IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 4280

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)
*Section 67 of the **Coroners Act 2008***

Deceased:	**BENJAMIN JAMES BROWNE**
Delivered On:	17 August 2020
Delivered At:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank 3006
Hearing Date:	4 August 2020
Findings of:	**SARAH GEBERT, CORONER**
Counsel Assisting the Coroner	Mr Lindsay Spence, Principal In-House Solicitor, Coroners Court of Victoria
Catchwords	*Police custody, arrest, concurrent use of alcohol and cannabis, Australian Army*

HER HONOUR:

Background

1. Benjamin James Browne[1], born 26 April 1989, was 29 years of age at the time of his death. He is survived by parents, Sandra and Matthew and younger siblings Samuel and Bonnie. Tragically, the family lost Ben's younger sister, Natalie, when Ben was 8 years of age.

2. Ben's mother said that no matter what Ben turned his hand to, he was determined to do his best. He participated in competitive swimming and cross country, played football for a local club and was always at the gym to maintain his fitness. He was training to be a registered nurse at the time of his death with a particular interest in mental health.

3. On 27 August 2018, Ben died from self-inflicted wounds arising from an incident on 20 August 2018 near his home in Bairnsdale.

The Coronial Investigation

4. Ben's death was reported to the coroner as it appeared to fall within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**). A reportable death includes a death that appears to be unnatural or violent, or to have resulted, directly or indirectly, from an accident or injury.

5. A coroner independently investigates 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. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.[2]

6. Victoria Police assigned Detective Senior Constable Derek Verity (**DSC Verity**) to be the Coroner's Investigator for the investigation into Ben's death. DSC Verity conducted inquiries on my behalf[3], including taking statements from witnesses and compiling a coronial brief of

[1] Referred to in my finding as Ben unless further formality is required.
[2] In the coronial jurisdiction facts must be established on the balance of probabilities 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.
[3] The carriage of the investigation was transferred from Deputy State Coroner English.

evidence. The brief includes statements from members of Ben's family, those present during the events of 20 August 2018, treating health professionals, the forensic pathologist who examined him, and investigating officers.

7. In addition to the material contained in the coronial brief, Ben's Australian Army, Veterans' Affairs records related to his 2018 compensation claim were obtained as well as his medical records from Advantage Health Point, where he had been a patient.

8. After considering all the material obtained during the coronial investigation, I determined that I had sufficient information to complete my task as coroner and that further investigation was not required. As Ben was in police custody prior to his death, an inquest was mandatory pursuant to section 52(2)(b) of the Act.

9. At the Inquest, submissions were made by Mr Lindsay Spence, Counsel Assisting. Ben's parents and siblings were present as well as DSC Verity who was available in the event that questions arose in relation to the evidence. [4]

10. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity.

Background

11. Ben was born in Darwin and later moved with his family to Myrtleford and then Bairnsdale in about 2004. When he was eight years old, he was riding his bike to school with his younger sister, when she was hit by a car and subsequently died as a result of the accident. He was very close to his sister and, whilst his father said that Ben *didn't show a lot of emotion* at the time, her death had a great effect on him. I note that her loss is documented in his Australian Army and medical records.

12. Ben completed his VCE at Bairnsdale Secondary College and was heavily involved in sports including playing football at Paynesville as well as boxing. During his school holidays Ben would work for his father who was an electrician. His father said that up *until the end of school Ben had what I would class as a pretty normal life.* [5]

13. On 27 November 2007 Ben joined the Australian Army as a rifleman under general entry and was posted to Townsville. At times during his service he consumed excessive alcohol and also

[4] Via WebEx
[5] Ben reported that he did experience some bullying at school which *prompted him to go to the gym and get buffed* (GP records from Advantage Health Point).

developed a methamphetamine habit (*significant intravenous ICE use …between 2010 and 2012*). His Army records document that he disclosed to heath clinicians *weekend binge drinking* but no drug use.

14. Ben was deployed to Dubai in 2009/10 (Operation Slipper) with no reported exposure to potentially traumatising events. He was not assigned to serve in Afghanistan.

15. In February 2012 Ben voluntary discharged himself after he felt that he had *lost interest in the army.* He said that leading to his discharge he was *bullied and harassed* by his peers.

16. Dr Erin Redmond recorded as part of her consultation with Ben on 21 February 2018,

> *Before service, Mr Browne said he was an idealistic young man who had dreams of serving his country, perhaps in the SAS and certainly overseas service. His dreams did not match the reality of military life.*

17. After discharge, Ben lived in Brisbane and was employed in the mining industry.[6] He began a relationship with a woman called Michelle which lasted for three years. According to his father, an occasion of drug taking caused the relationship to breakdown. His father said that Ben *was very hurt and had always loved her.*

18. In 2015 Ben returned to Bairnsdale and studied nursing at Bairnsdale TAFE obtaining a Diploma to practice as a Division 2 Nurse. His mother said that the family *were all very glad* when Ben returned to Bairnsdale *to be closer to* them. He worked in aged care at the La Trobe Hospital but lost his job in February 2018 for reasons not fully disclosed to his father. After losing this employment Ben moved in with his father.

19. Ben told Dr Redmond that he lost his hospital job because he found it difficult to concentrate and could not get himself out of a hypervigilance state from his Army days. Dr Edmond said that after leaving the Army in *a disillusioned state and over time* [Ben] *had developed a significant depressive illness that can be attributed to his failure to succeed and realise his dreams in the Army.*

20. According to PBS/Medicare records obtained by the Court, Ben consulted with General Practitioner, Dr Joshua Hurn once in relation to experiencing depression and anxiety. At this consultation on 12 September 2017 he was prescribed mirtazapine (with 5 repeat prescriptions) which Ben last filled on 6 August 2018.[7] He said during that consultation that

[6] His mother also said that he was also engaged in long haul furniture removal.
[7] Mirtazapine is an antidepressant.

he had some bad experiences in the Army, but he was now studying nursing and was in a *better place mentally.* He was referred to a psychologist but only attended consultations on 2 and 4 October 2017. His last consultation with Dr Hurn was on 16 April 2018 for immunisations required by his nursing course.

21. In June 2018 as a result of Dr Redmond's diagnosis of *major depression with features of anxiety*, Ben was awarded Permanent Impairment compensation under the *Military Rehabilitation and Compensation Act 2004* and received a lump sum payment of approximately $50,000. He spent about $4,000 to purchase a vehicle and it is also believed he purchased drugs.

22. The impairment was not considered stable or permanent and Dr Edmond considered that there was capacity for improvement with a review scheduled for the following 12 months. She recommended supportive counseling by a psychologist or psychiatrist, ideally one with experience in caring for military personnel. There is no evidence that Ben sought the help that was recommended.

23. On 15 June 2018 Ben's licence was suspended for 10 months as a result of breaching a demerit bond.

24. In the weeks leading up to Ben's death, his behaviour was observed to have become quite erratic. According to his father, *it was in the last few weeks that Ben's life seemed to really spiral out of control*. He also noted *Ben left about two weeks ago and was gone for a day at a time. He came back about three times during the two weeks. I spoke to him each time and he just seemed normal.*

25. On 28 July 2018 Ben was observed driving erratically and speeding in the Bairnsdale area. He was intercepted by police following calls to Triple Zero. Ben was found to have a blood alcohol level of 0.029%. Although 10 grams of cannabis was located in his vehicle, and he admitted to using earlier in the day, he returned a negative result when tested for this drug.

26. On 30 July 2018 Ben was routinely intercepted by police, during which he was interviewed for driving whilst suspended.

27. Ben's father said that in, *the three days or so before he died, he used to blatantly smoke* [Ice] in their home.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

28. At 1.47am, on 20 August 2018, Ben was located by police behind the wheel of his car in the APCO Service Station car park in Bairnsdale. He was interviewed by the attending police for drive whilst suspended and a defect notice was placed on his car.

29. At 7.00am, Ben's father noticed that his son's car was missing and assumed he had gone to nursing training but later discovered him lying on his bed. He saw him 7 or 8 times during the day and said, *He was being really quiet and I could tell that there was something not quite right. I tried to tell him that I didn't know what was going on if he didn't tell me.* He also noticed that he had been *smoking dope* throughout the day.

30. At about 6.00pm, Matthew left to go shopping and when he returned Ben walked out of his room and left through the front door. As he walked out, he said something like, *I've got to get out*.

31. The evidence suggests that Ben walked to his neighbour's house at number 4 and tried to open the front door. The occupant opened her front door and Ben said he was looking for his *mate* at number 7 after which he was directed across the road.

32. Ben tried to open the front door at number 7, saying *I'm Ben, I need to come in, let me in.* The male occupant locked the door but about 10 to 15 seconds later Ben entered from the unlocked rear sliding door.

33. Ben fell to his knees and put his head on the floor and *started talking about Michelle and screaming that he hadn't cheated.* He started crawling up the hallway towards the bedroom.

34. The female occupant tried to calm him down, but they feared for their safety and emergency services were called following which they escaped from the house. They subsequently heard *banging and smashing and then he started screaming really loud, He really escalated. As soon as that stopped, after about 30 to 40 seconds he came running out of the front door. He seemed to be staggering and had blood all over his head and face.*

35. Ben was estimated to have been inside number 7 for between 15 to 20 minutes. The occupants said that they observed no injuries on Ben before they left him alone. He was not wearing a shirt or shoes when he was observed leaving the property.

36. At about 7.10pm, a witness driving nearby observed a man holding a knife in his right-hand walking in the middle of the road. Ben was heading towards the Princes Highway.

37. At about 7.15pm, Sergeant (**Sgt**) Wealands, Patrol Supervisor in the East Gippsland Area and Senior Constables Jensen and Finch, from the Bairnsdale Police Station came across Ben running along the Princes Highway. The police were responding to a possible aggravated burglary and as well at least one report that Ben was in possession of a knife.

38. Sgt Wealands attempted to engage Ben in conversation however he ignored all requests and continued running with his hands near his chest, so he was unable to confirm whether Ben was in possession of a knife.

39. Sgt Wealands said that Ben was heading towards a local carwash and noticed numerous members of the public. He was concerned for the safety of the public so engaged with deploying OC foam. He said that the first deployment had no immediate effect, until Ben had run for about 10 metres where he dropped to the ground. Sgt Wealands said that he got out of his vehicle following which Ben jumped back up and continued running down the road. He said that he moved up again in his vehicle at which time he deployed more OC foam following which Ben dropped to the ground. Ben got up a further time before he was eventually subdued by police and handcuffed after a short foot pursuit.

40. Ben continued to resist but also said to police, *Save me, help me* whilst they were trying to calm him down. He also acknowledged that he had cut himself.

41. Police initially believed Ben had suffered abdominal wounds until the extent of his injuries became apparent, following which emergency services were immediately updated.

42. Ben was conveyed to the Emergency Department of the Bairnsdale Regional Health Service arriving at 7.33pm and at 9.30pm was transferred by air ambulance to the Alfred Hospital where he was admitted to the intensive care unit.

43. Ben's condition steadily deteriorated and on 27 August 2018 he was declared deceased. Ben was surrounded by members of his family at the time and organ donation was facilitated.

IDENTITY

44. On 27 August 2018, Sandra Browne visually identified her son, Benjamin James Browne, born 26 April 1989.

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

CAUSE OF DEATH

46. On 31 August 2018, Dr Melanie Archer, a registrar in forensic pathologist practicing at the Victorian Institute of Forensic Medicine, conducted an autopsy and provided a written report dated 14 January 2019. In that report, Dr Archer concluded that the cause of Ben's death was '*Incised injury to the neck'.*

47. Toxicological analysis was conducted on ante mortem blood specimens collected at 1.40am, 21 August 2018. There was ethanol at a concentration of 0.14 g/100 ml detected as well as the cannabis metabolite delta-9-tetrahydrocannabinol. No amphetamines or mirtazapine were detected.

48. Dr Archer noted that the concurrent use of cannabis and alcohol has the potential to result in significant intoxication, and this drug combination appears to have caused Ben's erratic behavior.

49. I accept Dr Archer's opinion as to the medical cause of death.

Police Investigation and Contact

50. On 20 August 2018, the police commenced a criminal investigation which, upon Ben's death, became a coronial investigation.

51. As part of the crime scene examination police located a bloodstained knife in the middle of the road outside Reece Hardware.

52. An examination of the premises at number 7 revealed extensive damage to the loungeroom, kitchen and hallway including smashed walls, TVs, furniture, computers, plate and cups. Numerous walls and floors were bloodstained and a knife was found to be missing from one of the knife blocks in the kitchen.

53. As Ben was in police custody immediately before his death, the police investigation was oversighted by Professional Standards Command in accordance with the Victoria Police Oversight Principles. An interim report was provided to the Court which noted the following,

Arrest of the deceased was lawful and reasonable as he was suspected of committing an aggravated burglary. Deployment of the OC spray was justified as the deceased was not responding to verbal directions, he was believed to be armed with a knife and was running in the middle of the Princess Highway where he was considered a risk to himself and others.

54. The Report further noted that the police were not aware at the time of the arrest that he was suffering such a serious injury to his neck, but upon learning this information immediately provided first aid and sought urgent clinical support.

55. Counsel Assisting made similar submissions at the Inquest and, based on all the evidence, there is no basis upon which the actions of police should be criticised.

56. I note that the family expressed their gratitude for the actions of police, ambulance and emergency personnel, which they said, *allowed us to spend some extra time with Ben and gave us hope that things might turn out alright.*

Intent

57. Whilst it is apparent that the injuries that lead to Ben's death were self-inflicted, the evidence suggests that in the weeks leading to his death Ben's life was spiralling out of control and he had consumed significant amounts of drugs, including Ice.

58. Ben had also been diagnosed with a depressive illness in the year of his death but there was no evidence that he sought the treatment he needed.

59. In the immediate period before his death, Ben was observed to be thought disordered and behaving irrationally. I note that Dr Archer considered that his erratic behavior may have been brought about by the substances he had consumed. I also note his pleas to police to help save him.

60. Having considered all these circumstances, I am not satisfied that there is sufficient evidence to find that Ben had the capacity to form the intention of taking his own life when he inflicted the injuries that lead to his death.

FINDINGS

61. Having investigated the death of Benjamin James Browne and having held an Inquest in relation to his death on 4 August 2020, at Melbourne, I make the following findings, pursuant to section 67(1) of the Act:

    (a) the identity of the Deceased is Benjamin James Browne, born 26 April 1989;

    (b) Benjamin James Browne died on 27 August 2018 at the Alfred Hospital, 55 Commercial Road, Melbourne, Victoria, from *Incised injury to the neck*; and

(c) the death occurred in the circumstances described above.

62. I convey my sincerest sympathy to Ben's family for their loss and the tragic circumstances in which his death occurred. As his mother noted at the Inquest, Ben was their first born son and he was very much loved by the whole family and is missed every day. The family were however able to have Ben *live on through organ donation – a chance to help others despite* the family's great loss.

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

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

Sandra Browne, senior next of kin

Matthew Browne, senior next of kin

Department of Veterans' Affairs

Detective Senior Constable Derek Verity, Warrnambool Criminal Investigation Unit, Victoria Police

Signature:

SARAH GEBERT

CORONER

Date: 17 August 2020

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.