IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 4246

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	Caitlin English, Coroner
Deceased:	Benjamin Gleeson
Date of birth:	31 August 1979
Date of death:	Between 4 September 2016 and 6 September 2016
Cause of death:	I(a) Carbon monoxide poisoning
Place of death:	Darraweit Guim Reserve Darraweit Valley Road, Darraweit Guim, Victoria

BACKGROUND

1. Benjamin Gleeson was a 37-year-old man who lived in Wallan at the time of his death.

2. On the morning of 6 September 2016 Mr Gleeson was found deceased in his car in the Darraweit Guim Reserve.

THE PURPOSE OF A CORONIAL INVESTIGATION

3. Mr Gleeson's death was reported to the Coroner as it appeared to be unnatural and so fell within the definition of a reportable death in the *Coroners Act 2008.*

4. 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.

5. The Coroner's Investigator prepared a coronial brief in this matter. The brief includes statements from witnesses, including family, the forensic pathologist who examined Mr Gleeson, treating clinicians and investigating officers.

6. I have based this finding on the evidence contained in the coronial brief. In the coronial jurisdiction facts must be established to the standard of proof of the balance of probabilities.[1]

IDENTITY

7. On 9 September 2016, Rodney Gleeson visually identified his son Benjamin Gleeson, born 31 August 1979.

8. Identity is not in dispute and requires no further investigation.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

9. Before their separation, Mr Gleeson and his ex-partner Jade Stanton were in a de-facto relationship for around 10 years. They had two children together, Ella and Mia, and Ms Stanton also had another son, Zac Stanton-King.[2]

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[1] This is 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.

[2] Statement of Jade Stanton dated 5 November 2016, Coronial Brief.

10. Ms Stanton states that Mr Gleeson was a marijuana smoker from the age of 14 and that around two years prior to his death he began using methamphetamine (also known as 'ice'). Ms Stanton notes:

'*When he was on ice his mood swings were really bad. He would smash holes in the walls and smash my laptop ... each time I tried to confront him about it. When I tried to speak to him about his ice usage he would deny it and explain his mood swings by saying he was stressed at work.*'[3]

11. Around November 2014, Ms Stanton states '*Ben kicked us all out of the house and we lived with Ben's sister Amanda in Wallan for 3 months. He lost the plot that day in some sort of rage, threw suitcases at us and told us to get ... out. During that time he would call and text me and say that if I didn't come back he would kill himself. He would ring me on some days and tell me he was driving his car and he was going to drive off a bridge etc.*'[4]

12. According to Ms Stanton, Mr Gleeson lost his job as a boilermaker in September 2015 due to absenteeism which she attributes to his drug use.[5]

13. Mr Gleeson's mother Leanne Noonan states that Mr Gleeson '*didn't go back to work at all*' following his grandfather's death on 20 October 2015. According to Ms Noonan, '*I think his death affected Ben a lot – I think he felt guilty that he hadn't seen him for at least 10 years, it was a long time*'.[6]

14. On 28 October 2015 Mr Gleeson attended his general practitioner and discussed relationship issues, depression and drug use. He had experienced suicidal ideation with a plan to crash into a tree. The general practitioner prescribed the antidepressant fluoxetine at 20mg daily and referred Mr Gleeson to Goulburn Valley Health who assessed his condition later that day. A plan was made to refer him to a psychologist.[7]

15. On 19 November 2015 Mr Gleeson was arrested after a family violence incident. He was remanded on 20 November 2015 and an Intervention Order (IVO) was made against him under the *Family Violence Protection Act 2008* on behalf of Ms Stanton and the three children as affected family members.[8]

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[3] Ibid.
[4] Ibid.
[5] Ibid.
[6] Statement of Leanne Noonan dated 1 November 2016, Coronial Brief.
[7] Goulburn Valley Health Assessment Details, Coronial Brief.
[8] Letter from the Justice Assurance and Review Office to the Coroners Court of Victoria dated 30 October 2017, Coronial Brief.

16. This IVO prohibited Mr Gleeson from further family violence as well as any attempts to contact the affected family members, to approach within 5 metres of the affected family members or to go within 200 metres of 20 Forbes Street, Wallan. The order was made for a period of one year.[9]

17. On 24 November 2015 Mr Gleeson was convicted of intentionally destroying property, intentionally causing injury, making a threat to kill and resisting an emergency worker on duty. He was sentenced to a 12-month Community Correction Order (CCO).[10]

18. On 25 November 2016 Mr Gleeson contravened his IVO by making contact with Ms Stanton. Contravening his IVO also contravened his CCO. He attempted suicide when police arrived to take him into custody.[11]

19. Mr Gleeson contravened the IVO and CCO again on several occasions by attempting to contact Ms Stanton while in custody.[12]

20. Mr Gleeson was released from custody on 19 January 2016 and received a new CCO set to expire on 18 January 2017. Mr Gleeson was to report to Greensborough Community Correctional Services (CCS) for supervision of his CCO.[13]

21. On 21 January 2016 CCS directed that Mr Gleeson visit his GP to obtain a Mental Health Care Plan. Mr Gleeson's first appointment with a mental health worker was 29 March 2016, and in the six CCS supervision appointments between 21 January and 29 March Mr Gleeson was repeatedly reminded to make appointments with his GP and mental health worker.[14]

22. CCS contacted Mr Gleeson's mental health worker on 13 May 2016. The mental health worker confirmed that Mr Gleeson had attended fortnightly appointments and was receiving treatment to address both his mental health and his drug and alcohol use.[15]

Suicidal behaviour and legal issues – January to September 2016

23. Ms Stanton states that, in the time after Mr Gleeson's release on 19 January 2016:

'Ben tried to commit suicide by gassing himself twice after he was released from gaol. He put me through hell. He sent me videos of him trying to kill himself. On these occasions he would

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[9] Order of the Magistrates' Court at Broadmeadows made 20 November 2015 in Case No F13856281 *Brett Ian Houguet v Benjamin John Gleeson.*
[10] Letter from the Justice Assurance and Review Office to the Coroners Court of Victoria dated 30 October 2017, Coronial Brief.
[11] Ibid.
[12] Ibid.
[13] Ibid.
[14] Ibid.
[15] Ibid.

send a message with the video saying "tell the girls I love them. I'm sorry". He would always say that he was sorry and then he would ring me in tears the next morning because it didn't work.'[16]

24. On 10 July 2016 Mr Gleeson was found in his car by police after an attempt to end his life by exhaust inhalation. He was then admitted as an inpatient to Bendigo Mental Health Service's Alexander Bayne Centre.[17]

25. On 13 July 2016 Ms Stanton provided Police with screenshots of messages from Mr Gleeson to herself as well as video and phone messages which Mr Gleeson had sent Ms Stanton during a suicide attempt.[18]

26. After confirming that Mr Gleeson had been discharged from his inpatient admission on 18 July 2016, Police attended Ms Noonan's address on 21 July 2016 and arrested Mr Gleeson for breaches of his Family Violence Order. Mr Gleeson was interviewed at Kilmore Police Station and bailed to appear at the Broadmeadows Magistrates Court at a later date. [19]

27. As of August 2016, Mr Gleeson faced 55 charges for contravention of his IVO. Corrections Victoria file notes indicate that these were the result of both Mr Gleeson and Ms Stanton initiating contact with each other at different times.[20]

Mental Health Care – July to September 2016

28. Mr Gleeson was admitted as an inpatient to the Alexander Bayne Centre from 11 July 2016 to 18 July 2016. His diagnosis on discharge was Major Depressive Disorder and Adjustment Disorder and he was prescribed the antidepressant mirtazapine at 30mg daily. He was referred for followup to Goulburn Valley Health's Lower Hume Community Mental Health Services.[21]

29. Beginning on 22 July 2016 Community Correctional Services was in regular contact with Mr Gleeson's mental health providers to confirm that he was attending appointments and enquiring as to his progress.[22]

30. Mr Gleeson was reviewed on 28 July 2016 by Consultant Psychiatrist Dr Vaidy Swaminathan where his dose of mirtazapine was raised to 45mg daily. He was reviewed again on 16 August

[16] Statement of Jade Stanton dated 5 November 2016, Coronial Brief.
[17] Statement of Rodney Gleeson dated 1 November 2016, Coronial Brief; Alexander Bayne Centre Discharge Plan dated 18 July 2016, Coronial Brief.
[18] Statement of Constable Joshua Price dated 14 October 2016, Coronial Brief.
[19] Ibid.
[20] Letter from the Justice Assurance and Review Office to the Coroners Court of Victoria dated 30 October 2017, Coronial Brief.
[21] Statement of Dr Sriram Rajasekar dated 11 January 2017, Coronial Brief.
[22] Letter from the Justice Assurance and Review Office to the Coroners Court of Victoria dated 30 October 2017, Coronial Brief.

2016 by Psychiatry Registrar Dr Sriram Rajasekar and mental health clinician Sonya Ojala. On this date Mr Gleeson '*reported that he had no suicidal plans or thoughts currently. Mr Gleeson also worked out a verbal safety contract with the scribe to mitigate the suicidal risk.*'[23]

31. At this review Mr Gleeson denied using any recreational drugs or alcohol.[24]

32. Dr Rajasekar and Ms Ojala offered an admission to a Prevention and Recovery Care Centre which Mr Gleeson declined. An alternative plan was made for ongoing contact and followup. Dr Rajasekar states that he '*advised Ms Ojala to keep a low threshold for inpatient admission as there was an upcoming court hearing which may alter his suicidal risk status. In order to mitigate his suicidal risk [Dr Rajasekar and Ms Ojala] planned to request for an adjournment in the court hearing*'. According to Dr Rajasekar, Mr Gleeson was happy with this plan, as was Ms Noonan who was contacted by phone.[25]

33. Ms Ojala made a home visit on 22 August 2016.[26] According to Ms Ojala's notes:

'*Ms Ojala had discussed bail and court matters with him. ... Mr Gleeson presented as polite and co-operative. He reported low mood that he attributed to not being able to see his children. According to Ms Ojala, his speech was observed to be normal and she observed nil formal thought disorder. He reportedly denied any ongoing suicidal/homicidal thought/plan/content. On the same day, Ms Ojala reportedly made a referral to Nexus support worker.*'[27]

Events proximate to death

34. Mr Gleeson's 37th birthday was on 31 August 2016. Ms Noonan recalls that on the following day they had a conversation: '*[Mr Gleeson] said "Mum I can't do this anymore. I don't want to be here anymore". I said, "What do you mean?". I thought he meant living at the house to start with. I was sad. I didn't know what to do. I said "Don't think like that, you've got two good reasons to be here". He didn't say anything*'.[28]

35. According to the Justice Assurance and Review Office:

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[23] Statement of Dr Sriram Rajasekar dated 11 January 2017, Coronial Brief.
[24] Ibid.
[25] Ibid.
[26] Ibid.
[27] Ibid.
[28] Statement of Leanne Noonan dated 1 November 2016, Coronial Brief.

'Mr Gleeson's final [Community Correctional Services] supervision session was on 2 September 2016. CCS conducted an informal Suicide and Self-Harm screening at the supervision appointment, which returned positive results. Mr Gleeson reported no suicidal ideation, however CCS identified that the upcoming Father's Day [4 September 2016] was a risk factor because he would not have contact with his children. Additionally, Mr Gleeson informed CCS that he was no longer seeing his mental health worker. Following the supervision appointment, the CCS case manager reported their concerns to Mr Gleeson's mental health worker.'[29]

36. At around 10.00pm on 3 September 2016 Ms Stanton saw Mr Gleeson's car drive past her house several times. In the morning she found a note in Mr Gleeson's handwriting at her front door which she recalls as reading '*Jade, I know you won't drop the charges. It's a given that I'll probably go back to gaol. There's no way I'll ever go back there. I'm sorry for everything, Love always Ben.*'[30]

37. On 4 September 2016 Rodney Gleeson attempted to ring Mr Gleeson. Mr Gleeson did not answer the call but sent back a text message stating '*Dad I really don't want to talk at the moment*'.[31]

38. On the morning of 6 September 2016 a resident of Darraweit Guim was walking his dog when he found Mr Gleeson's car in the Darraweit Guim Reserve. Mr Gleeson was inside the car, deceased.[32]

39. According to Senior Constable Sam Cubley, who attended the scene:

'The passenger doors of the vehicle and the boot were locked. The driver's side door was unlocked. All windows on the vehicle were closed.

I searched the vehicle further and located a small green hose-pipe which was attached to the vehicle's exhaust. The other end of the pipe was pushed up through a hole in the boot. I observed the keys to the vehicle in the on position but the vehicle was not running. The fuel tank gauge showed as empty.'[33]

[29] Letter from the Justice Assurance and Review Office to the Coroners Court of Victoria dated 30 October 2017, Coronial Brief.
[30] Statement of Jade Stanton dated 5 November 2016, Coronial Brief.
[31] Statement of Rodney Gleeson dated 1 November 2016, Coronial Brief.
[32] Statement of S/C Sam Cubley dated 9 December 2016, Coronial Brief.
[33] Ibid.

CAUSE OF DEATH

40. On 8 September 2016, Dr Paul Bedford, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an inspection of Mr Gleeson's body and provided a written report, dated 21 September 2016. In that report, Dr Bedford concluded that a reasonable cause of death was '*I(a) Carbon monoxide poisoning*'.

41. Toxicological analysis identified that Mr Gleeson's blood had an approximately 69% concentration of haemoglobin bound to carbon monoxide. Carbon monoxide displaces oxygen from haemoglobin, reducing the ability of blood to retain oxygen.

42. Normal concentrations of carbon monoxide in non-smokers living in an urban environment are generally less than 2%. In heavy smokers concentrations may reach 6%. Analysis of fatalities due to automobile exhaust inhalation has found concentrations ranging from 48% to 93%.

43. Toxicological analysis also identified the presence of methylamphetamine and amphetamine in Mr Gleeson's blood as well as the antidepressant mirtazapine.

44. I accept Dr Bedford's opinion as to cause of death.

Intent

45. Considering the circumstances of his death, I find that Mr Gleeson intended to end his own life.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

46. Mr Gleeson's death is part of a growing trend of deaths where methamphetamine ('ice') is a factor; he had a history of methamphetamine use and toxicological analysis indicates he was under the effects of the drug at the time of the death.

47. The rate of methamphetamine-related deaths in 2015 was double the rate in 2009. Although the most frequent cause of methamphetamine-related deaths is drug toxicity, more than half of such deaths arise from natural disease (22.3%), accident (14.9%) and suicide (18.2%).[34]

48. Research suggests that, along with its effects on physical health:

[34] Shane Darke, Sharlene Kaye and Johan Duflou, 'Rates, characteristics and circumstances of methamphetamine-related death in Australia: a national 7-year study' (2017) 112 *Addiction* 2191.

'Methamphetamine use is also associated with a substantial burden of psychopathology, including mood and anxiety disorders, suicide and violent behaviours. There is also an increased risk of developing a schizophreniform paranoid psychosis, a risk exacerbated by crystal methamphetamine use. Finally, regular methamphetamine use is associated with increased risk of violent assault upon others and the self.'[35]

49. The connection between drug use and interpersonal violence has been noted elsewhere, notably by the recent Royal Commission into Family Violence.[36] Mr Gleeson's history as a perpetrator of family violence may be an example of this connection.

50. Male perpetrators of domestic violence are also known to have a heightened risk of suicide. However, most suicides among male perpetrators of domestic violence occur within six weeks of the most recent incident of violence.[37]

51. Due to the connections between Mr Gleeson's death, drug abuse and family violence, I direct that this finding be distributed to the National Drug and Alcohol Research Centre and to the Department of Premier and Cabinet's Family Violence and Service Delivery Reform Unit.

FINDINGS AND CONCLUSION

52. Having investigated the death, without holding an inquest, I find pursuant to section 67(1) of the *Coroners Act 2008* that Benjamin Gleeson, born 31 August 1979, died between 4 September 2016 and 6 September 2016 at Darraweit Gum, Victoria, from I(a) Carbon monoxide poisoning in the circumstances described above.

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

Mr Rodney Gleeson and Ms Leanne Noonan, senior next of kin.

Office of the Chief Psychiatrist.

Goulburn Valley Area Mental Health.

Justice Assurance and Review Office.

National Drug and Alcohol Research Centre, University of New South Wales.

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[35] Ibid 2 (references omitted).
[36] See eg State of Victoria, Royal Commission into Family Violence: Summary and recommendations, Parl Paper No 132 (2014 – 16) p 28.
[37] Michael B MacIsaac et al, 'Prevalence and Characteristics of Interpersonal Violence in People Dying from Suicide in Victoria, Australia' (2018) 30 *Asia Pacific Journal of Public Health* 36.

Department of Premier and Cabinet Family Violence and Service Delivery Reform Unit.

Senior Constable Sam Cubley, Victoria Police, Coroner's Investigator.

Signature:

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CORONER

Date: 9 April 2018