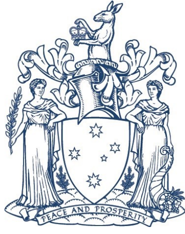

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 3244

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	**AUDREY JAMIESON, CORONER**
Deceased:	**MITCHELL BOYD BRANSON**
Date of birth:	**10 January 1999**
Date of death:	**Between 24 June 2019 and 25 June 2019**
Cause of death:	**Hanging**
Place of death:	**290 Eighth Street, Mildura, Victoria 3500**

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Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Mitchell Boyd Branson was a 20 years of age and resided in Mildura with his parents Darrel Branson and Sharon Branson at the time of his death. Mr Branson's 8-year-old sister and 22-year-old brother also lived in the family home. Mr Branson had a certificate 3 in Information Technology and worked voluntarily at both the Mildura West Primary School and the Irymple South Primary School. He had a history of mental ill health including Post Traumatic Stress Disorder and suicidality; at the age of 10 he had viewed disturbing and graphic imagery on the internet.

2. On 24 June 2019 during the evening, Mr Branson cooked dinner for his family. They ate together and he drank some alcohol. He had intended to go to a basketball game with his mother but decided against it as he was not ready in time.

3. On 25 June 2019 between 1.40pm and 2.00pm, Darrel Branson returned home from work after being contacted by his son's friends who were concerned for his welfare. Mr D. Branson found Mr Branson hanged in the garden shed of the family home. He immediately cut the ligature and contacted emergency services. Ambulance Victoria paramedics attended and confirmed that Mr Branson was deceased.

4. Mitchell Boyd Branson's death was reportable pursuant to section 4 of the *Coroners Act 2008* (Vic) ('the Act'), because it occurred in Victoria, and was considered unnatural and to have resulted from an injury.

INVESTIGATIONS

Forensic pathology investigation

5. Dr Malcolm Dodd, Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM), performed an external examination upon the body of Mitchell Boyd Branson, reviewed a post mortem computed tomography (CT) scan and referred to the Victoria Police Report of Death, Form 83. Dr Dodd commented that the external examination showed changes consistent with the reported circumstances of death. There was no evidence of offensive or defensive type injury. The post mortem CT scanning did not

identify any injuries nor other changes associated with the death. Toxicological analysis of post mortem blood detected the presence of ethanol (~ 0.10 g/100mL).[1]

6. Dr Dodd formulated the medical cause of Mr Branson's death as hanging.

Police investigation

7. Upon attending the Mildura premises, Victoria Police officers ("Police") did not identify any evidence of third-party involvement in Mr Branson's death. First Constable (FC) Christopher Donaldson was the nominated Coroner's Investigator.[2] At my direction, FC Donaldson investigated the circumstances surrounding Mr Branson's death, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by Mr Branson's parents, his close friend Cheyne Tricker Johnson, his girlfriend Emily Hill and his treating Genera Medical Practitioner (GP) Dr Mark Marrow.

8. During the investigation, police learned that Mr Branson had a history of mental ill health. He had told his family that he had viewed a horrifying and violent video on the internet at the age of ten; Mr Branson said that he accessed the video by the "dark web". His friend Cheyne Tricker-Johnson stated that this was the catalyst for his poor mental health. Mr Branson's mother. Sharon Branson stated that her son confided to her that he suffered Post-Traumatic Stress Disorder (PTSD) from the trauma of viewing the video. Mr Branson's parents indicated that they were not sure how their son could have accessed such imagery at so young an age and therefore were not sure if it was the true source of his distress and consequent mental ill health.

9. In 2015, Mrs Branson noticed a red mark on her son's neck, and he informed her that he had tried to hang himself when she asked about its origins. He refused to elaborate on the incident. Mr Branson would not see a medical practitioner in Australia to discuss his

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[1] Ethanol (alcohol) is a social drug. The blood-alcohol concentration (BAC) identified may be compared with the legal BAC for a fully licenced driver, whilst driving: ~ 0.05 mg/L.

[2] A Coroner's Investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the Coroner to assist the coroner with his/her investigation into a reportable death. The Coroner's Investigator receives directions from a Coroner and carries out the role subject to those directions.

mental health. His parents stated that he had informed them was consulting someone in Canada in relation to these issues. Mr Branson also told his mother that he had online completed an online mental health survey, which indicated that he lacked empathy for others and was desensitised to violence. Mrs Branson told her son that she did not believe that this was true for him and attempted to persuade him, to no avail, to consult a mental health professional in Australia.

10. In May 2019, Mr Branson attempted to end his own life by ingesting unknown drugs. His parents were not aware of this episode, but his friend Mr Tricker-Johnson was aware that it had occurred. On that occasion, Mr Branson did not leave any information concerning his decision making on mental state at the time of the attempted suicide.

11. During the evening of 24 June 2019, Mr Branson's parents described his behaviour as completely normal. Mr Branson had conversations by the social media mobile telephone application "SnapChat". He spoke with Mr Tricker-Johnson and his girlfriend Emily Hill. Throughout the evening Mr Branson communicated with his friend and girlfriend with both of them becoming concerned about his welfare owing to the tone of the communication:

    I just ruin everything I'm really sorry I've ruined your night and I'm sorry I'm not the person there for you in your time of need…

    I'm not (perfect) *I wish I was because you deserve that xoxo*

    I'm sorry xoxo[3]

12. Throughout that evening, Ms Hill sent many messages to her boyfriend providing insight into his value to his family and friends, as well as offering love and support. She indicated her intention to spend her life with Mr Branson. Mr Tricker-Johnson also sent a supportive message to his friend, indicating how much he appreciated their friendship. Neither Ms Hill nor Mr Tricker-Johnson received a response after midnight on 24 June 2019.

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[3] Coronial Brief, *Photograph of Mr Branson's Messages to girlfriend Emily Hill*, 24 June 2019 [unnumbered].

13. On the morning of 25 June 2019, Mr Tricker-Johnson went to Mr Branson's home and knocked on the door; he received no reply. Mr Tricker-Johnson contacted Ms Hill and they agreed that the behaviour was sufficiently concerning to warrant contacting Mr Branson's parents at work. Mr Tricker-Johnson contacted Mr D. Branson who returned home from work and found his son deceased shortly thereafter.

Coroners Prevention Unit Investigation[4]

Background

14. On 29 July 2019, Murray Primary Health Network (PHN) Strategic Projects Lead Alistair Bonsey contacted the Coroners Prevention Unit (CPU). Ms Bonsey indicated that between six people in the Mildura local government area (LGA) suicided between May and June 2019. The Murray PHN representative highlighted concerns that the suicides may meet the Centres for Disease Control and Prevention's definition of a suicide cluster; *A group of suicides or acts of deliberate self-harm that occur closer together in space and time than would normally be expected on the basis of statistical prediction and/or community expectation* (Centres for Disease Control, 1994).

15. The CPU reviewed the contents of the Victorian Suicide Register (VSR) and identified the six suicides of concern. The CPU also identified one death that was initially under investigation by the homicide squad.[5] On 1 July 2019, Victoria Police advised the Court that the death was not deemed to be suspicious by homicide squad and was considered a suicide.

Evidence of statistical clustering

16. To explore this, the CPU extracted information on all suicides which were reported between January 2010 and July 2020, where the location of fatal incident or the location of deceased's usual residence was in Mildura. CPU identified that, between May 2019

[4] 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, as well as assisting in monitoring and evaluating the effectiveness of the recommendations. The CPU comprises a team with training in medicine, nursing, law, public health and the social sciences.

[5] COR 2019 3097.

and June 2019, seven suicides of persons linked to Mildura[6] formed a statistical cluster ("Mildura Suicide Cluster" 2019).

Social Clustering

17. Murray PHN were concerned that some of the deceased persons within the Mildura Suicide Cluster may have known one another ("social clustering"). To investigate probable social clustering among the seven deaths, the CPU reviewed the Coronial Briefs and researched potential, general social connections of the deceased, such as educational intuitions and any utilised health services. The CPU did not identify any evidence that the deceased knew one another. On that basis, the Mildura Suicide Cluster was evident statistically but is not considered a social cluster.

Thematic Clustering

18. Given the strong evidence of statistical clustering, the CPU reviewed the coronial briefs to establish whether there were any commonalities in the stressors the deceased experienced subsequent to death ("thematic clustering"). The following is a short summary of the general themes in each death. Please note that these summaries were curated with the intent of providing an overview of potential thematic connections between the deceased; the summaries were not prepared by staff with clinical mental health training:

    a. Substance misuse was the singular theme common to each death. However, the severity of misuse varied from intermittent to dependency. Other main themes that recurred across multiple deaths were:

    b. In all seven deaths the deceased appeared to suffer from mental ill health, although only four individuals had a clinical mental ill health diagnosis.[7]

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[6] The CPU categorised this link by place of death or usual place of residence.

[7] COR 2019 2271, COR 2019 2530, COR 2019 2770, COR 2019 2875.

c. In five deaths,[8] there was evidence of interpersonal abuse, where the deceased was a victim and/or perpetrator. In three of these five deaths,[9] there was evidence of police contact in relation to the abuse.

d. In six deaths,[10] there was evidence of recent or threatened separation from and/or conflict with partner.

e. Two of the deceased were Aboriginal males.[11]

CPU Conclusions & Advice

19. Based on analysis of the available coronial brief material in the seven suicides, the CPU concluded that the identified suicides in Mildura represented a statistical cluster, but not a social cluster. There was evidence of substance use across all deaths, with varying levels of evidence and misuse reported (not all deceased had evident problematic use or dependence). Substance use is reported as a key issue in the Mildura region, though no drug and alcohol rehabilitation facilities exist. Aside from the above, themes were identified across multiple deaths at a time, but not all deaths.

PHN & DHHS Responses to the Mildura Suicide Cluster

Department of Health and Human Services (DHHS) response

20. DHHS supported Murray PHN in activating its suicide postvention response for the region once the health network identified the potential cluster. An overview of DHHS' response included:

a. Collaboration with Murray Primary Health Network to engage in the postvention response;

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[8] COR 2019 2266, COR 2019 2530, COR 2019 2770, COR 2019 2875, COR 2019 3244.

[9] COR 2019 2266, COR 2019 2530, COR 2019 2875.

[10] COR 2019 2266, COR 201 92271, COR 2019 2530, COR 2019 2770, COR 2019 2875, COR 2019 3244.

[11] COR 2019 2530, COR 2019 2875.

b. Engagement with Professor Jo Robinson, Head of Suicide Prevention at Melbourne University, to support the Mildura suicide postvention group, and

c. Collaboration with Family Safety Victoria.

Murray Primary Health Network (PHN) response

21. Immediately after Murray PHN identified that suicides in their region had occurred, the suicide postvention response for the region was activated. The elements of the response are described in a detailed submission dated 10 July 2019 from Murray PHN CEO Matt Jones. Additionally, Murray PHN engaged with Orygen and Professor Jo Robinson to review the Northern Mallee Suicide Postvention Protocols, which were found to be aligned with best practice. Some areas where postvention work could be strengthened were identified and this review has informed subsequent work in Mildura. The health network also conducted a thematic review of the 19 suicides that occurred in Mildura in 2019 to inform ongoing strategic activities for the Mildura Place Based Suicide Prevention Trial and Murray PHN.

22. Murray PHN identified four key issues for consideration by investigating coroners:

a. Prevalence of substance misuse and addiction in suicide deaths within the LGA – particularly in the context of sustained campaigning by the Northern Mallee Local Drug Action Team (LDAT) for establishment of drug rehabilitation and detoxification facilities in Mildura (no such services exist in the region).

b. For one death in the latter half of 2019, gambling addiction was the only known situational stressor.

c. Intersection of family violence/interaction with police and the justice system and deaths by suicide in the LGA – in early July Sunraysia Community Health Services and Victoria Police have entered into a formal agreement to provide enhanced support services to perpetrators of family violence in order to mitigate.

d. Victoria Police participation in postvention within Mildura LGA has resulted in rapid identification of emerging suicide clusters and elevated understanding by

members (self-reported) of suicide risk factors and the benefits of community supports. Adoption of state-wide postvention processes/protocols with high level endorsement and integration between VicPol and local communities could contribute to increased real time monitoring of suicide deaths towards enhanced postvention and prevention.

Potential Expansion of Cluster | Further 14 Suicides

23. Between September 2019 and April 2020, a further fourteen suspected suicides occurred in Mildura. Considered in the context of the historical data, these deaths appear to be an extension of the statistical cluster discussed here. From a preliminary review of the Victoria Police Form 83 text in each death, there are no obvious social nor thematic links between these 14 deaths and the seven deaths reviewed in this memorandum. Coroners investigating the subsequent deaths were provided a copy of the advice in relation to the first seven deaths in case it is of assistance in those investigations.

COMMENTS

Pursuant to section 67(3) of the *Coroners Act 2008* (Vic), I make the following comments connected with the death:

1. I endorse and applaud the Murray PHN's recognition of the Mildura Suicide Cluster and reporting the same to the Coroners Court of Victoria. I commend the swift response led by the Murray PHN and support offered to the health network by DHHS. I further commend the inclusion of Victoria Police in the "postvention" response, whereby areas of need may be more efficiently identified.

2. The coronial investigation into the Mildura Suicide Cluster has not identified social connections between the deceased persons. However, the statistical presence of a suicide cluster, as well as subsequent extension of that cluster, indicates that further and ongoing supports are warranted for those experiencing mental ill health in the Mildura LGA. The single, common theme identified across each death investigation is the presence of evident or supposed substance misuse. I note the revision of Mildura Base Public Hospital after twenty years of private management on 15 September 2020. The community and hospital board of directors have indicated their hope that the transition

will help to '*connect the hospital with local communities, service development and regional health planning*'. [12]

3. I will not make any specific recommendations in this matter in light of the:

   a. Recently increased availability in public health care in the Mildura LGA;

   b. Fact that the Mildura Suicide Cluster was statistical but not a "social cluster";

   c. Willingness of the Murray PHN and DHHS to determine and implement appropriate responses to the Mildura Suicide Cluster;

   d. Subsequent 14 deaths under coronial investigation, a statistical continuation of the Mildura Suicide Cluster, which may provide insight into issues warranting coronial recommendations, and

   e. Specific facts of this matter: A Coroner investigating another death within the cluster may identify appropriate recommendations to make.

4. I note that toxicological analysis of Mr Branson's blood identified a blood-alcohol concentration of 0.10 g/100mL in post mortem toxicology. There is no evidence to suggest that Mr Branson misused alcohol proximate to his death nor at another time. However, there is an increased rate of suicidal behaviour as well as completed suicide among individuals with an alcohol use disorder. Furthermore, post-mortem studies find alcohol or other drugs at measurable levels in 30–50% of suicides. Substance misuse predisposes suicide by disinhibiting or providing "courage" to overcome resistance in carrying through the act, clouding one's ability to see alternatives, and worsening of mood disorders. The association between alcohol consumption and self-harm/suicide is not entirely clear. Theoretically, consumption of alcohol may influence self-harm/suicide due to the depressant influence of the substance itself, or acute alcohol intoxication contributing to disinhibited or impulsive behaviours.

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[12] Mildura Base Public Hospital, *MBPH Returns to Public Management*, dated 15 September 2020, accessed 30 November 2020 <https://www.mbph.org.au/mildura-base-public-hospital-returns-to-public-management/>.

5. I offer my sincere condolences to Mr Branson’s family, friends and girlfriend for their loss.

FINDINGS

1. I find that Mitchell Boyd Branson, born 10 January 1999, died between 24 June 2019 and 25 June 2019 at 290 Eighth Street, Mildura, Victoria 3500.

2. I find that Mitchell Boyd Branson had a history of mental ill health and previous suicide attempts.

3. I find that Mitchell Boyd Branson refused to seek medical treatment in Australia in relation to his mental ill health and I further find that he sought advice online, in circumstances where it is unknown whether the same was professional, medical advice.

4. I accept and adopt the cause of death formulated by Dr Michael Dodd and I find that the cause of Mitchell Boyd Branson's death was hanging, in circumstances where I find that he intentionally ended his own life whilst he was intoxicated by alcohol.

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

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

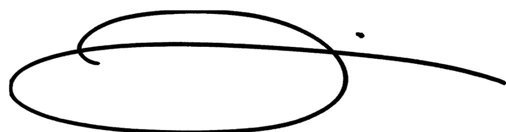
Darrel Branson & Sharon Branson

Murray Public Health Network, Chief Executive Officer, Matt Jones

Department of Health and Human Services Acting Manager Suicide Prevention, Fiona Rippin

First Constable Christopher Donaldson

Signature:



AUDREY JAMIESON
CORONER
Date**: 1 December 2020**