEET – SINK TO HAPPY DEATH – DAM IN', with the word 'HAPPY' scribbled out. Below those words was a line drawing of stick figure below a water-line, chained to a weight on the bottom of the water.

[39] Exhibit 1, Tab 9
[40] Exhibit 1, Tab 2
[41] Exhibit 1, Tab 2
[42] Exhibit 1, Tab 2

A speech bubble for the figure said 'LITTLE TO LATE' and another bubble next to that said '30 YRS & SOME WASTE, TOO LATE'.[43]

54. Also found in the car was a large concrete block. I note that the deceased's mother went to Bibra Lake to search the car in about May 2016 and, on the floor of the passenger side, noticed a large concrete block with a hole as if there had been a pole in it. She also saw screw drivers, pliers and shackles.[44]

55. Police investigators also ascertained that, following the deceased's disappearance:

a. the deceased's last interaction with a medical facility was on 27 January 2016 at RPH;[45]

b. the Registry of Births, Deaths and Marriages, had no registration of the deceased's death or change of name;[46]

c. the deceased was not a Centrelink customer. The last contact he made with Centrelink was on 23 November 2015;

d. the Department of Immigration and Border Protection had no record of the deceased having left Australia;[47]

e. the domestic airlines had no record of the deceased leaving Western Australia;

f. the deceased made no banking transactions on his three accounts. The last transaction related to the tow truck on 28 January 2016;[48]

g. the deceased had no contact with, and had not come to the attention of, police services in any jurisdiction

[43] Exhibit 1, Tabs 2 and 24
[44] Exhibit 1, Tab 4
[45] Exhibit 1, Tab 2
[46] Exhibit 1, Tab 2
[47] Exhibit 1, Tab 2
[48] Exhibit 1, Tab 2

in Australia. There were no linked crimes nor criminal association for the deceased ;[49]

h. the State Mortuary had no unidentified human remains which could have been the deceased;[50] and

i. the department of Corrective Services had no record of the deceased being incarcerated.

56. Investigators downloaded and examined the content of the deceased's mobile phone. It contained no information to assist in locating the deceased. The last attempted call was to the deceased's mother at 5.24 pm on 28 January 2016. The duration of the call was seven seconds. All subsequent calls to his phone were of short duration and were diverted to a voice-mail service.[51]

57. At the end of the police investigation, Detective Senior Constable Baker concluded that all avenues of inquiry had been exhausted and that the results of the search and the investigation indicated that the deceased was not likely to be alive.[52] In particular, Detective Senior Constable Baker identified the following circumstances as supporting that conclusion:[53]

a. the deceased's car was found 200 metres from the beach via a direct pathway, and it remained there for a week;

b. the deceased's valuables, including phone, laptop and wallet were in the car, even after it was towed away and stored for months;

c. among the deceased's personal property in the car were handwritten notes and a diagram detailing an intention and a mechanism of death by drowning. To this, I would add that a concrete block, the existence of which was consistent with the depicted

[49] Exhibit 1, Tab 2
[50] Exhibit 1, Tab 2
[51] Exhibit 1, Tab 20
[52] Exhibit 1, Tab 2
[53] Exhibit 1, Tab 2

intention to carry out the drowning death, was also found in his car;

d. if the deceased had gone into the ocean, it would be almost impossible to predict his movements thereafter because of a number of factors, including his state of mind. It is not unusual for the bodies of persons who have gone missing at sea to remain unrecovered.[54] I would add that this is the case even where the person has entered the water from the shore;[55]

e. immediately prior to his disappearance the deceased demonstrated unstable and bizarre behaviour, the cause of which is unknown;

f. the deceased has not contacted any friends or family members;

g. the deceased has not had any interaction with government agencies;

h. there have been no reported sightings of the deceased despite public awareness strategies; and

i. the deceased has not accessed his bank accounts.

58. Detective Senior Constable Baker added that no evidence was found to suggest any criminality related to the deceased's disappearance.[56]

59. In oral evidence, Detective Senior Constable Baker agreed that, aside from the checks that had been done, his conclusion that the deceased is dead is based on what he knows about the deceased's behaviour and background history and the fact that the deceased has not come to the notice of a government agency or law enforcement agency.[57]

[54] Exhibit 1, Tab 2
[55] Record of Investigation into Death of Robyn Louise Santen, 1502/2015, paragraph 91
[56] Exhibit 1, Volume 1, Tab 2
[57] ts 16 per Baker, A

HAS THE DEATH OF THE DECEASED BEEN ESTABLISHED?

60. On the basis of the facts identified by Senior Constable Baker, I am satisfied that the death of the deceased has been established beyond all reasonable doubt.

THE CAUSE OF DEATH

61. The location of the deceased's car and the notes found in it indicate a strong likelihood that the deceased entered the waters of the Indian Ocean at City Beach where he became immersed and drowned; however, it is also possible that he was killed by a marine predator.

62. I am therefore unable to find the cause of death with any certainty.

HOW DEATH OCCURRED - CONCLUSION

63. Given the deceased's mental health history, his recent symptoms and the evidence of his notes, it is certainly possible that the deceased entered the water with an intention to end his life. However, it is also possible, if perhaps somewhat less likely, that he entered the water for another reason or for no rational reason and then became immersed from fatigue or from another cause.

64. In these circumstances, and given that I have concluded that I cannot find the cause of death, I make an open finding as to how death occurred.

B P King
Coroner
12 July 2018