IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 3931

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**JUDGE SARA HINCHEY, STATE CORONER**
Deceased:	**CARMELO GUSMAN**
Date of birth:	3 March 1965
Date of death:	On or about 4 August 2015
Cause of death:	Single, contact-range shotgun discharge to the head
Place of death:	1388 Taylors Road, Plumpton, Victoria

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HER HONOUR:

BACKGROUND

1. Carmelo Gusman (**Mr Gusman**) was a 50-year-old man who lived at 39 Proctor Crescent, Keilor Downs at the time of his death.

2. Mr Gusman was of Maltese decent and met his wife of 27 years at school when he was aged 14. His marriage to Donna Gusman (**Ms Gusman**)[1] formed the only relationship of his life and the couple had two sons, Daniel and Ashley. Both children were adults at the time of Mr and Ms Gusman's deaths.

3. As a result of learning difficulties, Mr Gusman left school aged 14 and began an apprenticeship as a farrier. Despite leaving school illiterate, the career he built working with horses reportedly led him into the employ of some of the foremost horse trainers in the industry over the years. Mr Gusman reported to his treating psychologist, Marg Safron[2] (**Ms Safron**) that the skills he developed in the industry were regularly called upon to assist with problem horses for some time after changes in the stables meant that he was no longer employed on an ongoing basis.

4. After training and working as a farrier for several years, Mr Gusman began working at Toyota but was made redundant. Following this, he was employed as a car detailer at Pickles Auctions in Sunshine. Part of his work duties required him to lift wheelie bins above shoulder height. It was performing these duties that caused him to injure his back in approximately May 2014.

5. The available evidence suggests that Mr Gusman's back injury and subsequent physical restrictions caused him great distress. He became financially dependent upon WorkCover payments and his mental health deteriorated as he was unable to come to terms with the loss of his physical capacity. Ms Safron described the background of Mr Gusman's mental health deterioration this way:

   "*Mr Gusman found being physically disabled by the pain of his injury extremely distressing. This was not only due to the pain itself but because he relied on his physical prowess to retain his self-belief and self-value. This compensated for his negative feelings associated with his perception of his cognitive inadequacy. He described riding his bicycle the seven*

[1] See also *Finding into death with Inquest of Donna Maree Gusman* COR 2015 3932
[2] Psychological Report from Marg Safron to the Coroner, 6 January 2016, 2

kilometres to and from work and enjoying motorbikes and weekends hunting deer with friends. He stated that 'It is hard not to be the man of the house.' And 'I can't face that I can't do the things I used to do.' He knew his mental health was deteriorating '…but he was too stubborn and embarrassed to get help."[3]

6. From 2008, several years prior to their deaths, Mr and Ms Gusman's relationship was experiencing decline. They both began to pursue their individual interests more and shortly thereafter began to sleep in separate bedrooms.[4]

7. Mr and Ms Gusman spent more time apart and grew even more distant after Mr Gusman's workplace injury.[5]

8. Three-to-four months prior to her death, Ms Gusman moved out of the family home and began residing at an address in St Albans with two friends, Ms Beever and Ms Pywell.[6] Ms Gusman often confided in Ms Beever and told her she needed space from her husband. She told Ms Beever she was not in love with Mr Gusman anymore but was concerned that he would not cope with this news in light of his injuries.[7]

9. At around this time, Mr Gusman began to exhibit signs of paranoia, believing his neighbours were taking photos of him on behalf of WorkCover and keeping him under surveillance.

10. Mr Gusman had been told by various family members that they suspected Ms Gusman was having an affair with Mr Nicolaou. When their sons raised the issue with him, Mr Gusman replied that he would not accept it as truth until he heard it from Ms Gusman.[8]

11. At some stage after Ms Gusman moved into the house in St Albans, Daniel and Ashley attended the house demanding to see where Mr Nicolaou slept. Ms Gusman had told them Ms Beever was in a relationship with Mr Nicolaou and spoke to them outside, refusing to let them into the house.[9]

12. Just over a month before her death, Ms Gusman had heard from a friend that Mr Gusman had told her brother that he would kill Ms Gusman if she was with someone else. The evidence suggests that, upon hearing about the threat, Ms Gusman confronted Mr Gusman.

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[3] *ibid*
[4] Statement of Daniel Gusman, *Coronial Brief*, 37
[5] *ibid*, 38
[6] Statement of Deanne Beever, *Coronial Brief,* 47
[7] *ibid*, 47
[8] Above n 4, 38
[9] Above n 8, 42

He is reported to have said that it would jeopardise his gun licence and that he loved her too much to hurt her.[10]

13. In the weeks leading up to their deaths, Mr Gusman and Ms Gusman remained in contact and Ms Gusman continued to assist Mr Gusman in getting to doctor's appointments from time-to-time. The statements of those in contact with Mr Gusman at the time suggest that he continued to experience depressive symptoms and pain from his back injury.

14. In the days after Mr Gusman's threat referred to in paragraph 13 above, they met again when she agreed to go with him to a WorkCover appointment. On her arrival, they argued because Mr Gusman was concerned that they would be late. As Mr Gusman drove, she became scared because he was driving fast. She asked Mr Gusman to drive her back to her car and he then turned and raised his fist at her and stated, "*[i]f you don't shut your mouth, I'll shut it for you*."[11]

15. Ms Gusman told Ms Beever that, before she left Mr Gusman at his house that day, Mr Gusman asked her to take him to her own father's grave in Fawkner. Ms Gusman was alarmed by the request. She had always said she wanted to be buried with her father and she thought Mr Gusman was going to kill her.[12] Following the events of that day, Ms Gusman told Ms Beever that she had grown afraid of Mr Gusman and noticed a change in him.[13]

16. Ms Gusman told Ms Beever that Mr Gusman had been experiencing difficulty with his medications, which were making him down and depressed. Ms Gusman had reportedly been in contact with Mr Gusman's family to ask them to stay in touch with him. Ms Gusman subsequently told Ms Beever that Mr Gusman had been taken off the medication which had been causing him to feel depressed and that he seemed to be better.[14]

17. Mr Gusman had told several family and friends that he wanted to work things out with Ms Gusman and was depressed about their separation.

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[10] Above n 6, 49
[11] *ibid*, 49
[12] *ibid*, 49-50
[13] *ibid*, 49
[14] *ibid*, 50

THE PURPOSE OF A CORONIAL INVESTIGATION

18. Mr Gusman's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria and was unexpected and not from natural causes.[15]

19. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[16] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

20. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[17] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

21. The expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

22. For coronial purposes, the phrase "*circumstances in which death occurred*," refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

23. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the Court's "*prevention*" role.

24. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;

    (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

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[15] Section 4 *Coroners Act 2008*
[16] Section 89(4) *Coroners Act 2008*
[17] *Keown v Khan* (1999) 1 VR 69

(c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice. These powers are the vehicles by which the prevention role may be advanced.

25. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[18] 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 that they caused or contributed to the death.

26. In conducting this investigation, I have made a thorough forensic examination of the evidence including reading and considering the witness statements and other documents in the coronial brief.

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

Identity of the Deceased, pursuant to section 67(1)(a) of the Act

27. On 12 August 2015, Jeremy Graham of Identification Services at the Victorian Institute of Forensic Medicine produced a scientific report based on DNA comparison evidence collected from Daniel Gusman which identified the deceased to be Carmelo Gusman, born 3 March 1965.

28. Identity is therefore not in dispute in this matter and requires no further investigation.

Medical cause of death, pursuant to section 67(1)(b) of the Act

29. On 7 August 2015, Dr Malcolm John Dodd, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon Mr Gusman's body. Dr Dodd provided a written report, dated 18 September 2015, which concluded that Mr Gusman died from a '*single contact range shotgun discharge to the head*.'

30. Dr Dodd commented that Mr Gusman's body was located in close proximity to the shotgun and the external examination demonstrates that the muzzle of the shotgun was placed in the mouth.

31. Toxicological analysis of post mortem specimens taken from Mr Gusman were negative for common drugs or poisons.

[18] (1938) 60 CLR 336

32. I accept the cause of death proposed by Dr Dodd.

Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act

33. On 4 August 2015, Mr Gusman had a 3.00pm WorkCover appointment to receive clearance to resume work, a prospect about which he felt excited and relieved. He had arranged with Ms Gusman to drive him to the appointment.

34. At approximately noon that day, Daniel drove past the family home and noticed that Ms Gusman's car was in the driveway. He decided to return to the house later, to avoid arguing with his mother and making matters worse between his parents. Several hours later, Daniel returned to the address and observed that Ms Gusman's car had been moved to the front lawn. Daniel then spent the night at the family home and Mr Gusman did not return.

35. On 5 August 2015, Daniel located Mr Gusman's mobile phone, Ms Gusman's handbag and mobile phone, and a small amount of blood in the garage and on a door handle. He observed a knife pouch sitting on the sink and noticed a firearm missing from the gun safe in the shed. Both Daniel and Ashley became concerned about their parents' welfare. They reported their parents missing the following morning, 6 August 2015.

36. On 6 August 2015, while at Keilor Downs Police Station filing a Missing Person's report, Daniel and Ashley were informed by police members that their parents' bodies had been located in a vehicle outside 1388 Taylors Road, Plumpton, by a council worker inspecting the roads.

37. Ms Gusman was wrapped in blankets in the rear of the vehicle, laying across the rear foot well behind the front seats. Ms Gusman had injuries to her neck and chest. Mr Gusman was in the front passenger seat with a loaded double barrel shotgun located between his legs. He had a major head trauma.

38. The evidence supports a finding that, as she sat in the driver's seat, Mr Gusman stabbed Ms Gusman multiple times to the neck and chest before wrapping her in blankets and moving her body to the rear foot well.

39. I acknowledge that some of Mr and Ms Gusman's family members have raised concerns in relation to the facts of the case, specifically whether Mr Gusman was physically capable of moving Ms Gusman to the back seats of the car after stabbing her, in light of his back condition.

40. Prior to Mr and Ms Gusman's deaths, Mr Gusman consulted musculoskeletal pain specialist, Dr Steven Jensen, regarding management of his back condition. Mr Gusman first consulted Dr Jensen on 17 March 2015 and attended periodic follow-ups up until 27 July 2015.

41. During my investigation, I sought Dr Jensen's opinion about Mr Gusman's physical capacity in light of his back condition at the time of Ms Gusman's death; specifically, whether Mr Gusman's back condition would have left him unable to move Ms Gusman's body into its final resting position in the rear foot well of the car, without the intervention or assistance of a third party.

42. On this issue Dr Jensen stated the following:

> "*My opinion regarding this man's back pain was that he probably did suffer a lumbosacral "sprain" during the course of his normal work duties on approximately 22 May 2014. However, I was of the further opinion that there were profound psychosocial factors involved in his pain presentation that complicated the issue markedly.*
>
> *I note my entry of 24 March 2015 specifically states: "…degree disability far outweighs organic signs/MRI findings."*
>
> *I am, therefore, of the opinion that, from a strictly physical perspective, and on the balance of probabilities, Mr Gusman's physical capabilities were much greater than he was portraying, and he was purporting to be capable of.*"[19]

43. On the basis of the physical evidence as well as Dr Jensen's opinion, I am satisfied to the coronial standard that Mr Gusman was capable of the actions necessary to move Ms Gusman to the rear of the car without the assistance or intervention of a third party.

44. The evidence further supports a finding that after killing Ms Gusman, Mr Gusman placed a loaded shotgun in his mouth and discharged it, thereby ending his own life.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

Finding of suicide

45. Suicide is defined by the World Health Organisation as '*an act deliberately initiated and performed by a person in the full knowledge or expectation of its fatal outcome*.'

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[19] Statement of Dr Steven Jensen, dated 13 November 2017

46. A finding of suicide can impact upon the memory of the deceased person and can reverberate throughout a family for generations. Such a finding should only be made on compelling evidence, not indirect inferences or speculation.

47. In considering whether Mr Gusman's death was due to suicide, I note that there was no evidence of a third party's involvement in his death and there was evidence that the gunshot wound was self-inflicted.

48. On the available evidence, I am satisfied that the factors identified within the background, and which culminated in the homicide of Ms Gusman, led to Mr Gusman determining to end his own life.

Family Violence

49. The background and circumstances of both Mr and Ms Gusman's deaths highlight the existence of several risk factors[20] associated with an increased risk of both the occurrence and severity of family violence. In Mr Gusman's case, his risk of perpetrating family violence against Ms Gusman was increased by his access to weapons, previous threats to variously harm and kill her, his unemployment, his depression and mental health and his history of violent behaviour towards Ms Gusman. Further, the literature confirms the risk of family violence also increases upon a couple's separation.

50. Research indicates that there is a strong link between suicide and prior violent behaviour, with studies showing that the use of violent behaviour is a risk factor for suicide.[21] The Coroners Prevention Unit[22] (**CPU**) undertook research in 2016 which indicated that perpetrators of intimate partner violence who had contact with the legal system within the last 12 months were more likely to suicide, when compared to Victoria's male population generally. This was especially true when a perpetrator of intimate partner violence had contact with police in the 12 months prior to their suicide.[23]

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[20] The Department of Health and Human Services, *The Family Violence Risk Assessment and Risk Management Framework and Practice Guidelines 1-3* (April 2012) The Department of Health and Human Services website, https://providers.dhhs.vic.gov.au/family-violence-risk-assessment-and-risk-management-framework

[21] Stefansson J, Nordstrom P, Runeson B, et al (2015), "*Combining the Suicide Intent Scale and the Karolinska Interpersonal Violence Scale in suicide risk assessments*", BMC Psychiatry, 15, 226

[22] The CPU is a specialist service for Coroners, within the Coroners Court of Victoria. The CPU was created to strengthen the Coroners' prevention role and provide professional assistance on issues pertaining to public health and safety

[23] Coroners Prevention Unit, *Suicides of male perpetrators of intimate partner violence* (Victoria: 2015)

51. The CPU's analysis of suicides in 2014 by perpetrators of family violence, revealed 24 cases of suicide where the perpetrator had contact with the police or courts in relation to their violence within three months of their suicide. Of the suicides, 11 occurred within 24 hours of such contact.

52. The heightened rate of suicides amongst perpetrators of family violence who have had recent contact with the justice system indicates that this area may provide opportunities for intervention. However, the relationship between perpetration of family violence and suicide, and intervening factors, are not well understood.

53. I note that the Royal Commission made a number of recommendations with respect to perpetrators of family violence, particularly recommendations 86 to 93.[24] These recommendations are targeted at holding perpetrators of family violence to account for their actions and encourage the development of perpetrator interventions that '*address gender-related issues and other risk factors*,' including mental health issues.[25]

54. I am satisfied, having considered all of the available evidence, that no further investigation is required.

55. In the course of my investigation, other than the matters referred to above, I did not identify any prevention matters arising from the circumstances of Mr Gusman's death.

FINDINGS AND CONCLUSION

56. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the Act:

    (a) the identity of the deceased was Carmelo Gusman, born 3 March 1965;

    (b) the death occurred on or about 4 August 2015 outside 1388 Taylors Road, Plumpton, Victoria, from a single, contact-range shotgun discharge to the head; and

    (c) the death occurred in the circumstances described above, in which Mr Gusman acted with the intention to take his own life.

57. I convey my sincerest sympathy to Mr Gusman's family.

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[24] Victorian Royal Commission into Family Violence, *Summary and Recommendations* (2016) 69-71
[25] *ibid*, 28

58. Pursuant to section 73(1) of the Act, I order that this Finding be published on the Court's website.

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

(a) Daniel Gusman, Senior Next of Kin;

(b) Detective Senior Constable Elise Jinks, Victoria Police, Coroner's Investigator;

(c) Peter Lauritsen, Chief Magistrate; and

(d) Detective Inspector Tim Day, Homicide Squad, Victoria Police.

Signature:

JUDGE SARA HINCHEY
STATE CORONER

Date: 10 July 2018