

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 5599

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

Section 67 of the Coroners Act 2008

Inquest into the Death of JAMIE LEVON AUSTIN

Delivered On:	6 DECEMBER 2017
Delivered At:	THE CORONERS COURT OF VICTORIA 65 KAVANAGH STREET, SOUTHBANK
Hearing Dates:	23 AUGUST 2017 24 AUGUST 2017
Findings of:	MR PHILLIP BYRNE, CORONER
Representation:	MS JENNIFER COWEN ON BEHALF OF DSC ADAM BURNETT MS RACHEL ELLYARD ON BEHALF OF THE CHIEF COMMISSIONER OF POLICE MR ANDREW IMRIE ON BEHALF OF MR ANTHONY PATERSON, LSC BARRY JUDGE AND A/S MATTHEW WALSH
Counsel Assisting the Coroner	MS SARAH GEBERT, PRINCIPAL IN-HOUSE SOLICITOR

I, PHILLIP BYRNE, Coroner, having investigated the death of Jamie Levon Austin
AND having held an inquest in relation to this death on 23 & 24 August 2017
at The Coroners Court of Victoria
find that the identity of the deceased was Jamie Levon Austin
born on 16 June 1992
and the death occurred between 2 November 2015 and 3 November 2015
at 2918 Frankston – Flinders Road, Balnarring.

from:

1(a) HANGING

in the following circumstances:

PART 1: BACKGROUND AND BROAD CIRCUMSTANCES

1. Jamie Levon Austin, 23 years of age at the time of his death, resided with his parents Beverley and Colin Austin at 2 Clarke Street, Balnarring.
2. Jamie suffered mental health issues for some four years. He also struggled with alcohol and drug abuse. In 2011 Jamie sought treatment from a GP at the Red Hill Medical Centre, initially in relation to addiction to cannabis. Subsequently, Jamie was referred to a private psychiatrist (Dr. Robert Kruk). He also consulted several clinical psychologists including Dr Doyle. Unfortunately it would seem Jamie did not fully engage in therapy, failing from time to time to attend follow up appointments. Jamie was prescribed anti-depressants and anti-psychotic medications which again, from time to time, he did not take as prescribed. He apparently did not believe the prescribed medications and therapy were helpful in addressing his symptoms.
3. Research has demonstrated that particularly in young adolescents, symptoms of depression and anxiety are exacerbated by the consumption of alcohol. It is noteworthy that Jamie reported suicidal ideation on and off during the period from 2011 until his untimely death; often in the context of substance abuse.
4. I do not in this finding propose to refer in great detail to events in the last few days of October 2015, save to say Jamie's behaviour was at best somewhat erratic, including camping on the foreshore at Shoreham. His actions caused great anxiety to his parents who, with good cause, feared for his wellbeing.

1 NOVEMBER 2015

5. At approximately 10:30am on Sunday 1 November 2015, Detective Senior Constable Adam Burnett (Burnett) was a passenger in a motor car driven by his friend Mr Ryan Murray (Murray) on Point Nepean Road McCrae, when they were overtaken by a motor vehicle being driven erratically, and on any view, extremely dangerously. The carriageway at the location was one lane in each direction and traffic was described as "heavy". The vehicle overtook Murray's car at speed, on several occasions swerving onto the incorrect side of the road into the path of oncoming cars which, to avoid a head on collision, had to take evasive action by moving onto the dirt shoulder of the roadway. The manner of driving was such that Detective Senior Constable Burnett, although off-duty, took the decision to intercept the vehicle at the first opportunity. At the traffic lights adjacent to the McCrae shopping centre the vehicle that Burnett and Murray had observed was forced to stop behind traffic stopped at the traffic lights. Burnett approached the car, took the keys and removed the driver from the vehicle. Burnett's actions were timely and almost certainly averted a deadly outcome.
6. Burnett advised the driver he was a police officer and sought an explanation for the erratic/dangerous driving. Burnett videoed this initial discussion. I propose to address this interaction in greater detail later in this finding, suffice to say at this point that the driver said he was "suicidal" and conceded he was a "hazard".
7. Although off-duty Burnett arrested the driver who was subsequently identified as Jamie Austin of 2 Clarke Street, Balnarring.
8. Burnett called for the attendance of on-duty police. Shortly after, Sergeant Anthony Paterson (Paterson) and Constable Aaron Lord (Lord) arrived in a divisional van, followed shortly after by two members of the Rosebud Highway Patrol, Leading Senior Constable Barry Judge (Judge) and Senior Constable (at the time) Matthew Walsh (Walsh).
9. Jamie Austin was given a preliminary breath test at the scene which was positive. He was subsequently conveyed to the Rosebud police station where he was formally breathalysed and charged with exceeding 0.05%. Subsequently, after discharge from custody protocols were completed, Jamie Austin was discharged and left the police station in the company of a friend, Nicholas Stapleton (Nick).
10. On Sunday 1 November 2015, Mrs Beverley Austin, Jamie's mother, received a phone call from Jamie during which he told her he had been picked up by the police for drink driving and had lost his driving license for 8 months. He further advised his mother that his friend Nick was to pick him up from the police station and take him back to his (Nick's) home. Mrs Austin drove to Nick's house and took Jamie back to 2 Clarke Street, Balnarring.

11. The following day, 2 November 2015, Mrs Austin, her concern for her son's wellbeing heightened, consulted a GP at the Red Hill Clinic. Afterwards Mrs Austin returned home, picked Jamie up and conveyed him to the Rosebud police station to retrieve his car keys. She then took Jamie to Nick's place to drop off the keys as Nick said he would collect the car and drive it back to Clarke Street. At about 3pm Nick and Jamie arrived at Clarke Street with the car.
12. Mrs Austin described Jamie at home as distracted and disinclined to discuss his dilemma. At about 7pm, believing Jamie was upstairs, Mrs Austin went to his room to tell him dinner was ready. Jamie was not in his room. Mrs Austin searched the house, the sheds and the dam, but did not locate Jamie. Mrs Austin texted Nick, but he did not know where Jamie was. Mrs Austin, no doubt exhausted by this time, retired to bed at approximately 1am, a much worried mother.
13. The next morning, Tuesday 3 November 2015, Mrs Austin texted Jamie's contacts; no one knew where Jamie was. At midday Mr and Mrs Austin formally reported Jamie missing to the police station at Hastings.
14. At about 2pm Mr Austin decided to search the property adjacent to 2 Clarke Street. At that location, he located Jamie hanging from a tree by a green rope attached to a branch. A call to the 000 emergency number resulted in the attendance of ambulance paramedics who declared Jamie deceased at the scene; it was clear Jamie had been dead for some time. Police, including members of the local CIU, attended shortly thereafter and commenced an investigation. It was concluded there did not appear to be third party involvement, or suspicious circumstances.
15. The matter was reported to the coroner. Having considered the reported circumstances, and having conferred with a forensic pathologist, I directed an external only post mortem examination and ancillary tests.
16. The external post mortem examination was undertaken at VIFM by Forensic Pathologist Dr Heinrich Bouwer, who confirmed Jamie's death was due to

I (a) hanging.

Toxicological analysis of post mortem blood samples detected a low alcohol reading, diazepam, temazepam and delta-9-tetrahydrocannabinol (cannabis).

17. Acting Detective Sergeant Brett Daly of the Frankston CIU undertook the coronial investigation and subsequently provided a coronial brief of evidence.

18. The broad circumstances of Jamie Austin's death are relatively non-controversial. However, being categorised as a "police contact death", a number of issues were identified that warranted closer attention. I turn to address the principal controversy – whether the discretion provided under section 351 of the *Mental Health Act 2014* should have been exercised by attending police and Jamie psychiatrically assessed.

PART 2: SECTION 351 MENTAL HEALTH ACT 2014

19. The major focus of my investigation and formal inquest has been the discreet issue of whether any of the uniformed members in attendance at Point Nepean Road, McCrae, on the morning of 1 November 2015 should have exercised their powers under section 351 of the *Mental Health Act 2014*. In the vernacular this process is referred to as being "sectioned". I commence by providing some background regarding the course of my investigation.
20. At an early stage it became apparent that following protocols in place at this Court, Jamie's death was viewed as a "police contact death". In that circumstance I was assisted from the outset by Ms Sarah Gebert, Principal In-house Solicitor.
21. After examining the material available at the time, including the poignant video recording of Jamie taken by Detective Senior Constable Adam Burnett (Burnett) at the road side, the spectre of a section 351 intervention was raised. I formed a tentative view at that time that if the information Burnett claimed he conveyed to the uniformed members who attended was in fact conveyed it would have been appropriate for a mental health assessment to be facilitated.
22. On that basis, on my behalf, Ms Gebert advised the Chief Commissioner that the prospect was an adverse finding or comment may be made criticizing the failure of the uniformed members to exercise the discretion under section 351 and arrange for an assessment. I wanted to know whether such a finding, or comment would be resisted by the Chief Commissioner.
23. Subsequently, in a timely manner, I received, through Russell Kennedy Lawyers, a comprehensive 88 paragraph submission on behalf of the Chief Commissioner of Police. The submission was accompanied by attachments. In essence, for a variety of articulated reasons, sufficiently broadly summarized in paragraph 86 of the submission, it became clear no concession on the issue would be made. The relevant part of paragraph 86 reads:

"In the absence of evidence from the members, the Chief Commissioner of Police does not believe that there is sufficient evidence to say that the attending members' impression of Jamie Austin was inappropriate or that the members should have exercised their discretion to utilise the powers under section 351 of the Mental Health Act."

24. It was further submitted that I could not properly make a finding that it would have been appropriate for a uniformed police member to exercise the discretion under section 351 without hearing *viva voce* evidence from the members. I accepted that, in light of the submissions, it would not be appropriate to form a concluded view on the issue in a vacuum. It became clear that I would need to hear from the participants at the incident; Burnett, his friend Mr Ryan Murray (Murray) and the uniformed members who responded to Burnett's call.
25. Subsequently, at my request, the matter was listed for a Mention/Directions hearing on 16 May 2017. Jamie's parents, Mr and Mrs Austin attended unrepresented, Ms Gebert appeared to assist and Ms Rachel Ellyard of counsel appeared on behalf of the Chief Commissioner of Police. The principal reason for the Mention hearing was to seek to determine the future course of the matter.
26. At the Mention hearing it was submitted that it would not be open on the untested material available to me at that time to make an adverse comment or finding that it would have been appropriate for one of the on-duty members to exercise the discretion under section 351. Ms Ellyard did however accept that on the available material the discretion "could or might" have been exercised. While the dichotomy may appear fine, I see a significant distinction between SHOULD have been exercised and COULD have been exercised; that was the very area of contention. I indicated that precisely what was communicated to the uniformed members by Burnett at the scene would have a bearing on whether it would have been appropriate for discretion to be exercised.
27. Ms Ellyard indicated that she would like to make further submissions in relation to what was open to me if I was contemplating making a decision on the basis of what was conveyed at the scene, rather than what observations of Jamie were made by uniformed members during the subsequent period back at the Rosebud police station where Jamie was breathalysed and charged with exceeding 0.05%. I granted a further month for Ms Ellyard to lodge further submissions and indicated that it would be likely the matter would proceed straight to inquest if the Chief Commissioner maintained his position. I reiterated to the parties that my focus at inquest would be the issues pertinent to the exercise of the discretion under section 351.
28. A further submission under the hand of Ms Ellyard was received in mid-June. The crux of Ms Ellyard's submission is, I suggest, encapsulated in the following paragraph¹:

"In the sentences dealing specifically with the potential exercise of the discretion, the Coroner is invited to use the word "open" rather than the word "appropriate" when

*referring to the potential exercise of the discretion. This is because the latter word suggests that the discretion should have been exercised in a particular way. The evidence does not support a final view that the discretion **should** have been exercised, but rather that it **could** have been.”*

In effect the Chief Commissioner re-affirmed his position.

THE EVIDENCE

29. I do not propose to re-state in detail the observations of Jamie’s driving by Burnett and Murray, save to say they concluded it was highly dangerous and urgent action was warranted.
30. Pertinent to my focus was not only the driving per se, but the short initial dialogue between Burnett and Jamie which Burnett videoed on his phone. The video is of short duration, less than one minute. Quite frankly, Jamie’s presentation on that video was a pitiful sight; he was patently tearful and distraught.

THE EVIDENCE OF DETECTIVE SENIOR CONSTABLE ADAM BURNETT

31. In evidence, Burnett maintained that he advised the uniformed officers in the divisional van of his observations of Jamie’s driving and the fact that Jamie had said he was suicidal. He further claimed that he suggested that Jamie should be assessed under the *Mental Health Act*. Burnett stated that subsequently he “gave a briefing” to all four uniformed members present.
32. Significantly, Burnett said he could not remember if he showed the uniformed members the video he had taken some 4-5 minutes before the divisional van arrived. He further conceded he may not have even advised the uniformed members he had earlier videoed Jamie sitting on the gutter. Burnett maintained that when he raised the prospect of a “section 10”, one of the uniformed members corrected him saying that under the *Mental Health Act 2014* arrest for assessment was provided under section 351, not section 10. When put to Burnett that uniformed members Paterson, Lord, Walsh and Judge all denied that they were told Jamie had said he was suicidal. Burnett was adamant, claiming that he “—told them exactly what happened and what should be done”.
33. In cross examination by Mr Imrie, of counsel, for uniformed members Paterson, Walsh and Judge, Burnett conceded he did not in his formal statement, made at a time when he was aware of the conflict in evidence, refer to being corrected in relation to the relevant section

¹ Further Submission, paragraph 12

under which a mental health assessment can be required. In a question from me, Burnett explained it was just something he “overlooked”.

34. When examined by Ms Cowen, Burnett stated it was likely he conveyed his concerns initially to the first responders Paterson and Lord and subsequently all four officers in a group, but Judge was the “main person” he dealt with.

THE EVIDENCE OF MR RYAN MURRAY

35. Mr Murray, a friend of Burnett also gave evidence. In essence he supported Burnett’s contention that he advised uniformed members that Jamie had said he was suicidal. It is that part of Murray’s evidence upon which I propose to primarily focus.

36. Murray said that he observed Jamie’s “aggressive” driving for about 2 minutes, but couldn’t say if Jamie was deliberately crossing to the wrong side of the carriageway. Murray said he observed Burnett videotaping Jamie sitting on the gutter, distraught, visibly upset and crying. Murray stated he heard Jamie tell Burnett he was suicidal and claimed he heard Jamie utter words to the effect he was so depressed he was a “broken man”. Murray said that after Jamie told Burnett he was suicidal he wondered whether the erratic driving, into the path of oncoming cars, was in fact deliberate, stating:

“It was almost like a person with no care what the repercussions were of their actions—”

Murray said he concluded that Jamie was indicating that he just wanted to end it all and was at the end of his tether.

37. In answer to questions from Ms Gebert, Murray said he was 100% sure Burnett specifically told the older of the uniformed members (Paterson) that Jamie said he was suicidal and was “shocked” when subsequently he was advised the uniformed members denied they were told that Jamie was suicidal. Murray refuted any suggestion he could be mistaken.
38. In answer to questions put to him by Ms Cowen, Murray maintained that Burnett initially told the first two members who arrived that Jamie said he was suicidal and reiterated that statement to the other members upon their arrival. He also claimed Burnett said words to the effect “he should be sent to the services”, which he understood meant to be taken to hospital for a mental health assessment.
39. Mr Imrie put to Murray that he (Murray) had said in evidence that by “needing to be sent to services” he took that to mean the DPP. That of course is not consistent by his subsequent claim that he thought needing to be “sent to services” referred to a psychiatric assessment.

40. It is in my view significant that Murray said in evidence that he did not know whether Burnett advised the other officers that he had videoed Jamie prior to their arrival, nor did he recall Burnett showing the video to the other officers. That response could be viewed as an equivocal support of Burnett's contention that he told the on-duty members that Jamie said he was suicidal. On the other hand, in light of his earlier 100% claim of certainty that the statement was conveyed by Burnett, Murray may merely have failed to fully appreciate the import of my question.

THE EVIDENCE OF MR ANTHONY PATERSON (FORMERLY SERGEANT PATERSON)

41. Mr Paterson was a vastly experienced member of the Victoria Police having served in excess of 40 years in the force.

42. At the outset of her examination of Paterson Ms Gebert took him to the running sheet of the divisional van unit manned by himself and Lord. The running sheet made no reference to consideration being given to a mental health assessment. Paterson in *viva voce* evidence reiterated his position, saying he was adamant he was not told by Burnett that Jamie had said he was suicidal. He also maintained he was not told by Burnett that he had videoed Jamie prior to the arrival of the divisional van; claiming the first time he viewed the video was the day he made his formal statement.

43. Paterson said he was sure that if the information about Jamie claiming to be suicidal had been conveyed to his colleague Lord, out of his earshot, he was certain Lord would have conveyed that information to him. He was also adamant that neither Walsh nor Judge told him Burnett had told them that Jamie was suicidal.

44. Ms Gebert asked Paterson what would have been his response if Jamie had told him he was suicidal and intending to self-harm. Paterson said that if he had been told that by Jamie he would have arranged for some appropriate psychiatric assessment.

45. At the end of his examination by Ms Gebert, Paterson made an emotional response to the question whether there was anything he would like to add; saying:

*"Had I known, um, something about Jamie's history, had I known, um, that – of the – of this video footage, um, had I been more aware of the circumstances, um, yes, most likely a different course of action may well have been taken."*²

46. In answer to a question from Ms Ellyard, Paterson confirmed that before exercising the discretion he would need more than merely being advised Jamie had said to Burnett he was suicidal. In response to a question from me, Paterson explained that "a different course of

² Transcript p. 99

action may well have been taken” if he had seen the video, was aware of what Jamie conveyed to Burnett, and had spoken directly with Jamie.

47. Mr Imrie put the following question to Paterson:

“And based on all the information you had and that experience did you consider that Jamie had mental health concerns?”³

Paterson replied:

“It didn’t really even cross my mind, to be honest, with you, no.”

THE EVIDENCE OF ACTING SERGEANT MATTHEW WALSH

48. Mr Walsh said he made no close observations of Jamie’s presentation or demeanor at the scene saying he was with Lord on the opposite side of the divisional van to where Jamie was sitting on the guttering, although he said he was involved in a discussion with the “off duty member” and Lord. Walsh in evidence said:

“I can’t remember the exact conversation it was just a general description of an erratic driver. At no stage can I recall the CIU member told us that the driver was suicidal.”⁴

He added that until the day he made his formal statement, some 16 days after the incident, he was not aware Burnett had claimed he had advised the uniformed members that Jamie had told him he was suicidal. When pressed, Walsh said he did not “recall”/“remember” Burnett advising that Jamie had said he was suicidal, nor could he recall any discussion about either section 10, or section 351 regarding a psychiatric assessment of Jamie.

49. Ms Cowen put to Walsh that as he had merely said he couldn’t “recall” Burnett telling the uniformed members Jamie claimed to be suicidal, was it possible he was told but just could not recall being told. Walsh reiterated he could not remember or recall being told but added:

“---that’s a possibility---”⁵

Walsh was however clear that no discussion about section 10 occurred in his presence.

THE EVIDENCE OF LEADING SENIOR CONSTABLE BARRY JUDGE

50. Mr Judge who accepted that he was the “lead investigator” estimated the total time actually spent at the scene of the incident was between 5 and 10 minutes. He said his first observation of Jamie was he was sitting on the gutter with his head down looking “upset but

³ Transcript p. 113

⁴ Transcript p. 126

⁵ Transcript p. 140

nothing unusual.”⁶ He agreed that he had a conversation with Burnett who very briefly explained the manner of Jamie’s driving.

51. Judge maintained that at no stage did Burnett tell him that Jamie was suicidal, claiming to be “100% certain”⁷. Judge also said he did not believe Burnett told him about the video. In response to a question put by Mr Imrie, Judge said that if Burnett said he had taken a video he would have asked to view it. Judge also maintained he did not hear any of the other members correct Burnett as to the section under which a psychiatric assessment could be pursued.
52. Ms Cowen examined Judge about the nature of Jamie’s driving as conveyed by Burnett, suggesting it was significantly more erratic and dangerous than he (Judge) seems to have considered it to be. It was also put to Judge that Murray’s description of Jamie’s driving would suggest it was extremely dangerous, requiring several oncoming drivers taking evasive action to avoid head on collisions.
53. I have presumed Ms Cowen’s line of questioning of Judge was an endeavor to demonstrate that in relation to the exercise of discretion, more significance should have been placed upon the manner of Jamie’s driving suggesting consideration should have been given to whether it was indicative of Jamie deliberately intending self-harm, or harm to others. As I understood him, Judge maintained his position saying Jamie’s driving, whilst erratic, was consistent with impairment due to alcohol consumption. I must say that I was somewhat surprised that Judge, an experienced officer, claimed that the subsequent reading of 0.86% was a “mid to high range” alcohol reading.

THE EVIDENCE OF CONSTABLE AARON LORD

54. I had anticipated hearing from Lord, but was advised he was travelling somewhere in central Australia and, as I understand it, difficult to contact. I therefore did not have the benefit of gauging Lord’s evidence, but his statement forms part of the body of evidence and can speak for itself.

DISCUSSION

55. In seeking to reach conclusions as to whether it would have been appropriate for any of the on-duty members to exercise the section 351 discretion, I must endeavor to exclude the not inconsiderable benefit of hindsight; in effect I am required to put myself in the shoes of the on-duty members with the knowledge they had at the time.

⁶ Transcript p. 159

⁷ Transcript p. 165

56. Ms Ellyard submitted in relation to the controversy on the evidence that both positions are contradictory. In contrast, counsel for the members submitted that there was room for mere misunderstanding or misinterpretation. In my considered view there is no room for mere misunderstanding.
57. In light of the fundamentally contradictory versions of events into what I consider significant issues, I am required to consider both the credibility and reliability of the six witnesses who gave *viva voce* evidence. In my not inconsiderable experience, it is quite often not particularly difficult to reach a firm view as to the credibility of a witness. However, in some instances reaching a comfortable degree of satisfaction as to one or other version of events is difficult. I have found endeavouring to reach firm conclusions challenging.
58. Having heard and observed the witnesses in the witness box, this is one of those occasions. I don't think it could fairly be argued that any of the witnesses who gave evidence before me performed badly in the box; on the contrary.
59. The fundamental question remains to be addressed; should any of the uniformed on-duty members have exercised the discretion to arrest Jamie under section 351 of the 2014 Act and convey him for a psychiatric assessment for risk of self-harm or harm to others. I propose to indicate what matters I feel comfortably satisfied about, and what matters upon which I have not reached a comfortable level of satisfaction. Then on that basis determine whether any of the police members should have, rather than could have, exercised the discretion to arrest Jamie under the provisions of section 351 of the *Mental Health Act 2014*.
60. I am satisfied that Burnett did not advise any of the on-duty members he had videoed Jamie voicing suicidal feelings, nor do I conclude he offered to show the video recording to attending members.
61. I believe the matters Burnett conveyed to the uniformed members mainly related to the nature and extent of Jamie's driving that he and Murray observed.
62. I accept that the only occasion Jamie voiced suicidal ideation was to Burnett at the outset, he did not reiterate his feelings to other police members either at the scene or thereafter; on the contrary, at the police station prior to discharge he stated he did not propose to do anything silly. Consequently, I accept that the only time at which consideration could have been given to exercising the discretion was at the scene.

63. After earnest deliberation, and conceding some vacillation, I have been unable to reach a view with which I am comfortable on the critical issue of whether Burnett advised any of the uniformed members that Jamie had said he was suicidal.

64. I digress to reiterate that I could not be satisfied Jamie's untimely death would have been prevented even if he had been arrested under section 351 and conveyed for psychiatric assessment. For one thing, I am unable to predict what the outcome of any assessment may have been had one been undertaken. For that reason alone, even if I conclude the discretion should have been exercised, I could not conclude it was a causal or contributing factor in his death.

65. The legislative framework provided by section 351 of the *Mental Health Act 2014* requires analysis; it provides (as it relates to police officers rather than protective services officers):

- 1) A police officer on duty may apprehend a person if the police officer is satisfied that
 - a) the person appears to have a mental illness; and
 - b) because of the person's apparent mental illness, the person needs to be apprehended to prevent serious and imminent harm to the person or to another person.

It is clear therefore that before the discretion to arrest can legally be exercised two threshold criteria need to be met.

66. The issues surrounding the exercise of the discretion were relatively recently addressed by the full bench of High Court of Australia in David Stuart & Anor and Tania Kirkland-Veenstra⁸ (Kirkland-Veenstra). Although in that case it was the power provided by section 10 of the previous *Mental Health Act* that was in issue, the provisions of section 351 of the 2014 Act are, in my view, sufficiently analogous that the basic principles enunciated in Kirkland-Veenstra are pertinent in this matter.

67. Before turning to the judgement in Kirkland-Veenstra, I refer to other aspects of section 351. Section 351(2) provides that the police officer contemplating exercising the discretion under section 351(1) is not required to exercise any clinical judgement as to whether the person has mental illness. A mental illness is defined in section 4 of the 2014 Act as:

“a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory.”

At first blush one could view that as a very broad definition.

⁸ [2009] HCA 15

68. In Kirkland-Veenstra, Chief Justice French made several pertinent observations which assist in forming views about various requirements which need to be met to “enliven” the proper exercise of the discretion to apprehend. In relation to not requiring “clinical judgement” His Honour said:

*“A layman’s opinion conforming with the broad definition of mentally ill in section 8(1A) would suffice.”*⁹

His Honour added:

*“—the fact that a person has attempted suicide or prepared to attempt suicide is not of itself sufficient to support an inference that the person is mentally ill.”*¹⁰

A fortiori, a statement by a person that he/she is suicidal is not sufficient to conclude that that person is mentally ill. Importantly, His Honour also stated:

*“The power is not enlivened by objective circumstances but by the opinion of the officer.”*¹¹

This requires a subjective opinion by the person considering apprehending.

69. As referred to in the joint judgement of Justices Gummow, Hayne and Heydon in Kirkland-Veenstra, I am required to proceed on the basis of the underlying principle upon which the present (and past) Act is founded. Section 11(1)(3) provides:

“A person must have regard to the mental health principles in performing any duty or function or exercising any power or in accordance with this Act.” (my emphasis)

70. The evidence establishes to my satisfaction that none of the police members involved, including Burnett, were aware of Jamie’s previous mental health history. There was nothing on the LEAP database which would alert police to mental health issues.

71. Applying the aforementioned principles to circumstances of this case, there is no compelling evidence that any of the on-duty attending uniformed members considered Jamie appeared to have mental illness; they merely considered his presentation was due to the consumption of alcohol, possibly drug use, and a reaction to being caught drink driving. Therefore the first threshold criterion has not been met.

72. Although the matter ends there, for completeness I propose to consider whether the second limb has also been met. Even if the first criterion was met, a police officer considering

⁹ [2009] HCA 15, [54]

¹⁰ [2009] HCA 15, [54]

¹¹ [2009] HCA 15, [55]

whether to exercise the discretion would need to be satisfied that the second threshold criterion was met – a serious and imminent risk of self-harm existed.

73. In the present case at the time the on-duty members attended the scene of the incident Jamie was in custody, having been arrested by Burnett under the provisions of the Crimes Act. So even if there had been a serious and imminent risk of harm to self or others, that risk had evaporated – Jamie was going nowhere, other than to the Rosebud police station to be processed for drink driving.

74. It is also pertinent to this issue that from the time of being placed in the divisional van, until his release from custody at the Rosebud police station, it could not be reasonably contended that Jamie demonstrated signs of mental illness; Jamie specifically denied he intended to “do anything silly”.

75. In the final analysis, I do not believe the evidence permits a finding that it would have been appropriate for Mr Paterson, Acting Sergeant Walsh, Leading Senior Constable Judge, or Constable Lord to exercise the discretionary power under section 351 of the *Mental Health Act 2014*.

76. Although it was not specific to the decision Jamie ultimately took between 2 – 3 November to intentionally take his own life, he had, several days earlier, penned a well-crafted and poignant suicide note in which he articulated his gratitude to his parents for their unwavering support and the reasons behind the fateful decision he subsequently took; it makes sad reading.

FINDING

77. I conclude Jamie Austin, in deep depression, suffering from significant mental health issues, intentionally took his own life by hanging in a paddock at 2918 Frankston – Flinders Road, Balnarring, adjacent to his parents’ property between the days of 2 and 3 November 2015.

COMMENTS

78. It should not go unsaid that Jamie was in the custody (and care) of Victoria Police on 1 November 2015. In this context it is regrettable that I am unable to determine (to the required standard), certain important details of his custody that morning.

79. The existence of the video, puts it beyond doubt that Jamie made a disclosure that he was suicidal to a member of Victoria Police following being intercepted on 1 November.

80. I note that all the police members agreed that important information regarding someone in their custody (such as a disclosure in relation to suicidality) should, as a matter of course, be

shared between members. In fact, there was agreement that this was consistent with police training.

81. In addition, each member said (and it was submitted) that had they been aware of a disclosure by Jamie that he was suicidal, each member would have acted upon that advice in some way. Responses ranged from arresting Jamie under the *Mental Health Act 2014*, to taking some further action to investigate the matter; for example, probing the disclosure with Jamie.

82. Whilst I am unable to determine whether this information was passed on to any of the on-duty members, regrettably, it remains a fact that the disclosure was not acted upon.

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

Mrs Beverley & Mr Colin Austin, Senior Next of Kin;

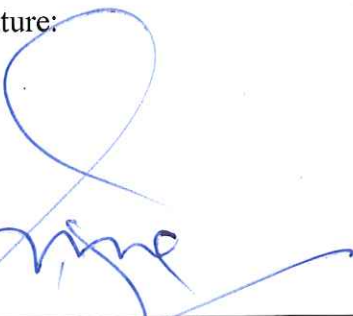
Russell Kennedy Lawyers on behalf of the Chief Commissioner of Police;

Norton Rose Fulbright on behalf of Detective Senior Constable Adam Burnett;

Moray & Agnew on behalf of Mr Anthony Paterson, Leading Senior Constable Barry Judge and Acting Sergeant Matthew Walsh; and

Detective Sergeant Brett Daly, Frankston Criminal Investigation Unit, Coroner's Investigator, Victoria Police.

Signature:


PHILLIP BYRNE
CORONER
Date: 6 December 2017

