IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2017 1659

FINDING INTO DEATH WITHOUT INQUEST

Form 37 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Simon McGregor, Coroner
Deceased:	**Mark Beames**
Date of birth:	12 October 1969
Date of death:	Unascertained
Cause of death:	Unascertained
Place of death:	Unascertained

I, Simon McGregor, Coroner, having investigated the death of Mark Beames

find that the identity of the deceased was Mark Beames

born on 12th October 1969

and the death occurred on an unascertained date, on or shortly after Thursday 4th September, 2014

at an unascertained place

from an unasertained cause.

HIS HONOUR:

INTRODUCTION

1. This investigation sets out what is known of the circumstances which lead to the disappearance of Mark Beames (Mark). He was a 44 year old Aboriginal man who was last seen alive in Wemba Wemba Country (Swan Hill) on the morning of Thursday 4th September, 2014.

2. In the ensuing five years, investigations by both New South Wales and Victorian police have failed to locate any trace of him. Mark's body has never been located and no one has been charged with any offences relating to his disappearance.

THE CORONIAL INVESTIGATION

3. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[1] 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.

4. 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

[1] Section 89(4) of the Coroners Act 2008.

comments or recommendations in appropriate cases about any matter connected to the death under investigation.

5. In the coronial jurisdiction facts must be established on the balance of probabilities. This is subject to the principles enunciated in *Briginshaw v Briginshaw*.[2] 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.

6. A coronial brief was prepared in this matter by Detective Senior Constable Kyllee Edis. It contained 12 statements, 3 exhibits and 15 appendices, including aerial photographs and medical records. I also had the benefit utilizing the NSW brief, which comprised an additional 6 statements, 2 recorded interviews and numerous other documents. All in all, I was assisted by approximately 3 lever arch folders of documents and one DVD.

7. I have made a thorough forensic examination of the evidence contained therein, including reading and considering the statements and other documents 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.

8. In considering the issues associated with this finding, I have been mindful of Mark's basic human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9, 10 and 19.

9. The right to life, as articulated in section 9 of the *Charter,* probably encompasses a positive duty to protect life through a comprehensive, thorough and independent death investigation process,[3] although the point has not yet been conclusively decided in Victoria. Regardless of the state of the law, I am satisfied that this has been done in this case.

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[2] (1938) 60 CLR 336.

[3] *Finding into Death with Inquest re Tanya Louise Day* (Unreported, 9 April 2020, Deputy State Coroner English) COR 2017 6424 at [153]; Hunyor, J, *Human Rights in Coronial Inquests*, (2008) 12 (SE 2) AILR p 66; Pound & Evans, *Annotated Victorian Charter of Rights*, (2nd Ed) (2019) Thompson Reuters, Sydney, at [9.120]; *McCann v United Kingdom* (1996) 21 EHRR 97; [1995] ECHR 31 at [157]-[164]; *Bare v Independent Broad Based Anti-corruption Commission* (2015) 48 VR 129.

BACKGROUND

10. Mark was born the 12th of October 1969. He was the oldest of two children by the same parents, both of whom predeceased him. Mark and his brother had three stepsiblings on their mother's side although the two parts of the family were not close.

11. Mark's mother drank heavily during her pregnancy with him, and continued to do so through the rest of her life. His father was a tough disciplinarian who did not understand Mark's struggles. As a child he had required speech therapy and, as at the time of his disappearance, he still could not read or write. Mark was very close to his brother, who fondly recalls him as being a gifted BMX rider before he was best by troubles in his teenage years.[4]

12. By the time he was 13 Mark was regularly smoking cigarettes, drinking alcohol and dabbling with marijuana. His brother recalled that they took their father's beer "all the time", and that Mark would then get so drunk at parties that he didn't seem to know what he was doing. This developed into a pattern of seizures and he was diagnosed with epilepsy. His brother said that he would sleep after an epileptic fit but then immediately begin consuming alcohol again as soon as he got the chance.[5]

13. Throughout his life Mark was only sporadically employed and mainly continued to live with his mother in Echuca, where he fathered two sons and a daughter.

14. For most of his adult life Mark was a client of an alcohol and drug residential rehabilitation program known as the Galiamble Men's Recovery Centre in St Kilda, where he was treated for an Acquired Brain Injury in addition to his epilepsy. His complex behaviours led him to threaten to hang himself when he became stressed. Sometimes this threat would be made multiple times each day but after storming out of the centre, Mark would return several hours later. His last residence at the centre was between 29 January and 4 February 2013. He discharged himself on that day but by 5 February he had been admitted to St Vincent's Hospital for a broken hip and discharged himself on the same day.[6]

15. It had been Mark's habit to move between various towns, living with family and friends, or at times on the street. By the start of 2014, Mark was living in Swan Hill, near his brother. On the 19th of January, he was stabbed in the presence of two other males after they had been

[4] Statement of Craig Beames dated 2 October 2014.
[5] Ibid.
[6] Statement of Mark Hammersley dated 10 March 2018.

drinking heavily throughout the day. An ambulance was called, but none of the men could recall any detail of what happened and Mark made no actual complaint to the police.

16. By mid 2014, he was sleeping in a back room at his maternal uncle's house[7] and was a client of the Swan Hill Mental Health Group, where he continued to present with epileptic fits and voicing suicidal ideation about hanging himself whilst intoxicated. He was non-compliant with taking his epilepsy medication, and was on two occasions admitted as a voluntary mental health patient to the Swan Hill District Health Service. [8]

17. On 2 September 2014 he attended the Swan Hill Mental Health Group office for a scheduled appointment. He was observed to be thinner than usual and to have an unsteady gait. He admitted that he had not filled his prescription medication, nor had he eaten for the past two days because he had no money.[9] During this appointment, his nurse Chloe Ryan referred him to the Swan Hill District Health Hospital Admission Risk Program (HARP) to assist him with self-management of his epilepsy, alcohol, housing and housing issues.[10] An appointment was also made for him to see his treating GP for alcohol withdrawal symptoms and general physical health problems, who subsequently then admitted Mark to Hospital.[11]

18. The emergency department records confirm that Mark discharged himself the following day and left in the company of his uncle and cousin, before his scheduled follow up appointments. Two of the nurses unsuccessfully looked for Mark at two ifferent locations in Swan Hill, in an attempt to give him his medications, and then advised his GP that they had not been able to locate him.

19. Later that day, one of those nurses, Nurse Ryan located him at his uncle's house, wearing the same clothes he had been wearing a hospital. [12] Despite smelling of alcohol and being unsteady on his feet, Mark said he had not been drinking. Mark told Nurse Ryan that he had suffered an epileptic fit the night before and again that morning. He said he had been vomiting and having blood noses. He denied having thoughts of harming himself or others. Nurse Ryan drove him to see his GP, who prescribed diazepam to assist with alcohol withdrawal and antiepileptic medication. A follow-up appointment was made for him, and Nurse Ryan returned Mark to his uncle's house at 2/18 Harrison Crescent, Swan Hill.

20. I commend Nurse Ryan for her efforts to assist Mark.

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[7] Statement of Neville Atkinson dated 2 October 2014.
[8] Statement of Chloe Ryan dated 12 March 2019.
[9] Ibid.
[10] Ibid.

Disappearance

21. Mark's paternal cousin Quinton Atkinson was walking to the Swan Hill Club to play the poker machines at around 1.00pm to 1.30pm on the 4th of September 2014. He recalls seeing Mark out the front of the club in the company of a known family friend. Quinton said hello to Mark, who in turn volunteered that he was "alright" despite the hospital band on his wrist, and was heading to the nearby Wamba Wamba Aboriginal Housing Community. Quinton then saw Mark walk off in the correct direction.[13] This was the last time a reliable witness saw Mark alive.

Investigation

22. Mark had been known to wander for periods of time, so it was not until 1 October 2014 Mark's uncle reported him missing to the Swan Hill police station. He explained that he had not seen Mark for approximately three weeks and had been making enquiries with family and friends as to his whereabouts, but that no one had heard from him.[14]

23. A police investigation commenced following this report, but no credible leads or forensic evidence was located, despite interviewing numerous witnesses and an State Emergency Service ground search of approximately 2.28 km of bush near the No. 9 Main Channel waterway in Swan Hill, as well as more extensive aerial and underwater sonar searches.[15]

24. On 4 February 2015, Detective Sgt Miles Rogers from Deniliquin New South Wales reported Mark's suspected death to the New South Wales State Coroner.

25. As the investigation progressed, the New South Wales State Coroner formed the view that there was a stronger jurisdictional nexus[16] with Victoria than New South Wales, and on 22 March 2017 the case was transferred to our court as a "suspected death," which fell within the definition of a reportable death in the *Coroners Act 2008* ('Act').[17].

26. At the time of his disappearance, Mark was receiving fortnightly disability pension payments from the Department of Human Services into a Bendigo bank account using his Centrelink card as identification. This was his only bank account. The bank records show that Mark

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[11] Statement of Michael Moynihan dated 8 October 2014.
[12] Statement of Chloe Ryan dated 12 March 2019.
[13] Statement of Quinton Atkinson dated 28 February 2019.
[14] Statement of Neville Atkinson dated 2 October 2014.
[15] Statement of Kyllee Edis dated 26 April 2019.
[16] See section 18 of the Coroners Act 2009 (NSW).
[17] See sections 3 and 4 of the Act.

attended the branch on the 3 September 2014 and withdrew $337.00 from the account before leaving a closing balance of $1.30. His expenditure pattern shows that he lived hand to mouth with these deposits. The next deposit into that account was duly made by the department, but it was never withdrawn. That account has remained untouched since that day.

27. The investigation was conducted by both the New South Wales and Victorian police.

28. Comprehensive proof of life checks have been conducted during 2018 and 2019, and there is no known record that would indicate that Mark was alive after the 4th of September 2014.

29. I am satisfied to the requisite standard of proof[18] that Mark is now deceased, and died on or shortly after the 4th of September 2014. Unfortunately, I cannot ascertain his cause nor place of death, but there are no remaining leads to be investigated, so it is time to make these Findings.[19]

30. My determination that Mark is deceased is based on the following material:

    (a) There has been no known contact by Mark with family members, despite his close ties to them.
    (b) There has been no recorded transactions on the account held by Mark, and he had no other source of funds. It is unlikely he could survive without access to these funds.
    (c) There has been no recorded contact between Mark and Centrelink, or Medicare, since his disappearance.
    (d) Australia wide proof of life checks have been conducted, all of which support the hypothesis that Mark is deceased.

FINDINGS AND CONCLUSION

31. I express my sincere condolences to Mr Beames' family and friends for their loss.

32. Having investigated the death by holding an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) The identity of the deceased was Mark Beames, born 12th October 1969;

    (b) The death occurred on an unascertained date by an unascertained cause; and

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

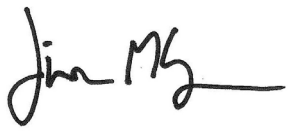
[18] See n2.
[19] Should fresh evidence emerge, my investigators, or any interested party, may make application to reopen the investigation under section 77 of the Act.

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

(a) Mr Jeremy Olfield, senior next of kin;

(b) Detective Senior Constable Kyllee Edis, Coroner's Investigator.

Signature:



Simon McGregor
Coroner

Date: 7 May 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.