QUEENSLAND COURTS

# OFFICE OF THE STATE CORONER

# FINDINGS OF INQUEST

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| CITATION: | **Inquest into the death of Leim Matthew Benson** |
| TITLE OF COURT: | Coroners Court |
| JURISDICTION: | Brisbane |
| FILE NO: | 1453/07(6) |
| DELIVERED ON: | 25 August 2008 |
| DELIVERED AT: | Brisbane |
| HEARING DATE(s): | 19 August 2008 |
| FINDINGS OF: | Coroner Lock |
| CATCHWORDS: | CORONERS: Inquest – Suicide, hanging |

REPRESENTATION:

Ms Eryn Voevodin, Counsel Assisting the Coroner

Mr Robert Whiteford of Counsel, representing Dr Brian Benson

Ms Lisa Hendy, Solicitor representing Ms Susan Thomsen

## CORONER'S FINDINGS AND DECISION

1. These are my findings in relation to the death of Leim Matthew Benson who died at the Royal Brisbane Hospital on 4 April 2007. These findings seek to explain how the death occurred.

2. The *Coroners Act 2003*[1] provides that when an inquest is held into a death, the coroner's written findings must be given to the family of the person who died and to each of the persons or organisations granted leave to appear at the inquest. These findings will be distributed in accordance with the requirements of the Act and also placed on the website of the Office of the State Coroner.

3. The inquest was held at the request of the family of Mr Benson who had expressed a number of concerns regarding the circumstances of his death. A pre-inquest hearing was held on 3 March 2008 and a further mention was held on 6 May 2008 and those issues were aired. Further enquiries and statements of other witnesses were obtained and a report was obtained from Mr Keith Harris, a researcher into suicide risk factors. A full brief of the evidence was provided to the legal representatives appearing for those given leave to appear. The inquest was then adjourned for hearing over two days commencing on 19 August 2008.

4. At the commencement of the inquest, the Counsel appearing for Mr Benson's father informed the court that his client did not now require any witnesses to give evidence or to be cross examined. Mr Whiteford stated that although there remained for the family a number of uncertainties, it was unlikely that the hearing of further evidence at an inquest would resolve any of them in a manner which would materially assist the court.

5. In that respect I agreed that, although there were a number of peripheral issues that could be resolved by hearing further evidence, on balance the brief of evidence was sufficient for me to make findings that would satisfy my statutory obligations. Furthermore the hearing of oral evidence would require the attendance of a number of witnesses which may have caused some unnecessary inconvenience to them and more importantly have caused some distress to some witnesses, in particular Ms Thomsen and to Mr Benson's family. I determined that on balance it was in the interests of those witnesses to accede to the request to not hear further oral evidence and to make findings based on the 27 documentary exhibits (A1 to F1) which were tendered to the court. I advised the parties that my written findings would be subsequently handed down at a date to be fixed. Those representing the persons given leave to appear were excused of any further appearance but would be advised when my findings were to be delivered and were welcome to attend.

**The scope of the Coroner's inquiry and findings:**

6. A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death. If possible he is required to find:-

[1] *Coroners Act* 2003, s45

a) whether a death in fact happened;
b) the identity of the deceased;
c) when, where and how the death occurred; and
d) what caused the person to die. [2]

7. There has been considerable litigation concerning the extent of a coroner's jurisdiction to inquire into the circumstances of a death. The authorities clearly establish that the scope of an inquest goes beyond merely establishing the medical cause of death.

8. An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:

*"It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends... The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires."*[3]

9. The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, the Act authorises a coroner to make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future.[4] However, a coroner must not include in the findings or any comments or recommendations, statements that a person is or maybe guilty of an offence or is or maybe civilly liable for something.[5]

**The Admissibility of Evidence and the Standard of Proof**

10. Proceedings in a Coroners Court are not bound by the rules of evidence because the Act provides that the court "*may inform itself in any way it considers appropriate.*"[6] That does not mean that any and every piece of information however unreliable will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its origin or source when determining what weight should be given to the information.

11. This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt. As already stated, it is an inquiry rather than a trial. If a witness refuses to give oral evidence at an inquest because the evidence would tend to incriminate the person, the coroner may require the witness to give evidence that would tend to incriminate the witness if satisfied it is in the public interest to do so. The evidence, when given, and any derivative evidence is not admissible against the witness in any other proceeding, other than a proceeding for perjury.[7] [8]

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[2] s45
[3] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[4] s46
[5] s45(5) and 46(3)
[6] s37(1)
[7] s39
[8] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625

12. A coroner should apply the civil standard of proof, namely the balance of probabilities but the approach referred to as the *Briginshaw* sliding scale is applicable.[9] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[10]

13. It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.[11] This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[12] makes clear, that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

14. If, from information obtained at an inquest or during the investigation, a coroner reasonably suspects a person has committed a criminal offence, the coroner must give the information to the Director of Public Prosecutions in the case of an indictable offence, and to the chief executive of the department which administers legislation creating an offence which is not indictable.[13]

**The Evidence**

15. It is not necessary to repeat or summarise all of the information contained in the exhibits, but I will refer to what I consider to be the more important parts of the evidence.

16. Leim Matthew BENSON died on 4 April 2007 at the Royal Brisbane Hospital. He was 33 years old at the time (DOB 22.03.74). His father, Dr Brian Benson, stated that he was a much loved member of the family and had many friends and workmates. He was a qualified charter vessel captain and had many skills, particularly with his marine and fishing interests. He was completing a mature age apprenticeship in carpentry. He had only days before spoken to a previous neighbour about his aims and his ten year plan. He lived his life with gusto and had future plans. His family have understandably struggled with the circumstances of his tragic death and question whether the reporting of the death (as a suspected suicide) is the true story.

17. The family raised a number of concerns some of which I will endeavour to address in this decision.

18. His death was reported to the Office of the State Coroner on 5 April 2007 by the Queensland Police Service on a Form 1.

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[9] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J
[10] *Briginshaw* v *Briginshaw* (1938) 60 CLR 336 at 361 per Sir Owen Dixon J
[11] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "*Inquest Law*" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13
[12] (1990) 65 ALJR 167 at 168
[13] S 48(2)

19. Ms Susan Thomsen began a relationship with Mr Benson in February 2006, shortly after they met. He was intending to move into Ms Thomsen's residence over the weekend of 31 March 2007.

20. Ms Thomsen says that on 31 March, after mowing the lawn, he bought a bottle of schnapps and other alcohol and drank much of it during the afternoon. She described that they had a disagreement the day before and tensions between them were still strained.

21. In the evening of 31 March 2007, Mr Benson and Ms Thomsen attended a trivia night function at a football club. According to Ms Thomsen, Mr Benson consumed a drug known as ecstasy at this time. She also states that both she and Mr Benson consumed alcohol during the course of the evening. She estimates he drank between 8 to 10 cans of bourbon and coke. She also drank 8 glasses of wine.

22. They left with their friends Janet and David Halligan. Mr Halligan says that Mr Benson was heavily intoxicated by the time they left the trivia function. During the evening he had said he was going to approach the president of the club over some alleged past indiscretion between the president and Ms Thomsen. Mr Halligan dissuaded him from approaching the president. Ms Thomsen describes that Mr Benson thought the president had been too flirtatious with her the previous year.

23. Ms Thomsen said in her statement that while at the trivia night, she confronted Mr Benson with having taken an ecstasy tablet earlier in the evening. She had not seen this, but said he exhibited some similar signs from a previous occasion she knew of when he had consumed ecstasy. She says he simply shrugged his shoulders at her in response. There is no evidence that Mr Benson was a regular user of this or any other illicit drug.

24. Mr Halligan said that Ms Thomsen and Mr Benson were having a minor argument but when they left they were "all over each other in the back of the car." This is confirmed by Janet Halligan.

25. The couple returned home to their shared residence at 12A David Street, Thorneside at about 12:30 am on 1 April 2007. Ms Thomsen says they proceeded to have an argument but she could not recall what it was about. They had some more wine. It is noted that she reported to Constable Booker that the argument was about him moving in as she was still not sure and she had two children and had concerns for them and did not want them disrupted.

26. According to the statement provided by Ms Thomsen, Mr Benson stormed upstairs and said, *"I might as well just go and hang myself".*

27. She states that she responded by asking him to, *"be quiet while you do that I'm listening to music",* and then possibly fell asleep. She said that she did not for a second believe he would do that. On previous occasions when he became angry he would just sit on the deck and have a smoke.

28. In the early hours of Sunday 1 April 2007 Ms Thomsen went on to the balcony to look for him. She saw Mr Benson suspended by a rope from the balcony. Ms Thomsen does not know where the rope that he used came from.

29. Ms Thomsen states she started screaming for assistance and she ran downstairs and tried to hold him up from the waist. He was not conscious and looked purple. She realised no-one had heard her calls as she attempted to hold Mr Benson up. She then left him to return to phone 000. She continued to yell out and ran inside to get a knife to cut him down. She had difficulty cutting the rope. She recalls someone helping her cut him down. This no doubt is Mr Johnstone.

30. Police arrived at the scene sometime after 01.40am. Constable Michelle Booker was the first officer on scene together with Senior Constable Loveday. They have both provided statements detailing that on arrival at the scene they saw a male person hanging by his neck from a rope that was suspended from the left side of the balcony railing, which was over the carport at the front of the house. On attendance they saw a female (Ms Thomsen) holding Mr Benson's legs and a male (neighbour Mr Johnstone) attempting to cut the rope with a knife. On cutting the rope, Mr Benson's body fell forward landing on his head. Two knives were on the ground, one of which was under his right leg. The knives were placed by Senior Constable Loveday in the back of the utility vehicle's tray that was parked under the balcony.

31. Senior Constable Loveday then proceeded to commence CPR resuscitations. He could discern no pulse. Ms Thomsen is reported by both officers to be hysterical and screaming. When she was asked how long he had been like this she replied, *"I don't know about 10 minutes."*

32. Queensland Ambulance Service (QAS) records indicate that they were called at 01.37hr and arrived at the scene at 01.48 hr. Police made a further ambulance request. On arrival, it was observed by QAS officers that he was in cardiac arrest with CPR in progress. His heart was asystole with no palpable pulse. A heartbeat returned with resuscitation. The believed down time was said to be at least 10 minutes. (This information was supplied by Ms Thomsen. It may have been longer depending on how long he had been hanging from the balcony before Ms Thomsen found him. )

33. Whilst at the scene Constable Booker reports that Ms Thomsen told her she had been supporting him and trying to hold him up. She ran in to ring 000 and ran back out. She then ran back in screaming for help. She got a serrated knife which did not cut the rope so ran back in to get another. This would account for the 2 knives that were found. A neighbour then arrived as she was trying to cut him down. She also described her relationship with Mr Benson and said *"it's all my fault, he said that he was going to kill himself and I didn't believe him."*

34. Constable Booker smelt alcohol on her breath and noted there were empty glasses and bottles of alcohol in the kitchen. When she attended upstairs Constable Booker noted that the appliance door cupboard had appeared to have been kicked or punched in and severely damaged. Ms Thomsen states that she had not heard anything that night.

35. Mr Benson was taken to the emergency department of Princess Alexandra Hospital and then to the intensive care unit (ICU) at Royal Brisbane Hospital. The police officers took Ms Thomsen with them to hospital and called his father. Ms Thomsen remained distraught and they arranged for a friend to be with her.

36. In hospital, both on a CT scan and clinically, he was shown to have severe cerebral oedema with features consistent with hypoxic brain injury. He remained in an unresponsive and unconscious state in the ICU. With the knowledge of, and in the presence of his family, he died shortly after his respirator was turned off on 4 April 2007.

37. Other Police attended the Thorneside residence after Mr Benson was taken to hospital. Senior Sergeant Gillard arranged for and assisted a Scenes of Crime officer to attend and take photographs. Scenes of Crime officer Sergeant Hunter took photographs of the scene and these were tendered as exhibits.[14] Constable Benton and Sergeant Van Den Bosch attended and removed part of the white fibre rope which was attached to the railing.

38. Dr Park from the Thorneside Family Practice provided a copy of his medical records concerning his treatment of Mr Benson. It was noted that he has been treated for excessive daytime drowsiness and fatigue. On 26 February 2007 he was prescribed Efexor XR 75mg to be taken daily. Efexor, the name given for Venlafaxine, is commonly prescribed as an anti-depressant or anti-anxiety drug. There is no evidence which would suggest he was being treated for depression or any other similar condition and it may be the prescription was for his fatigue related problem.

39. I also received a report from Mr Keith Harris, a project co-ordinator with the Australian Institute for Suicide Research and Prevention (AISRAP) who reported generally on the signs of suicide, including factors that indicate the likelihood of suicide. He considered there were a number of protective factors relevant to Mr Benson including that he was employed, had a caring and loving family and was reporting future plans. A number of risk factors were also evident including the consumption of a large amount of alcohol and taking of ecstasy in the hours prior to his death, the fact he had been twice divorced and that there were signs of his current relationship experiencing difficulties, the prescription of Venlafaxine and the possibility it was prescribed as an anti-depressant, signs of anger and agitation and his threat to commit suicide. He considered that these signs indicated a very high risk of suicide. It is also clear that many suicides are impulsive and unplanned. Alcohol use reduces inhibitions and is often associated with impulsive suicides.

40. An external autopsy was conducted by Dr Ansford (the pathologist) on 5 April 2007 at the John Tonge Centre (Qld Health Scientific Services). Toxicology samples were also tested.

41. In the autopsy report the Pathologist noted the following sign of recent injury:

*"there was a dry narrow linear abrasion with a brown base passing around the front and right side of the neck from a point below the middle of the right horizontal mandibular ramus (above the top of the larynx), 60 mm from the point of the chin and 100 mm above the suprasternal notch, to arch into the hairline 60 mm below the tip of the lobe of the right ear. It is 5 mm in maximum width. "*

42. There are no other injuries associated directly with the mark, but there are some scratches on the chin and abrasions on the forehead.

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[14] Exhibit B3

43. The Pathologist states that a faint residual abraded mark consistent with being made by a noose during suspension was present on his neck.

44. Antemortem blood samples (collected at 1750 hrs on 1 April 2007) show therapeutic levels of the anticonvulsant phenytoin and a trace of paracetamol. No alcohol or other drugs were detected in the first analysis of standard screening. A further test was carried out which found a low level of MDMA or ecstasy at approximately 0.01 mg/kg. Lesley Sharp, a forensic toxicologist, considered that it would be expected that there would be a negative result on alcohol given the time at which the ante-mortem samples were taken and the half life of alcohol.

45. The pathologist opines that Mr Benson's death was due to cerebral hypoxia due to compression of the neck by suspension and was consistent with the circumstances as outlined.

46. For completeness, an internal autopsy (limited to the determining the presence of sarcoidosis[15]) was performed by another pathologist on 12 April 2007. This was performed at the request of Mr Benson's family. On naked eye examination there was some variably enlarged lymph nodes in the mediastinum (soft tissues in the centre of the chest between the lungs and above the heart) possibly consistent with sarcoidosis. However microscopic examination showed changes in the lymph nodes consistent with burnt out (treated) sarcoidosis. Neck structures including that of the larynx were not removed.

**Conclusions:**

47. The sudden death of Mr Benson was without doubt a great shock to his family and friends and to his partner Ms Thomsen. He was well loved by his family. He may have had some stressors in his life but there was no indication that these were such that he was exhibiting any indications of suicide. It is known that impulsivity in suicide or suicide attempts is a recognised feature of many of these sad events. It is known that on this night he had been drinking reasonably heavily. His inhibitions may have been reduced. He may have taken an ecstasy tablet and there is some evidence that he had ingested this drug in some period leading up to his death. There is some evidence of an argument with Ms Thomsen and then a threat that he might as well hang himself.

48. From the point of view of his family and others who knew him well it is difficult to understand why he would consider taking his life by hanging himself. Unfortunately the most likely scenario is that he acted on an irrational impulse when he hung himself from the balcony early that morning. It is possible and as likely as any other explanation that his intention to hang himself was induced by an impulsive act of attention seeking which went badly wrong as distinct from a deliberate act with an intention of taking his own life. The evidence is clear however that he was the person that placed the rope around his neck and climbed over the balcony rail. There is no evidence suggestive

[15] Sarcoidosis is a chronic disease of unknown cause that is characterized by the formation of nodules resembling true tubercles especially in the lymph nodes, lungs, bones, and skin.

of any third party involvement in his death, nor is there any evidence that a reasonable person could have foreseen what was about to occur.

**Findings required by s 45:**

49. I am required to find, as far as is possible, who the deceased was, when and where he died, what caused the death and how he came by his death. I have already dealt with the last of these issues, being the circumstances of Mr Benson's death. As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses I am able to make the following findings in relation to the other aspects of the death.

    (a) The identity of the deceased was Leim Matthew Benson.

    (b) The place of death was Royal Brisbane Hospital, Brisbane, Queensland.

    (c) The date of death was 4 April 2007.

    (d) The formal cause of death was:

        1(a) cerebral hypoxia due to or as a consequence of;
        1(b) compression of the neck (suspension);

**Concerns, Comments and Recommendations:**

50. Section 46 of the Act provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future. The state of the evidence is such that no such comments or recommendations can be made. More research needs to be done to identify strategies which will bring about better prevention of such sad cases. The funding of such research is a function of many agencies including government, medical research facilities and the community generally. It is not necessary for a specific recommendation to be made about the necessity for such research as it is already well known in the public domain.

I close this inquest.

**John Lock**
**Brisbane Coroner**
**25 August 2008**