IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 003523

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the Death of Jamie Alexander Knowles

Delivered On:	4 March 2025
Delivered At:	Melbourne
Hearing Dates:	4 March 2025
Findings of:	Coroner Simon McGregor
Police Coronial Support Unit	Leading Senior Constable Kelly Ramsey
Albury Wodonga Health	Mr. Stanley Goh, MinterEllison
Keywords	In care, Mental Health and Wellbeing Act 2022, inpatient temporary treatment order, temporary leave, suicide

I, Coroner Simon McGregor, having investigated the death of Jamie Alexander Knowles, and having held an inquest in relation to his death on 4 March 2025 at Melbourne, make findings as follows.

INTRODUCTION

1. On 24 June 2024, Jamie Alexander Knowles was 24 years old when he passed by suicide. At the time of his death, Jamie was receiving inpatient psychiatric care at the Albury Wodonga Mental Health Service's Kerferd Unit in Wangaratta, Victoria.

2. Jamie was born on 11 June 2000 in the Canberra Hospital in the Australian Capital Territory.[1] He was the son of Meagan and Mark Knowles. Jamie had one brother, Ethan Foster who is five years older than Jamie.[2] Jamie was raised by his parents until he was about two years old. They were living in a small unit in Griffith in the Australian Capital Territory.

3. When Jamie was one year old, the Canberra Police found him on a major road in the early hours of the morning. His maternal grandparents, Arthur and Elizabeth Foster - known to the family as Paul and Anne - were contacted and took Jamie into their care. [3] They were living in Wodonga, Victoria at the time. A lengthy custody battle occurred between Jamie's grandparents and Jamie's father, with Jamie eventually placed in to the permanent care of his grandparents.[4]

4. During Jamie's initial time living with his grandparents, his health was poor and he displayed behaviours of a child with a traumatic upbringing. Jamie was withdrawn and nervous and showed fear of people other than his grandparents. He would hide in cupboards

[1] Coronial Brief, page 8, paragraph 14. Statement of Elizabeth (Anne) Foster.
[2] Coronial Brief, page 7, paragraph 10. Statement of Elizabeth (Anne) Foster.
[3] Coronial Brief, page 9, paragraph 17. Statement of Elizabeth (Anne) Foster. Coronial Brief, page 18, paragraph 10. Statement of Arthur (Paul) Foster.
[4] Coronial Brief, page 10, paragraph 21. Statement of Elizabeth (Anne) Foster.

around the house when others came to visit. [5] Once Jamie was around 4 years old, his trust of others increased and he was presenting as a happy young child, full of joy.

5. In 2004, when Jamie was four years old, he commenced kindergarten. He engaged with other children well and was well liked by all.[6] In 2005 he commenced at the Wodonga South Primary School. Ethan, Jamie's older brother also attended this school. Jamie continued to thrive throughout his primary school years.[7] There were short periods where Jamie and Ethan were being picked on by other children as they were being raised by their grandparents. This bullying was short-lived and the remainder of his primary school attendance did not involve bullying.[8]

6. In 2011, Jamie commenced high school at the Victory Lutheran College in Wodonga. Jamie enjoyed high school and went on to become school vice captain during Year 10.[9] He showed strong interest in playing cricket, football and clay target shooting.[10] Sometime in Year 10, Jamie made the decision to leave school to take up a roof plumbing apprenticeship.[11]

7. Jamie worked as a roof plumber from 2019 until 2021, when he completed his apprenticeship. Throughout these years, Jamie's friends from school fell to the wayside and new friendships began. Jamie had also started smoking cannabis and experimenting with other drugs. He also began to drink alcohol quite heavily.[12]

8. From 2020, Jamie began to struggle with his mental health, leading to care being provided by general practitioner Dr Wilson Leow at the Albury-Wodonga Family Medical Centre.[13] His initial presentation was for drug-induced psychosis.[14] Jamie was first admitted for

[5] Coronial Brief, page 10, paragraph 22. Statement of Elizabeth (Anne) Foster. Coronial Brief, page 19, paragraph 13. Statement of Arthur (Paul) Foster.
[6] Coronial Brief, page 11, paragraph 24. Statement of Elizabeth (Anne) Foster.
[7] Coronial Brief, page 11, paragraph 25. Statement of Elizabeth (Anne) Foster.
[8] Coronial Brief, page 20, paragraph 18. Statement of Arthur (Paul) Foster.
[9] Coronial Brief, page 11, paragraph 26. Statement of Elizabeth (Anne) Foster.
[10] Coronial Brief, page 20, paragraph 20. Statement of Arthur (Paul) Foster.
[11] Coronial Brief, page 11, paragraph 27. Statement of Elizabeth (Anne) Foster.
[12] Coronial Brief, page 21, paragraph 25. Statement of Arthur (Paul) Foster.
[13] Coronial Brief, page 21, paragraph 25. Statement of Arthur (Paul) Foster.
[14] Coronial Brief, page 32, paragraph 2. Statement of Dr. Wilson Leow.

inpatient psychiatric care to the Albury Wodonga Health Kerferd Unit in Wangaratta in November 2020. Jamie was ultimately diagnosed with schizophrenia, and he went on to spend various periods in the Kerferd Unit, as well as the Jarrah Prevention and Recovery Unit (Jarrah House) in Wodonga and Benambra Mental Health Rehabilitation Team (Benambra House), also in Wodonga.[15] Jamie would often experience seizures and schizophrenic episodes.

9. Throughout 2021-2023 Jamie began to use methylamphetamine. His behaviour and social life worsened, leading to drug debts and the need to sell various belongings to fund his drug use. He would live with his grandparents between admissions to a mental health facility. His relationship with his grandparents also deteriorated. He would distance himself from them and hide the issues he was facing.[16]

10. On 13 August 2023 Jamie suffered a schizophrenic episode which culminated in Jamie assaulting his grandfather Paul. The incident caused great distress to Jamie's grandparents. Jamie was taken into custody by police under the *Mental Health Act 2014* and an intervention order was taken out to protect Paul from Jamie. The intervention order prohibited Jamie from being at his grandparents' house unless prior written agreement was given.[17]

11. From the time that Jamie obtained his driver licence in 2018 he would travel to Canberra in the ACT to spend time with his father, Mark. He would also, on occasion visit his mother in Wollongong in New South Wales. After most visits with his father, Jamie would return to his grandparents telling them about arguments or disagreements that had taken place between them. Some of the argument and conflicts turned violent.[18]

12. Between late May and early June of 2024, Jamie went to visit Mark for approximately four weeks. During this visit, Jamie stopped taking his prescribed clozapine, later reporting that

[15] Coronial Brief, page 21, paragraph 28. Statement of Arthur (Paul) Foster. Page 32, statement of Dr. Wilson Leow. Page 34, history of admissions, Statement of Lucinda Green.
[16] Coronial Brief, page 22, paragraph 33. Statement of Arthur (Paul) Foster.
[17] Coronial Brief, page 22, paragraph 35. Statement of Arthur (Paul) Foster.
[18] Coronial Brief, page 12, paragraph 34. Statement of Elizabeth (Anne) Foster.

the local community mental health team 'would not give it to [him] despite him asking for it.[19] Jamie called his grandmother, Anne, most days to tell her what was happening. During this visit, Jamie detailed that Mark would get him to drive around Canberra to deliver drugs.[20] It was during this visit that Mark and Jamie also went to see Mark's father, Thomas (Tom) Knowles, in New South Wales. Jamie called Anne while he was there and was crying during the call. Jamie told Anne that Tom had told him to leave as he was in danger. Jamie told Anne that he was down the road from the house and had locked himself in his car. Anne told him to find somewhere safe to sleep then come back to Wodonga. Jamie told Anne he was not going to drive back through Canberra as there were demons there.[21]

13. When Jamie arrived back at his grandparents' house, he was scared and highly distressed. Later that day he opened up and told his grandparents what had happened at Tom's house. He told them that he drove Mark to Tom's home and that there had been a big argument and that at some point Tom had a gun and Mark had tried to get it off him.[22]

14. On 14 June 2024, Jamie's grandparents contacted Jamie's case manager with concerns about his heightened behaviour. Jamie had returned home from being out all night and was pacing around the house and verbalising threats to others and paranoid delusions. Police ultimately attended, with Dr Jo-anne Brown from the Albury Wodonga Mental Health Service also in attendance. Jamie was taken into care pursuant to an involuntary assessment order.[23] He was transported to the Wodonga Hospital Emergency Department, then later admitted to the Kerferd Unit, a place he had previously expressed he did not like.[24]

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[19] Statement of Dr Lucinda Green, Coronial Brief.
[20] Coronial Brief, page 13, paragraph 36. Statement of Elizabeth (Anne) Foster.
[21] Coronial Brief, page 13, paragraph 37. Statement of Elizabeth (Anne) Foster.
[22] Coronial Brief, page 13, paragraph 39. Statement of Elizabeth (Anne) Foster. Page 25, paragraph 50. Statement of Arthur (Paul) Foster.
[23] Pursuant to sections 144-151 of the *Mental Health and Wellbeing Act 2022*.
[24] Coronial Brief, page 55, paragraph 6. Statement of Dr. Neil Wareing. Page 61, paragraph 10. Statement of Jo-Anne Brown.

THE CORONIAL INVESTIGATION

15. Jamie'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.

16. Jamie was subject to an inpatient temporary treatment order[25] at the time of his death and, as such, his passing is deemed to be 'in care' and subject to a mandatory inquest, pursuant to section 52(2) of the Act.

17. 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.

18. 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.

19. Victoria Police assigned Senior Constable Joseph Larkin to be the Coronial Investigator for the investigation of Jamie's death. Senior Constable Larkin conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

20. This finding draws on the totality of the coronial investigation into the death of Jamie Alexander Knowles, 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

[25] Made on 15 June 2024 under s 184 of the *Mental Health and Wellbeing Act 2022*, Coronial Brief, Extract of Albury Wodonga Health medical records, page 88.

or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[26]

21. In considering the issues associated with this finding, I have been mindful of Jamie'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

22. Upon admission into the Kerferd Unit on 14 June 2024, Jamie tested positive to THC[27] and methylamphetamine.

23. On 15 June 2024, Jamie was placed on an inpatient Temporary Treatment Order by Psychiatrist Dr Rashmi Gururajan due to his disorganised behaviour, recent drug use and lack of insight into his mental state.[28]

24. Jamie was reviewed on 17 June 2024 by Consultant Psychiatrist Dr Christopher Shing. Jamie denied taking any substances prior to his admission and demonstrated lack of insight into his admission and his mental health issues. He denied that his grandparents were worried about him and denied needing to change his current medication. He stated Clozapine had been 'fine', but that he didn't want to go back on it. Jamie appeared irritated and he engaged poorly with the medical staff.[29]

25. On 20 June, 2024, Dr Shing drove Jamie from Kerferd House to his home so he could collect his own car. Jamie then drove his car back to Kerferd House. Jamie had opened

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[26] 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.

[27] Delta-9 tetrahydrocannabinol (**THC**) is the active ingredient in cannabis.

[28] Coronial brief, page 37, Treatment and Progress in Hospital, paragraph 1 and 2. Statement of Lucinda Green.

[29] Coronial Brief, page 37, Treatment and Progress in Hospital, paragraph 3. Statement of Lucinda Green.

up to Dr Shing telling him of the challenges he faced in his life and what life looked like after his release from Kerferd House.[30]

26. On 24 June, 2024, Jamie spoke to Dr Shing and requested leave to attend and prepare for a surprise birthday party for his brother in Wodonga the next day. Jamie had mentioned this at an earlier review.[31] Other reviews conducted by nurses showed that Jamie had settled over the weekend, and he denied any thoughts of harm to himself or suicide ideation. He presented as composed and the nursing report from the morning was that Jamie had been very settled.[32]

27. As the proposed leave involved long-distance travel and other potential risks, including possible substance use, Dr Shing requested contact details for someone who could verify the times and other details for the proposed leave. Jamie could not provide this and was told by Dr Shing that the leave would not be approved at this stage. Jamie was evidently disappointed and exasperated by the decision and told Dr Shing that he wanted to 'clear my head', before coming to talk to him again. Jamie requested an hour of unescorted leave to go for a walk, and this was granted.[33] He left his wallet on the ward and left the unit. Jamie never returned to the unit.[34]

28. At approximately 2:05 pm on Monday 24 June 2024, Mr Bruce Morrison was driving along Castle Creek Road, Castle Creek, Victoria. Mr Morrison noticed a figure suspended from a tree branch by a strap approximately 30 metres from the roadside and called 000.[35] At 2:19 pm, Senior Constable Joseph Larkin and Constable Danielle Vickers from the Wodonga Police station arrived at the scene. Senior Constable Larkin checked on Jamie but found no signs of life. Paramedics arrived shortly after and formally pronounced him deceased at 2:26 pm. Located nearby was a red Holden Rodeo that was registered to Jamie.

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[30] Coronial Brief, page 41, 1st paragraph. Statement of Dr. Christopher Shing.
[31] Coronial Brief, page 41, 2nd paragraph. Statement of Dr. Christopher Shing.
[32] Coronial Brief, page 169 NEBMHS progress notes. Coronial Brief, page 170 & 171. Progress notes.
[33] Coronial Brief, page 41, 2nd paragraph. Statement of Dr. Christopher Shing.
[34] Coronial brief, page 37, last paragraph. Statement of Lucinda Green.
[35] Coronial Brief, page 4, paragraph 4. Statement of Bruce Morrison.

Inside the vehicle were various documents in Jamie's name and a small bag believed to have contained methylamphetamine.[36]

29. Police members from the Crime Investigation Unit attended and took photographs of the scene. They inspected Jamie's body and were satisfied that there were no suspicious circumstances in relation to his death.[37] Police then attended the home address of Mr and Mrs Foster to advise them of Jamie's passing, and notified Kerferd House.[38]

Identity of the deceased

30. On 4 July 2024, Jamie Alexander Knowles, born 11 June 2000, was identified via fingerprint comparison. Identity is not in dispute and requires no further investigation.

Medical cause of death

31. Specialist Forensic Pathologist Dr Heinrich Bouwer from the Victorian Institute of Forensic Medicine conducted an external examination on 26 June 2024 and provided a written report of his findings dated 18 July 2024.

32. The examination revealed an incomplete ligature abrasion around Jamie's upper neck with a suspension point behind the head, in keeping with the position the body was found in. There were no significant other injuries.

33. Toxicological analysis of post-mortem samples identified the presence of lorazepam, olanzapine, risperidone and its metabolite hydroxyrisperidone, clozapine, haloperidol, methylamphetamine and its metabolite amphetamine, and cannabis.

34. Dr Bouwer provided an opinion that the medical cause of death was 1(a) neck compression secondary to 1(b) hanging, and I accept his opinion.

[36] Coronial Brief, page 42, paragraphs 4 – 8. Statement of Senior Constable Joseph Larkin.
[37] Coronial Brief, page 43, paragraph 10. Statement of Senior Constable Joseph Larkin.
[38] Coronial Brief, page 43, paragraph 12. Statement of Senior Constable Joseph Larkin.

REVIEW OF CARE

35. After Jamie's passing, Albury Wodonga Health (**AWH**) commissioned a Serious Adverse Patient Safety Event (**SAPSE**) Review and a report was submitted to Safer Care Victoria. A document summarising the SAPSE review findings, learnings and associated recommendations was also submitted to the AWH Board Patient Safety, Quality and Service Review Committee.

36. I was assisted in my investigation by provision of that summary document and a statement prepared by Ms Kim White, Executive Director of Quality Governance and Patient Experience and Chief of Nursing at Albury Wodonga Health. Ms White's statement summarises feedback provided by Jamie's grandparents to AWH in the course of the review, including their concerns about Jamie being permitted temporary leave while commencing clozapine and having access to his car. The SAPSE panel considered these issues and concluded that the commencement of clozapine would not have influenced the decision to grant Jamie day leave from the Kerferd Unit. They acknowledged that providing Jamie with access to his car keys did not breach any legislation or policy, but did increase his overall level of risk.

37. On the basis of their review of Jamie's case, the SAPSE panel made a number of findings, including:

    Finding 1

    The period of leave[39] was granted from 19 June–10 July 2024. Although not in breach of the legislation, consideration to approving leave daily would ensure the level of risk is assessed contemporaneously and minimise the risk of harm. The policy for leave approval in the mental health setting is not consistent with current legislation, nor does it outline requirements for clinicians to consider when granting leave, such as the use of private vehicles, personal searches, or family engagement in leave approval processes.

[39] Leave of absence for compulsory patient, made by Dr Christopher Shing on 19 June 2024 under sections 212 and 214 *Mental Health and Wellbeing Act 2022*, which permitted Jamie up to 1 hour of unescorted leave per day for shopping/recreation/exercise.

Finding 2

The risk assessment tool did not accurately assess the level of risk of suicide for [Jamie]. This increased the likelihood of the Consultant not assessing [Jamie] as being at risk of suicide and led to the approval of unescorted leave with access to his car and car keys.

Finding 3

The inconsistent process to include [Jamie] and family in the care planning process led to key information not being shared with the whole treating team in a timely way. This increased the likelihood that the Consultant assessed [Jamie] as low risk of suicide/harm and approved unescorted leave.

Learning 1

The Consultant drove his own vehicle with the consumer as passenger to collect the consumer cars at his grandparents' house. The service does not have a current policy position on staff using private vehicles for work related purposes, including transporting consumers. Such document should outline the processes to ensure full protections with insurance in the event of an accident and consideration for WorkSafe regulations.

38. I am reassured by the robustness of the SAPSE review and the concomitant recommendations made by the panel to address these issues in future cases, namely, that AWH:

3) Standardise the processes for a leave of absence from the Inpatient Mental Health Units, aligning with best practice examples and state-based legislation. Ensure family and carers are included formally in the decision to grant a leave of absence during an inpatient admission.

4) Implement revised risk assessment tools and processes in conjunction with the Zero Suicide Framework project with Safer Care Victoria.

5) Develop and implement a procedure on the use of private vehicles to transport patients, staff, and consumers at Albury Wodonga Health and communicate and implement it into practice.

39. For the avoidance of doubt, whilst I am satisfied that suboptimal care planning processes increase the likelihood that a Consultant Psychiatrist will inaccurately assess a patient as being at low risk of suicide or self-harm, I am not satisfied to the requisite standard that the missed information in Jamie's case was of such weight in the context of his broader presentation that it would have altered the outcome of the leave approval process in his case.

CPU REVIEW

40. Independently of the SAPSE process, I directed the independent practitioners in the Mental Health and Disability Team of the Coroners Prevention Unit (**CPU**)[40] to review the mental health care Jamie received in the weeks leading up to his passing. Having reviewed the Coronial Brief and the Albury Wodonga Health records, the CPU clinicians advised me that in their opinion, the mental health care provided was reasonable and appropriate. The CPU did not identify any opportunities for prevention.

41. It is important to bear in mind that under the *Mental Health and Wellbeing Act 2022*, Jamie's treating team had an obligation at all times to provide mental health and wellbeing services with the least possible restriction of Jamie's rights, dignity and autonomy with the aim of promoting his recovery and full participation in community life.[41] In my view, the AWH clinicians involved in Jamie's care acted in accordance with this principle.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Jamie Alexander Knowles, born 11 June 2000;

    b) the death occurred on 24 June 2024 at 950-956 Castle Creek Road, Castle Creek, Victoria, 3691, from 1(a) neck compression, 1(b) hanging; and

    c) the death occurred in the circumstances described above.

43. Having considered all of the circumstances, I am satisfied that Jamie intentionally took his own life.

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[40] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[41] Section 18, *Mental Health and Wellbeing Act 2022* (Vic).

44. Having considered all of the evidence, I am satisfied that the mental health care provided to Jamie was reasonable and appropriate in all the circumstances.

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

Pursuant to section 73(1B) 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:

Elizabeth Anne Foster, Senior Next of Kin

Mark Knowles, Senior Next of Kin

Albury Wodonga Health (C/- Lauren Aspley, MinterEllison)

Senior Constable Joseph Larkin, Coronial Investigator

Signature:

Coroner Simon McGregor

Date: 5 March 2025

NOTE: Under section 83 of the *Coroners Act 2008* (**the Act**), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.