Santa Rosa Sheriff's Office
Sheriff Bob Johnson

RESPONSE TO REQUEST FOR INSPECTION AND/OR COPIES OF PUBLIC RECORDS

In accordance with section 119.07(1)(e), F.S., the Santa Rosa County Sheriff's Office Custodian of Records contends that a record or part of a record you have requested is confidential and exempt or exempt from inspection and/or copy and states the statutory basis for said exemption as follows.

	SUBJECT	CITATION	
	Active Criminal Intelligence & Investigative Information	119.071(2)(c)	E
	Bank Account Numbers: Debit, Charge & Credit Card Numbers	119.071(5)(b)	E
	Body Camera Recordings (Certain Locations)	119.071(2)(l)••	C
	Child Protection Team Records	39.202(6)	C
	Confessions Prior to Disposition	119.071(2)(e)	E
	Criminal History Information	943.053	E
	DHSMV Records	119.0712(2)	C
	Emergency 911 Requests for Help – Identity of Caller	365.171(12)	C
	Juvenile Offender Records (Misdemeanor Charges)	985.04	C
	Marsy's Law – PII (Name is Not Exempt)	Fla. Const. Art. I, 15(b)(5)	E
	Occupational Exemption - PII	119.071(4)	E
	Security System Information or Plan (To Include Surveillance Video)	282.318(4)	C
✓	Social Security Numbers	119.071(5)(a)	C
	Uniform Traffic Citation – Driver Information	316.650(11)(b)1	E
	Victims of Child Abuse & Sexual Offenses	119.071(2)(h)	C
	Other:		

C = CONFIDENTIAL & EXEMPT E = EXEMPT

Rev. 03/25/2024

TO: PUBLIC FROM: SRSO Records Unit (AR) DATE: 06/17/2024
STATUTORY CITATION FOR REDACTION(S) ON COVER SHEET

Warrant Service (This Agency)

SANTA ROSA COUNTY SHERIFFS OFFICE
5755 EAST MILTON RD

Report Date / Time	Report Number	Case Number/Cad Number	Reporting Officer Name
6/17/2024 08:04 AM	SRSOCHG0006311M	/ SRSO24CAD059598	KIM, JOSHUA JIN

Originating Agency ORI	Occur Date Time Range	Jurisdiction
FL0570000	11/21/2023 16:00:40 - 06/17/2024 08:03:00	IN JURISDICTION

OBTS Number	Other Number	Clearance

Location of Occurrence

County	Location Type	Location Description
SANTA ROSA	BUSINESS	SANTA ROSA COUNTY SHERIFF'S OFFICE

Street Number	Street	Apt/Lot/Bldg	City	State	Zip Code
5755	EAST MILTON RD		MILTON	FL	32583

Suspect

First Name	Middle Name	Last Name	Suffix	Race	Sex	Height	Weight	Hair	Eyes
BENJAMIN	JACOB	BROWN		WHITE	MALE	601	185	BRO	UNK

MNI #	SSN	Date of Birth	Age	ID Type	Drivers License or other ID	State	OCA / Agency ID
SRSO22MNI000999		06/07/1983	40	E	B650070832070	FL	

Place of Birth:	

Address

* RESIDENCE / 3995 W MADURA RD , GULF BREEZE, FL 32563 / 8506882889

Charge :

Counts	Charge	Bond Amount	
1	782.07.1	$0.00	☑ No Bond

Charge Degree	Charge Level
S	FELONY

General Offense Code	Arrest Offense Code
COMPLETED	HOMICIDE-NEGLIG MANSL

Charge Description

KILLING HUMAN OTHER THAN BY MURDER OR HOMICIDE

Administrative Code - Description

-

Bond Set by Charges

Bond Amount	
	☑ No Bond

Bond Type(s)

Probable Cause

On 11/21/2023, Benjamin Jacob Brown DOB 06/07/1983, at 1645 Nantahala Beach Rd, Santa Rosa County, and State of Florida did violate Florida State Statute 782.07 (1), Manslaughter; by

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Culpable Negligence, by the killing of a human being (Hillary Ellington Brown) without lawful justification under chapter 776 of F.S.S. This to wit:

On 11/21/2023 patrol deputies with the Santa Rosa County Sheriff's Office responded to Restore Plastic Surgery located at 1645 Nantahala Beach Rd in reference to a medical emergency. Upon their arrival fire fighters from Midway Fire Department were actively working a cardiac arrest patient identified as the victim, Hillary Ellington Brown. Soon after Lifeguard Paramedics arrived and transported the victim to an emergency room in Navarre, FL.

Once at the emergency room she was stabilized and later transported to the Intensive Care Unit at Sacred Heart Medical Center where she remained on life support, never regaining consciousness, until her death on 11/28/2023.

After her passing on 11/30/2023, the District 1 Medical Examiner, Dr. Deanna Oleske M.D., obtained custody of the victim for an autopsy. This was also the same time this case was assigned to your affiant for follow up. Your affiant was then advised about possible suspicious circumstances surrounding the victim's death.

After reviewing the initial report taken by deputies your affiant noted several statements made by the staff of Restore Plastic Surgery. 1.) The victim is Benjamin Brown's wife. 2.) The victim was having multiple surgical procedures performed at one time. 3.) The victim, after undergoing other procedures, was receiving injections of lidocaine to parts of her face when she began to "convulse" and began to have a seizure. Your affiant learned that several employees of Restore Plastic Surgery were on duty at the time of this incident.

Your affiant spoke to one of the employees via a recorded phone interview. This employee prior to this interview had contacted your affiant and expressed concern over the events that occurred on 11/21/2023. This employee began by stating she had only worked for the business for a few days before this occurred. In that short time, she expressed there was a lot of negligence in the office that led to Hillary's cardiac arrest. She stated prior to the surgery the victim took "a plethora of pills" however she was unaware of what they were. She stated the victim had prepared her own IV bags which were supposed to contain diluted xylocaine which was being used as a local anesthetic. During the surgery the IV bags ran out at which time Brown poured "two containers into a bowl", "He didn't dilute them or anything" and began to inject her arms, and later her face. When he did this Hillary began to say that her vision was blurry. She said her face was really "puffy" but Brown continued. She stated she thought that was a sign she was overdosing, and this was when she began "convulsing".

It was at this point the victim was suffering a medical emergency. This employee stated Brown was asked if they should call 911 several times, but "he wanted to try and do it himself". She said he was asked 4 or 5 times by several staff members, but he continued to tell them to wait. She stated there was no oxygen in the room, and no EKG to monitor her heart. She said there was nothing they could

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have done and 911 should have been called. She stated this lasted for 10 to 15 minutes before 911 was eventually called by another employee, and not at the direction of Brown.

Your affiant asked about medications in the office, she stated "everyone had access", she stated she thought it was just in Brown's office in a drawer not locked up. This included pain medication, "opioid type", Valium and weight loss medication. I asked controlled substances? and she said yes. She further expressed concern stating there were no cameras at the building and stated the building was still under construction.

Your affiant then spoke to another employee, which was also recorded. This employee noted many of the same details as the first employee however clarified the pills that were taken were pre-op medications which were Versed, Tramadol, Gabapentin, maybe Valium, and antibiotics. She believed these medications were taken at about 1pm and the procedure began around 2pm. This employee stated that after the first set of procedures (Lower abdomen) the victim took a break and was up and walking around. Then at around 3:30pm they began the next procedures. Brown was injecting local anesthetic into her lips, and her eyes. Your affiant asked what she was being injected with, she stated typically it was lidocaine, epi, sodium bicarb mixed with LRS. The purpose of this was to numb the area but it is not straight lidocaine and "not as potent". This mixture was used for the first procedure. However, for the second round of procedures Brown used Xylocaine mixed with epi in her lips, around her ear and eyes which she stated went fine. She continued stating he started with her left eye and said Hillary complained she started seeing orange, also not being able to see, but when he opened her eyes, she was able to see and added that when the injections happen "it kind of swells up". Your affiant asked if it was common for people to express vision concerns (other patients). She stated Brown always tells patients to tell him if they see stars, or have vision complaints to let him know since he is close to the eye, but she had never heard anyone complain before. Brown then began to inject the victim's right eye, and this is when she started to seize. This employee was asked about life saving measures, she stated she performed CPR. I asked about life saving medical supplies possibly a "crash cart" but she did not remember anything like that. This employee expressed the same lack of equipment in the office and delay in calling 911.

Your affiant then spoke to a third employee, which was also recorded. She stated the victim had lied down on the bed however she got back up and went into Brown's office because she had not been "marked up". She said it only takes 5 minutes, but it was about 30 minutes. When the victim came back into the room, the victim then took another dose of Versed. She stated the same about the bags of local anesthetic, including the victim preparing the bags herself and that at one point they had run out. After running out, Brown asked her to get more Lidocaine. She stated they were out of Lidocaine and had been, She stated she had told him that. Brown and the victim both instructed her to get "Xylocaine". She described it as a small bottle that already contains "epi". Brown then instructed her to "get pliers and pull the whole top off the vial" instead of pulling it from the bottle with a needle and she was instructed to pour two whole vials into a sterile bowl. Brown then injected her with that. She stated it didn't have any "Temesint" in it, so "it wasn't diluted any". She did know that. She stated the injections

were done near Hillary's eyes and she was reporting blurry vision and soon after is when she began to have seizures.

She continued and stated there was not a crash cart in the room and "there should have been". She further explained you should always have one if you're cutting open bodies. I asked if the office had a AED, and she stated "I don't think we did, if we did it was back in the shed somewhere". She further alluded to as far as life saving devices, and stated they did not have anything. She again expressed the need to call 911 sooner and was instructed to wait to call. She stated she made the decision to call 911 not Brown. We talked about the security of the medication in the office. She stated the medication in the office was just in a cabinet in the office and as far as inventory it was off the top of the victim and Brown's head. This included all the medication the office used to include controlled substances.

Your affiant then conducted interviews with both medical doctors who cared for the victim while at the emergency room, and in the Intensive Care Unit. Both doctors confirmed they were seeing the victim and attempting to treat her for lidocaine toxicity. They advised that early into their care they suspected the victim would not survive. Once further medical evaluations were completed, they confirmed that outcome and kept the victim on life support systems for the preservation of organs.

Your affiant later learned this was not the first incident where Brown had over medicated the victim for surgery and had difficulty waking her up. During an interview with a former employee your affiant was told that one day (January 2023) she was witness to a procedure where the victim was receiving a brow lift. She was instructed to give the victim "Versed", she believed it was 4 milligrams, this would have been the typical dose. She was still awake; then Brown and the victim both advised to give her (the victim) more, which she did. She stated she may have given a third dose, but she was not completely sure. After this she was out of the room and then could hear Brown yelling the victim's name in an attempt to wake her up. This "was not normal" which concerned her and she responded to the room. She and another tech shared a concerned look, but was told it was ok by Brown, so she left the room. However, after walking out of the room, it occurred again (during the same procedure). This time Brown had more urgency in his voice as he was having difficulties waking her up. This tech further added that in another surgical environment which she had worked in, she had never seen someone having difficulties in being woken up like that day.

Your affiant, after learning this spoke to the other tech who was also present during this procedure. That tech was also a former employee who expressed that she left the business after this incident due to concerns of a neglectful practice. She corroborated the same series of events, and stated there were certain amounts of drugs patients were supposed to take for procedures based upon weight. She said Brown referred to the victim as his “little alien” and intentionally gave the victim higher doses of medications.

Your affiant concluded after these interviews a common concern, over actions, or inactions by

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Brown. This information was further brought to the attention of the district 1 Medical Examiner's Office.

Your affiant was also made aware of findings by the Department of Health (DOH) for the State of Florida. Following there investigation into Brown, Joseph A. Ladapo, MD, PhD, Surgeon General for the State of Florida, ordered a emergency restriction of Brown's medical license. In that document several of these same incidents were reported and documented. This included the following: (For this report the victim is referred to as 'H.R.')

82. The minimum prevailing professional standard of care requires physicians to ensure that fluids injected into a patient are properly prepared.
83. Dr. Brown fell below the minimum prevailing professional standard of care by permitting H.R. to prepare the tumescent solution and then using tumescent solution prepared by the patient without being able to ensure that it was the correct concentration or solution.
84. Dr. Brown injected 600 ml of the tumescent solution into H.R.'s abdomen and 200 ml into each of H.R.'s arms.
85. Dr. Brown used all of the contents of the one-to-two I.V. bags, and requested staff bring him Xylocaine.10
86. Dr. Brown instructed an assistant to pour the Xylocaine into a bowl and then drew the fluid into a needle and injected undiluted Xylocaine into H.R.'s arms.
87. Dr. Brown did not document injecting undiluted Xylocaine into H.R.'s arms.
88. Dr. Brown performed the scar revision and muscle plication procedures.
89. H.R. assisted in her own procedure by suturing the skin back together.
90. During this portion of the procedure, H.R. became restless and her feet began twitching.
91. Dr. Brown then performed liposuction of H.R.'s arms and her twitching worsened.
92. Dr. Brown took a break after completing H.R.'s arm liposuction.
93. Dr. Brown documented that he injected a "more concentrated" solution of lidocaine into H.R.'s face and lips containing "20 ml of saline, 20 ml 1% lidocaine with epinephrine and 20 ml 0.5% Bupivacaine.11"
94. However, witnesses observed Dr. Brown inject undiluted Xylocaine into H.R.'s face.
95. Dr. Brown failed to accurately record the anesthetic medication and/or dosage given to H.R. during her procedure.
96. H.R. stated that her vision started to blur, and she told Dr. Brown that she saw "orange."
97. Restlessness, muscle twitches, and blurred vision are all early signs of lidocaine toxicity.12 (12- Lidocaine toxicity is the rapid onset of severe central nervous system (CNS) depression, seizures and cardiac arrhythmias following local anesthetic administration)
98. Dr. Brown continued injecting lidocaine/Xylocaine in H.R.'s face.
99. During the procedure, H.R. became unresponsive and began to have a seizure.13 (13- A seizure is a sudden, uncontrolled burst of electrical activity In the brain. It can cause changes in behavior, movements, feelings and levels of consciousness. Lidocaine-induced seizures are a warning sign for subsequent cardiac toxicity which can be lethal. Conservative management is the best option for treatment of lidocaine induced seizure.)

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100. A seizure can be a medical emergency and requires immediate transfer to a higher level of care for assessment and triage.
101. When a patient experiences a seizure during a medical procedure, the minimum prevailing professional standard of care requires a physician to immediately initiate emergency transfer to a higher level of care.
102. A medical assistant asked Dr. Brown if they should call 911 and Dr. Brown said "no." Over the next 10-20 minutes, a medical assistant asked Dr. Brown if they should call 911 and Dr. Brown said "no," or "wait." The medical assistant was scared and a new employee, so she did as Dr. Brown instructed.
103. Dr. Brown failed to immediately initiate emergency transfer to a higher level of care when H.R. experienced a seizure.
104. Dr. Brown instructed staff to retrieve a pulse oximeter, blood pressure cuff, stethoscope, oxygen tanks, and EKG leads.
105. One assistant brought back the pulse oximeter and blood pressure cuff. H.R.1s blood oxygen saturation and blood pressure were low.
113. The minimum prevailing professional standard of care requires physicians to be aware of the medications a patient ingests prior to a procedure.
114. Dr. Brown fell below the minimum prevailing professional standard of care by permitting H.R. to administer her own medications, and therefore failing know which medications H.R. ingested prior to the procedure, in addition to her pre-operative medications.
115. After approximately 10-20 minutes, H.R.'s breaths were shallow, and her pulse and blood oxygen levels were low.
119. EMS transported H.R. to the Ascension Sacred Heart Emergency Department in cardiac arrest with an elevated lactic acid level and suspected lidocaine toxicity.
125. Additionally, and most egregiously, Dr. Brown's treatment of H.R. was careless and haphazard. Dr. Brown did not know what medications H.R. ingested prior to the procedures; used a tumescent solution prepared by an untrained, unlicensed, and unsupervised person; and then injected an unknown amount of undiluted lidocaine/Xylocaine into H.R. The level of disregard Dr. Brown paid to patient safety, even when the patient was his wife, indicates that Dr. Brown is unwilling or incapable of providing the appropriate level of care to his future patients. Dr. Brown's most problematic violation during H.R.'s procedure was his failure to react swiftly in response to a serious medical emergency. Despite less experienced staff members requesting to call 911, Dr. Brown delayed the transport of H.R. by telling his staff "no" or to wait. This was compounded by his staff's apparent lack of knowledge and training. Despite H.R. experiencing a medical emergency, Dr. Brown's staff were unable to locate and utilize any life saving devices like an AED or crash cart.
126. The practice of medicine involves applying appropriate clinical judgment, skill, and technique to the real-world treatment of patients. At every level of the practice of medicine, a physician needs to exercise this good judgment, and failure to do so can result in patient harm, and even death.
127. An independent medical expert has determined that Dr. Brown's treatment of H.R. was a violation of the standard of care. The scope and variety of issues with Dr. Brown's practice in the office setting constitute a danger to future patients. Dr. Brown's poor management of his practice has

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prohibited him from being able to ensure the safety and wellbeing of patients undergoing in office procedures. Therefore, Dr. Brown's continued unrestricted practice as a medical doctor presents an immediate, serious danger to the health, welfare, and safety of the public.

On 05/15/2024 your affiant received the final report from the office of the Medical Examiner. The report was prepared by Dr. Deanna Oleske M.D., Chief Medical Examiner. Dr. Oleske ruled the cause of death to be ‘complications following lidocaine toxicity’. This injury occurred by ‘lidocaine toxicity during cosmetic surgery performed in a freestanding clinic’. Dr. Oleske further noted the following complications.

B. Received both Versed (midazolam) and Valium (diazepam) prior to and during the procedures
C. Tumescent fluid with 1000 mg lidocaine for liposuction of the arms and for abdominal scar revision / mini-muscle plication
D. Additional undiluted Xylocaine (lidocaine) injected into the arms prior to the end of the liposuction procedure (unknown amount or concentration)
E. Started to have signs of lidocaine toxicity (muscle twitching and restlessness)
F. Received undiluted subcutaneous Xylocaine (lidocaine) into the face (unknown amount or concentration)
G. During administration of local anesthetic to the face (eyes and lips), self reported vision changes (blurry vision and seeing orange) prior to having a tonic-clonic seizure lasting for several minutes
H. Following the seizure, was unresponsive, not breathing and in cardiopulmonary arrest
I. Cardiopulmonary resuscitation efforts were initiated, and transported to a free standing emergency room by emergency medical services
J. Diagnosed with lidocaine toxicity

Dr. Oleske did also note that toxicological testing of the victim’s blood is ‘non-contributory to the cause of death’, meaning the victim did not overdose by means of self-administered substances.

All these witness interviews were submitted as evidence, subpoenaed copies of the DOH report, and a copy of the medical examiner’s report was also obtained as evidence.

In conclusion, witness interviews all corroborated that when the victim began to show signs of overdose Brown continued injecting unknown amounts of Lidocaine and did not stop until the victim went into a seizure and cardiac arrest. When this occurred, Brown delayed the reporting of the incident to 911 and used his status as a doctor to do so, when it is required by law. Brown showed a history of allowing unsafe practice to occur and took no precautions for the well being of human life, even after an incident where he could not wake the victim during a procedure in January of 2023.

Based upon these circumstances, your affiant has probable cause to believe Benjamin Jacob Brown, having culpable negligence did violate F.S.S. 782.07 (1); Manslaughter, by Culpable Negligence. And did through said culpable negligence caused the killing of a human being (Hillary Ellington Brown).

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Jail Booking Facility

Booking Date/Time	Booking County	Booking Facility	Booking Facility Phone
	SANTA ROSA	SANTA ROSA COUNTY JAIL	850-983-1100

Booking Facility Location	Booking Number
5755 EAST MILTON ROAD MILTON, FLORIDA 32583	

Booking Comments

Court

Court County	Court Location
SANTA ROSA	4025 AVALON BLVD MILTON, FL 32583

Court	Court Phone	Court Appereance Date / Time	Court Fine
SANTA ROSA CIRCUIT COURT	(850)981-5570		

Comments

Warrant Service

Service Date/Time	Case Number	Warrant Number
6/17/2024 8:03:07 AM	6/17/2024 8:03:07 AM	SRSO24WAR001826

Location Type	Location Description
JAIL FACILITY	SRSO JAIL

Street Number	Street	Apt/Lot/Bldg	County	City	State	Zip Code
5755	EAST MILTON RD		SANTA ROSA	MILTON	FL	32583

Officer Name Rank / ID #	Involvement On Report / Reporting Role	Officer Agency Org/Unit
KELLY, MITCHELL SCOT LE SERGEAN 1288		SANTA ROSA COUNTY SHERIFFS OFFICE SHF/CHF/MAJ/OPS/PATROL/D1
KIM, JOSHUA JIN LE DEPUTY 1435	REPORTING OFFICER	SANTA ROSA COUNTY SHERIFFS OFFICE SHF/CHF/MAJ/OPS/PATROL/D4

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The undersigned certifies and swears that he/she has just and reasonable grounds to believe that the above named Defendant, committed violation(s), of law, on the below date(s) and time(s), as listed in the probable cause associated with this report:

Reporting Officer

Officer Name	Office Rank	Officer ID No
KIM, JOSHUA JIN	**LE DEPUTY**	**1435**

Officer Agency

SANTA ROSA COUNTY SHERIFFS OFFICE

Officer Signature Joshua Kim

Sworn and subscribed before me, the undersigned authority

This the ______ day of ________________, __________

DEPUTY OF THE COURT, NOTARY OR LAW ENFORCEMENT

◯ No Bill / Petition ◯ Issue Warrant ◯ Prosecution Approved

Signature of Assistant State Attorney Date