IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 001065

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, CORONER
Deceased:	BE
Date of birth:	17 May 1972
Date of death:	24 February 2023
Cause of death:	1(a) NECK COMPRESSION 1(b) HANGING
Place of death:	[redacted]

INTRODUCTION

1. On 24 February 2023, BE was 50 years old when he was located deceased in his garage. At the time of his death, BE lived in Marong with his three teenage sons.

Background

2. As a child, BE was allegedly sexually and physically abused and at 7 years of age, he was placed into a care home.

3. In 1990, at 18 years of age, BE joined the Australian Army (**the Army**). During his service, BE was deployed to the 1999 East Timorese crisis. Consequently, he developed Post-Traumatic Stress Disorder (**PTSD**), was *'heavily using drugs and alcohol'* and was discharged from the Army.

4. In 1996, BE fathered a daughter, FE, with his then partner. However, the couple separated, and BE rekindled a previous relationship with KD (**KD**), whom he married. BE and KD went on to have three sons.

5. KD recalls that BE became violent after his discharge from the Army and recounted multiple physical altercations. KD contacted Child Protection several times and sought Family Violence Intervention Orders.

6. Following his discharge from the Army, BE struggled to maintain stable employment. According to KD, *'he tried to do lots of jobs'* but was *'frequently unreliable'.*

7. In August 2022, following the deterioration of BE and KD's relationship, they divorced and maintained sporadic contact regarding their sons' living arrangements.

Medical History

8. In the years after his discharge from the Army, BE underwent multiple hospital inpatient admissions on account of his PTSD. He received funding through the Department of Veteran Affairs (**DVA**).

9. In 2021, BE commenced attending a psychiatrist. He presented with *'a long history of Post-Traumatic Stress Disorder and recurrent depression along with past poly substance use disorder (substance use (alcohol and marijuana))'.* He had chronic *'morbid thoughts'* but denied any suicidal intent and identified his children as protective factors.

10. BE was prescribed a medication regime to manage his symptoms and underwent Eye Movement Desensitisation Reprocessing (**EMDR**) therapy. By December 2021, he demonstrated mild improvement and was *'more motivated and more relaxed'.*

11. In April 2022, BE had completed the course of EMDR therapy and reported *'there were no further triggers for his emotions and that he was going out [of the house] in confidence'.*

12. In November 2022, the psychiatrist clinic contacted BE to suggest he book a revisit, which he accepted. A meeting was booked for January 2023, however, as BE's referral had expired the appointment could not proceed.

13. At the time of his death, BE was prescribed escitalopram and medicinal cannabis. In February 2023, BE self-ceased the medicinal cannabis as he believed he was able to manage his symptoms without.

THE CORONIAL INVESTIGATION

14. BE'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.

15. 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.

16. 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.

17. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of BE's death. The Coroner's Investigator 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.

18. This finding draws on the totality of the coronial investigation into the death of BE 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 or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

19. On 19 February 2023, KD was at the Kingdom Hall in Golden Square. BE approached her and said words to the effect of, *'I'm leaving because of you'.* Concerned, KD attended the Bendigo Police Station and sought a FVIO.

20. On 21 February 2023, Victoria Police members served the FVIO on BE at his home.

21. On 22 February 2023, BE attended upon a new GP. BE requested the GP complete paperwork for VicRoads to reinstate his drivers' licence – which had been suspended due to BE's medication for PTSD. BE told the GP that *'he had no medical conditions and was taking no current medications. He advised [the GP] that he had changed his life and was eating healthy and undertaking exercise'.* However, without BE's medical records, the GP declined to sign the paperwork.

22. On 24 February 2023, BE attended another GP. He requested a referral to his psychiatrist for ongoing follow up and sought a medical assessment for his VicRoads licence. Medical notes recorded during the consult read, *'nil suicidal thought, no self harm tendency. . .coping with life well.*

23. The GP stated the psychiatrist referral was *'for ongoing care'* and there were *'no signs that [BE] was in the midst of a psychological crisis. . . he specifically denied suicidal thoughts'.*

24. After the appointment, BE returned home. At 12:21pm, he recorded himself using his mobile phone. He was in the garage and stated, *'just worked out some major things in my life. . . not doing too good with it'.*

25. At approximately 4:30pm, BE's sons returned home from school and discovered him suspended in the garage. The eldest son cut the noose and inadvertently cut BE's scalp. The boys contacted emergency services.

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[1] 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.

26. Emergency services arrived and commenced resuscitation efforts. At 5:24pm, BE was declared deceased.

27. In the home, Victorian Police members located a notebook. An entry dated 21 September 2023 read, *'some days are so hard to deal with'.*

Identity of the deceased

28. On 24 February 2023, BE, born [redacted], was visually identified by his former spouse, KD, who completed a formal Statement of Identification.

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

Medical cause of death

30. Forensic Pathologist Dr Chong Zhou (**Dr Zhou**) of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on the body of BE on 27 February 2023. Dr Zhou considered materials including the Victoria Police Report of Death for the Coroner (**Form 83**), VIFM contact log and post-mortem computed tomography (**CT**) scan and provided a written report of her findings dated 28 February 2023.

31. The post-mortem examination revealed a furrowed and abraded ligature mark about the neck, which was consistent with the rope used. A laceration was present at the back of the head, which likely occurred when the rope was cut. There was no evidence of an underlying skull fracture and no evidence of intracranial haemorrhage.

32. The post-mortem CT scan showed a fracture to the left greater horn of the hyoid bone, patchy bilateral non-specific increased lung markings and rib fractures consistent with CPR.

33. Toxicological analysis of post-mortem samples identified the presence of delta-9-tetrahydrocannabinol at a concentration of ~ 9 ng/mL, and its metabolite, 11-nor-delta-9-carboxy-tetrahydrocannabinol, at a concentration of ~ 68 ng/mL.

34. Dr Zhou provided an opinion that the medical cause of death was 1 (a) NECK COMPRESSION and 1 (b) HANGING.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

1. On 9 September 2024, the Royal Commission into Defence Veteran Suicide (**RCDVS**) handed down its final report. The RCDVS was a three-year investigation into the *'systemic issues and risk factors relevant to suicide and suicide behaviours of serving and ex-serving Defence members'*.

2. When examining the issue of veterans' wellbeing, the RCDVS considered a vast range of areas including health, housing, employment, income and finance and how these stressors related to the high incident of veteran suicide.

3. The RCDVS published concerning statistics on the heightened suicide risk faced by current and former Australian service people. It found that male ex-serving members who served in combat or security roles in the Australian Army are 112% more likely to die by suicide than Australian males, their female counterparts are 452% more likely to die by suicide than Australian females.

4. These statistics demonstrate that the phenomenon of suicide amongst serving and former defence members cannot be understated and needs to be urgently addressed. In the report's foreword, the Commissioners jointly wrote, '*As Commissioners, we insist that it is both necessary and possible to reduce the number of deaths by suicide and experiences of suicidality among serving and ex-serving [Australian Defence Force] members'.*

5. The RCDVS handed down 122 recommendations, aimed at ensuring early intervention and the provision of appropriate services. They encourage greater transparency and accountability across the institutions responsible for the well and wellbeing of current and former Australian Defence Force members.

6. Pertinent recommendations include Recommendation 5: '*support all serving members to decompress, rest and reintegrate, especially after high-risk experiences'* and Recommendation 39: '*address risk factors for suicide and suicidality and report on progress as part of enterprise-level risk management'*.

7. The report is a thorough analysis of the myriad issues that affect current and former Australian Defence Force members. The risk of suicide faced by this cohort is worrying and I encourage the implementation of the RCVDS' recommendations with the hope of providing a better transition into civilian life, and overall outcome, for those who have served our country.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was BE, born [redacted];

    b) the death occurred on 24 February 2023 at [redacted]; and

    c) I accept and adopt the medical cause of death ascribed by Dr Zhou and find that BE died due to neck compression and hanging in circumstances where he intentionally took his own life.

2. AND I find that BE intentionally took his own life on an extended background of mental ill health and of interpersonal stressors.

3. AND FURTHER I note that BE was engaged with medical treatment, and that he was relatively compliant with the same. However, I find that he was not entirely forthcoming as to the nature and severity of his mental ill health such that his treating clinicians who saw him in the days prior to, and on the day of his death, could not have foreseen the course of action he eventually adopted.

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

Pursuant to section 73(1A) of the Act, I direct that this finding be published on the Coroners Court of Victoria website.

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

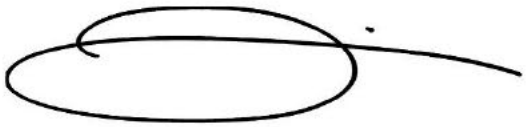
FE, Senior Next of Kin

KD

The Department of Veteran Affairs

Leading Senior Constable Todd Deason, Coroner's Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 23 January 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 investigation. 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.