IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 6196

**FINDINGS INTO DEATH WITH INQUEST**

*Form 37 Rule 60(1)*

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

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| **Inquest into the Death of:** | **JAKE JAMES-KOTSANAS** |
| Delivered On: | 14 December 2016 |
| Delivered At: | Coroners Court of Victoria<br>65 Kavanagh Street, Southbank |
| Hearing Dates: | 26 – 28 JULY 2016 |
| Findings of: | **CORONER JOHN OLLE** |
| Counsel Assisting the Coroner | **Ms Jessica Wilby, Coroners Court In-House Solicitors Service** |

I, JOHN OLLE, Coroner having investigated the death of Jake James-Kotsanas

AND having held an inquest in relation to his death on 26 - 28 July 2016
at the Coroners Court at MELBOURNE
find that the identity of the deceased was Jake James-Kotsanas
born on 23rd September 1991
and the death occurred on 6th December 2014
at the Alfred Hospital, Prahran
**from:**

1(a) HAEMORRHAGE FROM INCISED WOUNDS TO THE NECK AND WRISTS

**in the following circumstances:**

1. Jake James-Kotsanas, aged 23 years, was temporarily residing with his uncle Peter in Hawthorn East at the time of his death. He is survived by his maternal grandparents, Geoffrey (Geoff) and Lesley James, his mother Natalie and younger brother Nicolas (Nic).

2. Jake's formative years were shaped by domestic violence. At aged four years, he was assaulted by his father whilst attempting to protect his mother. This incident resulted in a placement of Jake and his infant brother Nic to the care of his maternal grandparents. Geoff explained that Jake, though traumatised by the incident was a gentle and kind boy who gradually settled into his new home. The following decade was uneventful however in his mid-teens following a brief and unsuccessful reconciliation with his mother in country Victoria, and despite the protestations of Geoff and Lesley, Jake moved in with his father in Melbourne. Jake was barely sixteen years old when his father gave him a syringe with heroin, prior to injecting heroin himself. Jake awoke to discover his father deceased alongside him, having fatally overdosed.

3. Jake's life spiralled into decline. His behaviour became erratic, at times placing his grandparents in fear for their safety, and for the safety of Nic. Nonetheless, they loved Jake and remained a constant in his life. I note their frustration that mental health services were unable to lawfully contain Jake during his adolescence. In his late teens and early twenties, drug addiction led to drug induced psychosis, bizarre and increasingly violent behaviour, mental health inpatient and outpatient treatment with Jigsaw at Barwon Health. In early July 2014, following unsuccessful attempts to locate Jake, Barwon Health closed his file. Although Jake's case was closed, Dr Bauer, consultant psychiatrist, explained Barwon Health offered continued family support and follow-up. On 2 September Geoff contacted Barwon Health to advise Jake was in prison, and due for release in October 2014. Geoff

advised Barwon Health that although various intervention orders were in place, the family were prepared to continue to support Jake, conditional upon Jake seeking support for his mental health and substance use. Barwon Health offered nonclinical support options, however there was no further contact with the family.

4. Upon release, in compliance with his parole conditions, Jake attended his Community Corrections Office appointments. At the time of his death, his corrections file was in the process of transfer between the Box Hill and Geelong corrections offices. He was residing variously at Geelong and Melbourne.

5. Several nights per week, Jake resided at his uncle Peter's home in Hawthorn East. According to Peter, Jake was a private person who would come and go as he pleased. Though they rarely conversed, Peter noted nothing untoward about Jake's mental state. However, several weeks prior to his death, Jake was extremely sad, confiding to Peter that his closest friend had suicided. Of note, Jake's former girlfriend noted a deterioration in Jake's mental state in the days prior to his death, which she believed was consistent with illicit drug use.

6. On the night of 6th December 2014 Jake returned to Peter's home, acting strangely. Peter left and returned several hours later to find Jake in the roof cavity. The events which unfolded are indicative of Jake suffering a drug induced psychosis. He fell through the ceiling holding a knife, uttering paranoid ideation and threatening his uncle. Peter fled the house, with Jake, armed with a knife, in pursuit. They ran along Burke Road Camberwell. Police members responded promptly to emergency calls. They were confronted by the distressing scene of Jake self-inflicting knife wounds.

7. I am satisfied that Jake's welfare was the sole motivation of all attending police members. Their collective dedication and professionalism in circumstances which can only be described as harrowing, was exemplary. I join the voice of Jake's grandfather Geoff who acknowledged their efforts. Without hesitation I accept the evidence of the Critical Incident Response Team (CIRT) Team Leader Senior Constable Aaron Henneman. Having explained the priority was to stop Jake harming himself and obtain urgent medical attention he addressed the family:

> "I just want to say to the family that you know- it was a tough thing to go to but we did the best we could."[1]

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[1] T- 91-92

**Purposes of the Coronial Investigation**

8. The primary purpose of a coronial investigation of a reportable death[2] is to ascertain, if possible, the identity of the deceased person, the cause of death (interpreted as the medical cause of death) and the circumstances in which the death occurred.[3] An investigation is conducted pursuant to the *Coroners Act 2008* (the Act). The practice is to refer to the medical cause of death incorporating, where appropriate, the mode or mechanism of death, and to limit the investigation to circumstances sufficiently proximate and causally relevant to the death.[4]

**Standard of proof**

9. Coronial findings must be made on the basis of proof of relevant facts on the balance of probabilities and subject to the principles enunciated in *Briginshaw* v *Briginshaw*[5].

**THE EVIDENCE**

10. Detective Sergeant Steven Martin, Homicide Squad was the Coroner's Investigator (CI) and compiled a detailed and comprehensive coronial brief. I have been provided with copies of the Victoria Police Critical Incident Management Review Report and the Victoria Police Post Incident Review Team Report.

11. My finding is based on the evidence contained in the coronial brief as well as the evidence presented at inquest and any documents exhibited at that time.

**INQUEST**

12. Prior to the commencement of the inquest, it was apparent most facts about Jake's death were known and not in dispute. This included his identity, the medical cause of his death, and the circumstances surrounding his death.

13. However, given that this was a police contact death, I determined that I would convene a public hearing by way of an inquest and hear evidence from the following witnesses:

- Dr Renee Bauer
- Peter Kotsanas
- Constable Peter Landgridge

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[2] Section 4 of the Act requires certain deaths to be reported to the coroner for investigation.
[3] Section 67 of the Act.
[4] Coroners are also empowered to report to the Attorney-General on a death they have investigated; the power to comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice; and the power to make recommendations to any Minister, public statutory or entity on any matter *connected with the death*, including recommendations relating to public health and safety or the administration of justice. Sections 72(1), 72(2) and 67(3) of the Act regarding reports, recommendations and comments respectively.
[5] *Briginshaw v Briginshaw* (1938) 60 C.L.R. 336.

- Acting Sergeant Paul Basinski
- Senior Constable Karl Lewicki
- Senior Constable Aaron Henneman
- Acting Inspector Phillip Edge
- Senior Constable Nathan Pennell
- Inspector Darryl Thompson

**MEDICAL EXAMINATION**

14. A post mortem examination was conducted by Associate Professor David Ranson, Forensic Pathologist of the Victorian Institute of Forensic Medicine (VIFM). He determined the cause of death to be:

    1. (a) Haemorrhage from incised wounds to the neck and wrists.

15. Associate Professor Ranson noted the autopsy revealed evidence of significant vascular injury as well as penetrating injuries of deep neck structures including the oropharynx and associated neck musculature. He further noted the wrists revealed evidence of severing of major arteries in these areas. In the setting where there is extensive open skin injury overlying severed arteries, the severed vessels may bleed extensively into the environment.

16. Jake was found to have drugs in his system at the time of his death. Associate Professor Ranson noted the toxicological analysis revealed a mixed drug pattern including amphetamines and cannabis. In his opinion the levels of these drugs may have significantly affected Jake's mental state.

**CIRCUMSTANCES IN WHICH THE DEATH OCCURRED**

17. My task has been aided by Counsel Assisting, Ms Jessica Wilby and Counsel for the Chief Commissioner of Police Mr Paul Lawrie. Mr Lawrie's succinct and accurate recitation of the circumstances are set out hereunder. I thank both counsel and my coronial investigator for the assistance provided me throughout my investigation and inquest.

18. Shortly prior to midnight on 5th December 2014 Jake was in crisis. He had armed himself with a large knife and threatened his uncle, Peter Kotsanas. Jake had also commenced to inflict serious cuts to his wrists.

19. Police were called and attended at the vicinity of Burke Road and Victoria Road, Camberwell where Jake had followed his uncle on foot and continued to threaten him.

20. Over the next twenty minutes police tried to communicate with Jake in an effort to stop him self-harming and relinquish the knife. Tragically, Jake continued to inflict grievous injuries to his wrists and then to his neck. He could not be stopped until specialist police arrived who were able to use Tasers to incapacitate him. Emergency medical aid was immediately available but, ultimately all medical intervention was to no avail.[6]

**POLICE RESPONSE**

21. At 11:44:08pm, Peter Kotsanas telephoned 000 Emergency to report that Jake was in the roof space at 1 Temple Court, Hawthorn East and "going crazy". Peter Kotsanas also reported that Jake was probably alcohol or drug affected.

22. At 11:46:40pm Boorondara 311, comprising LS/C Whitehead and C/Langridge, were tasked to attend at 1 Temple Court. Whilst en route C/Langridge requested a LEAP location check and person check via D24. There was a prompt response with information given to Boroondara 311 (and other units on the same channel, such as Boroondara 251) that Jake had warnings [warning flags] for heroin and cannabis use as well as a history of suicidal and self-harming behavior and an unstable psychiatric condition.

23. At 11:50:00pm Boroondara 251, compromising A/Sgt Basinski and C/Field, requested details of the job to be sent through to their Mobile Data Terminal ("MDT").

24. At about 11:51pm C/Langridge telephoned Peter Kotsanas on his mobile number (which had been provided through D24). Although the conversation was brief and broken, C/Langridge was able to determine that Jake was running up Victoria St to Burke Rd. This new information allowed Boroondara 311 to locate Jake as quickly as possible.

25. At 11:54:15pm Boroondara 311 advised that they had arrived (Code 5) at Burke Rd and that they had sighted a male (Jake) with a knife. They immediately tried to restrict Jake's movements by maneuvering their divisional van to create a barrier between Jake and Peter Kotsanas. C/Langridge and LS/C Whitehead soon realized that this tactic was not sufficiently effective and so both decided to attempt to cordon him on foot. All the while the purpose of this approach was to: restrict Jake's movements; separate him from Peter Kotsanas and other members of the public; engage with him verbally in an attempt to have him drop the knife; and allow time for other members and specialist resources to arrive.

26. At about the same time Boroondara 251, who had been monitoring the situation, responded from an address in Park Street, Kew. At 11:55:00pm, whilst on route, A/Sgt Basinski

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[6] Submissions Mr Lawrie Counsel for Chief Commissioner of Police

requested a dog squad unit to attend. Camberwell 311 was also redirected from another task to attend.

27. Simultaneously other units responded without the need for explicit direction. They included:

- East 541- Detective S/C Paliaga and Detective S/C Nicol
- CIRT 371- LS/C Henneman, LS/C Lewicki and LS/C Robotham
- CIRT 361- LS/C Haun, LS/C Wattie, LS/C Foo, and LS/C Mancura
- CIRT 251 Sgt Gynther and LS/C Wallace
- Oakleigh 750- A/Sgt Pepperall, C/Martino, C/Sawn and C/Hamill
- Boroondara 719- S/C Irvine and C/Hanvey

28. LS/C Whitehead tried to engage with Jake. C/Langridge recalled that LS/C Whitehead asked Jake repeatedly to drop the knife but adopted a calm "approachable" manner the entire time. They managed to cordon Jake reasonably effectively in front of the shops on the east side of Burke Road, just south of the service station. Throughout this time Jake was slashing at his wrists and not responding to either police member.

29. At 11:57:00pm Boroondara 311 radioed for urgent assistance and provided a situation report with their precise location. Thirty seconds later Boroondara 251 arrived and immediately formed a cordon now compromising four police members around Jake in the vicinity of the service station. A/Sgt Basinski joined LS/C Whitehead's efforts to attempt to communicate with Jake.

30. At about 11:58pm both C/Langridge and A/Sgt Basinski deployed OC foam towards Jake. It is not clear which member was the first to deploy but it appears both did so in quick succession. Neither attempt appeared to have delivered a "primary dose" to Jake and he showed no effect. At about the same time A/Sgt Basinski confirmed a request for an ambulance to attend the scene.

31. By about 11:59pm Jake had crossed Burke Road from east to west and moved to the garden area outside Le Pine Funerals and A/Sgt Basinski transmitted an updated situation report. It was at this location that A/Sgt Basinski and C/Langridge again deployed OC foam but with no effect. The evidence indicates that there were a total of six attempts to use OC foam in the attempt to disable Jake. Whilst the earlier deployments appear to have missed Jake's eyes and face (therefore not resulting in a "primary exposure"), A/Sgt Basinski was confident that his last effort resulted in "a primary dose direct to his face". Unfortunately, this still had no apparent effect on Jake save that it prompted his only verbal engagement

with police when he said words similar to "I thought you were trying to help me, spraying me isn't." Detective S/C Palagia observed:

> "The foam had absolutely no effect on this male. He then proceeded to start wiping the foam from his face and off his hair. I remember seeing him flick the foam onto the grass."

32. At 12:01am East 541 (Detective S/C Paliaga and Detective S/C Nicol) arrived and transmitted a situation report.

33. At 12:02am A/Sgt Basinski transmitted a further situation report and advised that Jake was now stabbing himself in the throat and that OC foam had no effect. The members continued to cordon Jake as he sat on the grass outside Le Pine Funerals but they could not safely move closer than approximately 5 meters because he refused to relinquish the knife. They had no other option but to wait for the arrival of CIRT personnel and continue their attempts to persuade Jake to give up the knife. A/Sgt Basinski and LS/C Whitehead continued in attempts to communicate but, as A/Sgt Basinski noted in his oral evidence, "he continued to do it [self-harm] and he looked straight through us when we were trying to talk to him."

34. At 12:07am A/Sgt Basinski reported that Jake was "going at his throat again" and requested another ETA for the CIRT units. He also asked if they had Tasers.

35. At about the same time an ambulance arrived and was on standby.

36. CIRT 371 arrived at 12:09am. LS/C Lewicki, a qualified negotiator, immediately made his way to cordon and moved behind the other members in an attempt to have Jake focus on him and not be distracted by the police vehicle lights on Burke Road.

37. LS/C Lewicki tried different verbal approaches and explained that the police were there to help him and get him medical attention but, as LS/C Lewicki described, he was "looking straight through me". CIRT 361 arrived at about 12:11am.

38. At about 12:12am LS/C Lewicki tried to fire his Taser but it malfunctioned. He quickly called for assistance from LS/C Henneman who passed over a replacement within 30 to 40 seconds.

39. At about 12:13am LS/C Lewicki fired this second Taser. Jake was supine at the time and the Taser had some incapacitating effect but Jake still had hold of the knife and appeared to be trying to fight the effects of the Taser to inflict further grievous injury on himself. Detective S/C Nicol observed:

"The male was still trying to pull the knife into his chest... He appeared determined to get the knife into his chest... The male was doing everything within his power to get through the convulsions and continue to thrust the knife into his chest."

40. LS/C Henneman instructed LS/C Lewicki to maintain the charge to the probes and within seconds LS/C Foo (From CIRT 361) fired his Taser from Jake's right hand side. It was only then that Jake dropped the knife and LS/C Henneman was able to move in the last few meters to secure him. Jake was observed to continue to struggle with Henneman (and others) who took several attempts to secure his wrists with flexible handcuffs.

41. At 12:14:00am A/Sgt Basinski reported that Jake was in custody and disarmed. As soon as Jake was secured Detective S/C Nicol ran over to the waiting ambulance to inform them that it was safe to come over to treat Jake.

**VICTORIA POLICE RESPONSE WAS REASONABLE AND APPROPRIATE**

42. Mr Lawrie submits the following aspects reflect the appropriateness of the police response:

a) Boroondara 311 arrived at the scene within 8 minutes of having received the call from D24. En route, C/Langridge obtained important information about Jake from LEAP inquiries. He also made contact with Peter Kotsanas by mobile telephone and was able to determine that Jake was running up to Burke Road.

b) C/Langridge and LS/C Whitehead were able to isolate Jake from Peter Kotsanas.

c) LS/C Whitehead attempted to communicate with Jake in a clear and calm manner which had the greatest chance of avoiding any escalation of his behaviour.

d) Boroondara 251 arrived within approximately 3 minutes of Boroondara 311. A/Sgt Basinski was effective in taking command. He made requests for appropriate specialist units to attend and provided regular situation reports that were available to all police members on that radio channel.

e) All members at the scene at that time acted in a coordinated manner and maintained a cordon to best try to limit Jake's movements.

f) OC foam was appropriately deployed on multiple occasions but to no effect.

g) The first CIRT team arrived 10 minutes after Boroondara 251 and very quickly LS/C Lewicki attempted to negotiate with Jake.

h) It was only when LS/C Lewicki and LS/C Foo deployed their Tasers that Jake was incapacitated and police could disarm him.

i) Medical attention was rendered very shortly thereafter by ambulance officers who had been waiting nearby.

**DRUG INTOXICATION**

43. Toxicological analysis revealed the presence of: Methylamphetamine (~0.6 mg/L); Amphetamine (~0.1 mg/L); and metabolites of Cannabis.

44. The effects of acute Methamphetamine ("Ice") intoxication are notorious. Natalie George, toxicologist, described some of these effects in Attachment 2 to the Toxicology Report. They include (in neutral terms) excessive hyperactivity and marked personality changes.

45. The police members who were attempting to help Jake reported a number of specific manifestations of "excessive hyperactivity and marked personality changes" where it seems likely that Jake's consumption of Methylamphetamine was the cause (or, at least, a significant cause):

a) Irrational and aggressive behaviour towards his uncle;

b) Verbal non-responsiveness;

c) Appearing to look "straight through" persons talking to him; and

d) A seemingly complete insensitivity to pain.

**TACTICAL EQUIPMENT- TASER**

46. I turn to the issue of tactical equipment, available to attending police members. A/Sgt Basinski and C/Langridge expressed an opinion that they would like to see Tasers made more widely available to "first responder" police units.

47. LS/C Pennell gave detailed evidence concerning the operation of the Taser, its limitations and some of the risks associated with its use. I accept his evidence in particular the complex exercise to train a police member to be a Taser operator and also to maintain his or her competency.

48. Inspector Thompson's evidence detailed the Taser pilot programs conducted at Ballarat and Bairnsdale and the current program to roll out X2 Tasers to major regional police service areas. I note the distinction drawn between the context of policing in the metropolitan area to major police service areas because of the greater availability of specialist resources such as CIRT and the Dog Squad. I further note though no current equivalent program to roll out Tasers in the metropolitan area, it is nonetheless an issue under constant review with consideration drawing upon learnings from the pilot programs and the regional roll out.

## CONCLUSION

49. I have previously referred to the eloquence and dignity of Jake's grandfather, Geoff James. His public expression of gratitude and sympathy for attending police members was a powerful moment in my inquest. I endorse the final comment of Mr Lawrie's submission:

> "The police members involved trying to help Jake have been deeply affected by these events and their inability to prevent Jake from so grievously harming himself. They have however taken much from the opportunity to meet and speak with Jake's grandfather, Mr Geoffrey James. The members have asked, through Counsel, to again express their sincere condolences to Mr James and the rest of Jake's family. They wish they could have stopped him in time."[7]

50. Geoff submitted a frustration that mental health services were unable to lawfully detain Jake through his adolescence. His submission was forceful and emanated from a man who, along with his wife Lesley, had done everything in their power to support Jake throughout his life. It must be noted however that mental health practitioners must comply with their obligations to treat in a least restrictive environment. As previously stated, I do not consider Jake's years of mental health treatment prior to his period of incarceration, sufficiently proximate to the cause of death. Nonetheless, I have received a detailed report and heard evidence of Dr Renee Bauer, consultant psychiatrist, Barwon Health who provided valuable overview and insight into the complexity of Jake's mental health and treatment. Dr Bauwer detailed the outpatient and inpatient services provided Jake over a number of years. She explained Barwon Health would have been an option to treat Jake following his parole, should he so choose.

51. In conclusion, the circumstances of Jake's death are tragic. As a child Jake was subjected to the horror of domestic violence, suffered by his mother, himself and his sibling. As an adolescent, Jake witnessed the aftermath of his father's fatal heroin overdose. On the night of his death, Jake was suffering a drug induced psychotic episode. He had recently recounted his sadness following the suicide of a close friend. Despite the best endeavours of attending police officers, Jake self-inflicted grievous knife wounds to his neck and chest. The accounts of attending police were chilling, in particular the manner in which Jake held the blade to his throat as they implored him to lay down the knife. As I stated at inquest, I find the scene confronted by them as harrowing and their efforts to help Jake, exemplary. I do not consider there were any options available to them, which could have averted this tragic outcome.

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[7] Submissions Mr Lawrie Counsel for the Chief Commissioner of Police

52. I applaud the endeavors of Victoria Police to train and make available Tasers to operating members. Operating police can only be advantaged by offering this option. However, it remains speculative whether this tragic outcome could have been averted had all police been trained and provided tasers.

**FINDINGS**

Pursuant to section 67(1) of the *Coroners Act 2008*, I make the following findings connected with Jake's death:

50. I find that Jake James-Kotsanas, born on 23rd September 1991, died on 6th December 2014 at the Alfred Hospital, Prahran in the circumstances outlined above.

51. I find that the cause of his death is:

    1(a) HAEMORRHAGE FROM INCISED WOUNDS TO THE NECK AND WRISTS

52. I convey my sincerest condolences to Jake's family and friends.

53. Pursuant to section 73(1) of the *Coroners Act 2008,* I order that this Finding be published on the internet.

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

    a. Geoffrey and Lesley James, Maternal Grandparents
    b. The Chief Commissioner of Police
    c. Detective Sergeant Steven Martin, Coroner's Investigator

Signature:

**JOHN OLLE**
**CORONER**
Date: 14 December 2016

Coroners Court of Victoria