IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2013 / 0122

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of: LEANNE MARGARET PATTERSON

Delivered On:	16 November 2015
Delivered At:	Melbourne
Hearing Dates:	20 October 2015
Findings of:	Judge Ian L. Gray, State Coroner
Representation	Mr R Gipp, instructed by Victorian Government Solicitors' Office, on behalf of the Chief Commissioner of Police Ms E Brimmer, instructed by Russell Kennedy Pty Ltd, on behalf of Senior Constable Pikkert
Counsel Assisting the Coroner	Ms Sarah Gebert, In House Legal Solicitor, Coroners Court of Victoria

I, Judge Ian L. Gray, State Coroner having investigated the death of LEANNE PATTERSON

AND having held an inquest in relation to this death on 20 October 2015
at Melbourne
find that the identity of the deceased was LEANNE MARGARET PATTERSON
born on 6 April 1960
and the death occurred between 5 and 8 January 2013
at 36 Brett Drive, Indented Head, Victoria
from:

1 (a) GUNSHOT WOUND TO HEAD

in the following circumstances:

BACKGROUND

1. Ms Leanne Patterson (Ms Patterson) was born on 6 April 1960 and was 52 years old at the time of her death. She was survived by her sister and parents, with whom she had remained close throughout her life.
2. Ms Patterson married Mr Neil Patterson (Mr Patterson) on 19 December 1981. There were two children of the relationship, a son, Darren, born in 1988 and a daughter, Megan, born in 1990.
3. Both children had moved out of the family home at the time of Ms Patterson's death.
4. The course of both Mr Patterson and Ms Patterson's lives had been very much shaped by injuries incurred in a series of separate motor vehicle collisions. As a result of these collisions, both Mr Patterson and Ms Patterson suffered from chronic pain, reduced mobility, depression and sleeping problems. Their combined health issues impacted adversely on their ability to participate in employment and more broadly in the community. Their health issues also impacted adversely on their financial situation and required them, in 2009, to relocate from their home in Eltham to what had previously been the family holiday home at Indented Head. Given that many of the residents of Indented Head are retirees or seasonal, Mr Patterson and Ms Patterson were relatively socially isolated.
5. Mr Patterson in particular had isolated himself. He was not in contact with his own family, did not attend Ms Patterson's family functions and his children were not able to nominate any friends that he was in contact with. Ms Patterson, although reportedly lonely, remained in contact with her family and had a small circle of friendly acquaintances.

6. No history of family violence between Mr Patterson and Ms Patterson had been reported to Victoria Police, health service providers or other agencies. However, Ms Patterson's sister and the couple's children have all provided statements indicating a history of emotional, social, and physical abuse perpetrated by Mr Patterson against Ms Patterson.[1]

DISCOVERY OF DECEASED'S BODY

7. On the evening of 6 January 2013, at around 7.30pm, three brief calls were made from Ms Patterson's phone to her daughter Megan's phone. On each occasion the call was unanswered and a message was left by Mr Patterson.[2] Phone records indicate that the phone was in the vicinity of Megan's home at the time these calls were made.[3]

8. Shortly after these calls were made, Mr Patterson unexpectedly arrived alone at Megan's home in South Morang. Megan had been expecting her parents to attend at her house the following day on 7 January 2013 to collect her dogs.

9. During his brief visit, Mr Patterson told Megan he had some money for her and handed her five envelopes, advising of the amounts and who they were for. The envelopes were then placed in Megan's safe at his request. He further gave Megan the change from his pockets, a number of blank, empty registered post envelopes and a wallet he owned. He told Megan that there had been a change of plans and that she could bring the dogs to him the following morning.[4]

10. Upon Mr Patterson leaving the premises, Megan noticed that he had also left a large amount of prescription medication in both her parents' names and a variety of items Megan had previously given to her mother as gifts. Megan subsequently discovered that the envelopes placed in her safe were addressed to her and her brother and contained a significant amount of cash. Two of the envelopes were marked with the words "help towards the burial money".[5]

11. Megan attempted to contact her mother during the night. She sent texts at 11.33pm, 12.25am and 4.45am.[6] Megan also contacted her brother who was travelling in Cambodia, expressed serious concerns about her father's behaviour and sought his advice. He suggested that Megan keep trying to contact her mother and that if she was really concerned to call the police.[7]

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[1] Coronial Brief, p.101, 104, 107.
[2] Coronial Brief, p.99.
[3] Coronial Brief, p. 175.
[4] Coronial Brief, p. 99-100.
[5] Coronial Brief, p.100.
[6] Coronial Brief, p. 175
[7] Coronial Brief, p. 104.

12. Having received no response from her mother, Megan phoned the Port Arlington Police Station between 6.30am and 7.00am on 7 January 2013. The phone call was diverted to the Geelong Police Station, where it was answered by Senior Constable (SC) Teresa Pikkert. Megan explained her father's visit the previous evening and her concern that she had not been able to contact her mother. SC Pikkert asked why Megan had not gone to check on her parents and was told that Megan lived in Melbourne and that her parents lived in Indented Head. Megan sought advice on what she should do. SC Pikkert advised her that she could call the Port Arlington Police Station and ask them to do a welfare check if that is what she wanted. Megan told her that she had called the Port Arlington Police Station and the phone had been diverted to Geelong. SC Pikkert advised her that the Port Arlington Police Station would be open at 8.00am and provided her with the phone number. SC Pikkert then questioned Megan about how worried she was for her parents and told her that if she believed the matter was more urgent she could call the Bellarine Police Station and ask them to do the welfare check now as they were on duty. The number was provided.[8]

13. In a supplementary statement SC Pikkert stated that, although she did not specifically recall explaining to Megan that she could call 000 or that SC Pikkert could call 000 on her behalf, based on her usual practice she believed she would have done so. She also stated that she did not understand Megan's call to be a request for a welfare check, instead she understood the call to be a request for advice only. She stated that if Megan had requested a welfare check, she would have sent a unit by calling 000.[9]

14. Megan's recollection of this conversation is that she had said that she would like a welfare check done. She recalls that she was questioned about how urgent it was, was told there was no one to do it, was asked why she didn't call earlier, and told to call Port Arlington Police Station when they opened. According to Megan she felt belittled and rejected and couldn't face calling the Port Arlington Police Station.[10]

15. Megan continued to try and contact her mother throughout the day of 7 January 2013, without success. At approximately 7.00pm, Megan contacted her cousin, and told her about Mr Patterson's visit and about the envelopes. Her cousin informed her father, Mr John Estlick, Ms Patterson's brother-in-law. It was decided police should be called.

16. At approximately 1.30pm on 8 January 2013, Mr Estlick contacted Sergeant Grant Langmaid of Drysdale Police Station and organised a welfare check on the couple. Police

[8] Coronial Brief, p.95-96.
[9] Supplementary statement of Senior Constable Teresa Pikkert 19 October 2015.
[10] Coronial Brief, p.100 -101.

attended the address at approximately 1.45pm on 8 January 2013, scaled the locked front gates and entered through the front sliding door which was unlocked. The body of Ms Patterson was discovered on a reclining lounge chair in the living room, which her daughter has advised she used as her bed, owing to her injuries. Ms Patterson had a single gunshot wound to her left temple area and was clearly deceased.[11] No exit wound was observed. She was covered to her chest in a doona and had two cloths placed under her head near the wound, ostensibly to absorb the blood.[12] There was no other sign of injury or any sign of a struggle.[13]

17. The body of Mr Patterson was discovered slumped on the lounge next to Ms Patterson, with a rifle between his legs. He had two gunshot wounds to his forehead and was clearly deceased. There were no signs of any other injuries to Mr Patterson, nor signs of struggle.[14]

18. One of Mr Patterson's wounds, which extended from the top of his nose to his forehead appeared to have been cause by a bullet which had not penetrated the skull but which had ricocheted to the ceiling above and beyond, causing some damage. This bullet was searched for but not located.[15]

19. One spent ammunition cartridge was located in the rifle and another under Mr Patterson's legs. A third cartridge was searched for but not located at the house.[16]

20. A number of folders, letters and documents were arrayed upon the kitchen bench as follows:

- EFTPOS cards, drivers licence, club membership and gun license all in the name of Mr Patterson,
- A letter addressed to Mr Patterson from his lawyers to which annotation had been added, by hand, expressing animosity towards the particular lawyer with carriage of Mr Patterson's Transport Accident Commission (TAC) case.
- A printed card from a Chinese massage business to which annotation had been added, by hand, indicating that Mr Patterson believed that the Chinese masseuse had been having an affair with Ms Patterson and that she had allegedly told him this. The annotation went on "Sorry Megan and Darren but I just couldn't take any more. The TAC drove us both nuts. I think you'll get the message BLACK HAWK DOWN. Love always mum and dad xxxxxxxxxxxxxxx your mum was in too much pain please forgive me."

[11] Coronial Brief, p.21- 22.
[12] Coronial Brief, Exhibit 4.
[13] Coronial Brief, p. 35.
[14] Coronial Brief, p.35.
[15] Coronial Brief, p. 55.
[16] Coronial Brief, p. 4.

- A note with pin numbers, and directions to wills and instructions in relation to safes and financial matters.
- Bank account details and instructions about a further account. [17]

21. All of the annotations and notes were hand written and were seized for the purposes of conducting handwriting analysis.

22. Ms Patterson's handbag was also located on the bench, but the contents appeared undisturbed and were not arrayed in the same manner.[18]

23. Drops of blood were observed at various places around the house, including on the kitchen floor, kitchen taps, kitchen cupboards, master bedroom floor, master bedroom bed, master bedroom ensuite, and in the hallway. Megan has advised that the master bedroom was in fact her father's room and that her mother used a separate room. Samples from various points in the blood trail were taken for the purposes of conducting DNA analysis.

24. Located in the double garage of the house were three similar "tinny" boats with outboard motors, each on a separate trailer and each fully equipped with boating and safety items. Excerpts of various song lyrics had been typed and printed and attached to the boats. Bottles of alcohol were located on the nearby workbench.

25. The remainder of the house was secure, with all other doors locked and windows closed. There were no signs of forced entry to the premises and nothing appeared to be missing.[19]

26. Police inquiries revealed that Ms Patterson's last known contact was with her father at 4.24pm on 5 January 2013 when she phoned him in hospital. Earlier on 5 January 2013, she had also spoken to her daughter Megan at 10.15am and her mother at 4.09pm. None of the family members described these conversations as unusual.[20]

27. Police inquiries revealed that Mr Patterson's last known contact was when he visited his daughter Megan on the evening of 6 January 2013, as described above.

CORONIAL INVESTIGATION

28. Ms Patterson's death was a reportable death pursuant to section 4 of the *Coroners Act 2008* because it occurred in Victoria and it was unexpected, unnatural and violent.

29. The Coroners Court of Victoria is an inquisitorial jurisdiction. The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred. The cause of death refers to the medical cause of death, incorporating where

[17] Coronial Brief, Exhibits 4, 11, 12, 13.
[18] Coronial Brief, p. 35.
[19] Coronial Brief, p.30, p.34.
[20] Coronial Brief, p.41,

possible the mode or mechanism of death. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances to the death, but is confined to those circumstances sufficiently proximate and causally relevant to the death and not merely all circumstances which might form part of a narrative culminating in death.[21]

30. With that purpose in mind, an investigation into the death was undertaken and a coronial brief was prepared by Detective Senior Constable Liana Jackson. As part of that investigation, the following inquiries were made.

Medical investigation into the death

31. An external examination, post mortem CT scan and autopsy were performed on both Neil and Leanne Patterson by Forensic Pathologist, Associate Professor (A/Prof) David Ranson of the Victorian Institute of Forensic Medicine.[22] The medical cause of death for both Mr Patterson and Ms Patterson was determined to be gunshot wound to the head.

32. The report confirmed that Mr Patterson had suffered two separate gunshot wounds. In A/Prof Ranson's opinion, the first guttering wound, while likely to have resulted in a period of incapacitation may, nonetheless, also have been associated with a period of survival during which Mr Patterson was capable of carrying out coordinated activities including firing a gun. In A/Prof Ranson's opinion the second gunshot wound would have been immediately fatal.

33. Both external and internal examinations of the bodies revealed mild to moderate decomposition. However, no accurate conclusion could be drawn from the autopsies as to the precise time or order of the deaths.

34. A full toxicological analysis conducted on blood and urine samples from Ms Patterson revealed the presence of 7-aminoclonazepam, codeine, morphine, amitriptyline, nortriptyline, paracetamol and zolpidem.

35. The presence of these substances can be explained by Ms Patterson's known prescription medications, except for the 7-aminoclonazepam. clonazepam is metabolised to 7-aminoclonazepam. Ms Patterson's General Practitioner (GP) records did not indicate that she had been prescribed clonazepam. Mr Patterson's medical records indicate that he had been frequently prescribed clonazepam over a period of two and half years. He had most

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[21] *Harmsworth v The State Coroner* [1989] VR 989; *Clancy v West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

[22] Coronial Brief, p. 158 -178/ Coronial Brief Neil Patterson p. 140 -157.

recently been prescribed clonazepam on 19 December 2012[23], with the medication dispensed on the same day.

36. The levels of zolpidem and 7-aminoclonazepam detected in Ms Patterson's blood samples were very high and would have been likely to cause sedation. A/Prof Ranson commented that the toxicological findings implied that Ms Patterson could have been significantly sedated and suffering from a diminished conscious state at the time that she received the fatal wound.

37. A full toxicological analysis conducted on blood and urine samples from Neil Patterson revealed the presence of ethanol, codeine, morphine, 7-aminoclonazepam, zolpidem and paracetamol. It was noted that the concentration of sedating drugs was lower than that found in Ms Patterson's samples.

38. In the toxicological report, it is also noted that the effects of alcohol are increased when consumed with other drugs capable of depressing the central nervous system such as benzodiazepines (like clonazepam) and opiates (like codeine and morphine).

Firearm and Ballistics Report

39. Senior Constable Stephen Farrar examined the rifle and cartridges seized from the Indented Head property upon discovery of the bodies.[24] The seized rifle was a Sturm 'Ruger', model 96/22, .22 rim fire rifle. This rifle was registered under Mr Patterson's name. The rifle and associated ammunition items were found to be fully functional and operating within normal limits. Examination confirmed that the spent cartridges had been fired from the seized rifle.

40. Although the injuries suffered by Mr Patterson and Ms Patterson indicate that at least three shots were fired, as noted above only two cartridges were located at the property.

41. The fragments of two bullets were retrieved from Mr Patterson and Ms Patterson, but were not suitable for testing. As noted above, a third bullet, which appeared to have entered the ceiling cavity, could not be located.

GSR Report

42. Forensic Officer, Kylie Beeson, with the Victoria Police Forensic Services Centre examined items of clothing worn by Ms Patterson and Mr Patterson at the time of the deaths for the presence of gunshot residue (GSR). No GSR testing of the hands of Mr Patterson and Ms Patterson was undertaken. The report was able to determine that the clothing sampled was in

[23] Coronial Brief Neil Patterson p.434a.
[24] Coronial Brief, p.55-57.

relatively close proximity to a discharged firearm, but could not determine whether either of Mr Patterson or Ms Patterson had pulled the trigger.[25]

Blood Analysis

43. Swabs were taken from several points in the blood trail around the house. The source of the blood at each point was determined by Jessica Chang of the Victoria Police Forensic Services Centre to be Mr Patterson (with a probability of 100 billion in favour of this conclusion). Blood from the swab taken from the hallway near the billiard table indicated a mixed DNA profile, with the blood coming from Mr Patterson and one other, possibly Ms Patterson.[26]

Handwriting Analysis

44. A handwriting analysis performed by Tahnee Dewhurst compared the notes and annotations suspected of being written by Mr Patterson and left arrayed on the kitchen bench with documents confirmed to have been written by Mr Patterson. This revealed strong support for the proposition that the letters had been written by Mr Patterson.[27]

45. However, investigation also revealed that, due to ongoing pain in Ms Patterson's right wrist, Mr Patterson sometimes filled out forms on her behalf.

Phone Records

46. Analysis of Ms Patterson's phone records indicated she kept in close contact with family and friends. Conversely, Mr Patterson rarely used the two phones that he owned.[28]

47. The records of phone use in the days preceding the discovery of Ms Patterson and Mr Patterson's bodies[29] largely concur with witnesses' statements about their last contact with the deceased couple. However there is some uncertainty about the use of Ms Patterson's phone on 6 January 2013. As noted above her parents' and daughter's last confirmed contact with her was on 5 January 2014. However, Ms Patterson's phone records indicate further activity on her phone after this time. At approximately 1.16 pm on 6 January 2013 Megan received a missed call from her mother's phone followed by a somewhat garbled text message at 1.25pm. Megan surmised that the text message had been sent by her father who did not know how to use the phone properly. She was able to decipher that the intended message was "we will be there".[30]

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[25] Coronial Brief, p.53-54.
[26] Coronial Brief, p. 58-67.
[27] Coronial Brief, p.68-74.
[28] Coronial Brief, Exhibit 7, 8 and 9.
[29] Coronial Brief, p.175-177.
[30] Coronial Brief, p.99.

48. At 1.26pm on 6 January 2013, a further phone call was made from Ms Patterson's phone to her father's number in the hospital. The duration of the call was 1 minute 57 seconds. Police inquiries were unable to clarify whether the call was made by Ms Patterson and whether anyone was spoken to at the hospital. Her family have no recollection of this call.

49. As noted above, around 7.30pm on 6 January 2013, three brief calls were made from Ms Patterson's phone to her daughter Megan's phone. On each occasion the call was unanswered. The phone appears to have been in the possession of Mr Patterson at this time because the voice messages left on her phone were from Mr Patterson.

Bank Records

50. Examination of Mr Patterson's 'Victoria Teachers Mutual Bank' account, National Australia Bank (NAB) VISA credit card, Commonwealth Bank account, and NAB and Westpac accounts held jointly with Ms Patterson, did not indicate any unusual or large withdrawals which would suggest any pre-planning leading up to 6 January 2013 when he visited Megan's house.[31]

Fingerprint Analysis

51. No fingerprinting was undertaken on the rifle, gun cabinet, arrayed documents or any other object or location in the premises.

Ms Leanne Patterson's Medical Records

52. Medical Records in relation to Ms Patterson were obtained from:

    a. Barwon Rheumatology Service, Geelong
    b. Gateway Plaza Medical Clinic Medical Records, Leopold
    c. Dr John Cunningham (specialist) at 25 Erin Street, Richmond
    d. Dr Penelope Wong (specialist) at 73 Ryrie Street, Richmond
    e. Barwon Health Pain Management Clinic

53. These records revealed that Ms Patterson suffered long-term chronic pain caused by separate car crashes occurring in 1983, 2001 and 2010. She was unable to work, had trouble sleeping and grew depressed. Ms Patterson also suffered from type 1 diabetes and was a smoker.

54. Ms Patterson was on a long list of medication to treat her health issues. According to her GP records, at the time of her death, Ms Patterson's prescription medications included amitriptyline hydrochloride, oxycodone, paracetamol and codeine, zolpidem and Diabex.[32]

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[31] Coronial Brief, Exhibits 25 – 29.
[32] Coronial Brief, p368 – 373.

55. Ms Patterson's chronic back pain meant she could only comfortably sleep in a chair and got exhausted relatively easily. According to her medical records, she required Mr Patterson to do most of the housework and he acted as Ms Patterson's carer.[33] (Conversely Mr Patterson's medical records indicated that he was dependent on Ms Patterson to do the housework and that she was effectively his carer.)

56. Ms Patterson's anti-depressant medication was prescribed by her GP and it does not appear that she was referred to a psychologist or psychiatrist in relation to her depression. However, her medical records indicate that she was seen by a number of specialists in relation to her chronic pain issues who identified a significant psycho-social dimension to her health problems and recommended that any treatment strategy recognise and address this.[34] A multi-disciplinary assessment undertaken at the Pain Management Unit at the Geelong Hospital also identified a number of issues, in addition to the pain she was suffering, including: social isolation after moving from Melbourne to Indented Head; loss of role as care giver to her children, and poor cognitive function secondary to her many medications. Her medical records indicate that Ms Patterson was reluctant to progress to any multi-disciplinary pain management program because she was focussed on further testing and the belief that there was an undiagnosed cause of her pain.[35]

Mr Neil Patterson's Medical Records

57. Medical Records in relation to Mr Patterson were obtained from:
    a. Alpha Medical Clinic, Mill Park
    b. Bulleen Plaza Medical Clinic, Bulleen
    c. Rehabilitation Epworth Healthcare
    d. Mr Stephen Doig (orthopaedic surgeon).

58. These records revealed that Mr Patterson also suffered chronic pain as a result of two separate transport crashes in 2002 and 2006. He was consequently unable to work, had trouble sleeping and was taking a variety of medications. His medical records indicate that he told his doctors he was reliant on his wife in both personal and domestic activities.[36]

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[33] Coronial Brief, pp 343, 488, 553.
[34] Coronial Brief, pp 332, 337, 344.
[35] Coronial Brief, Exhibit 16.
[36] Coronial Brief Neil Patterson pp.447, 450, 460.

59. It is difficult to assess precisely what medications Mr Patterson was being prescribed at the time of his death because of the number of doctors involved in his care, not all of whom appear to have been fully aware of each other's involvement.[37]

60. From at least 2009 until late May 2012, Mr Patterson was prescribed the following medications by his GP at the Bulleen Plaza Medical Centre: fentanyl, zolpidem and Panadeine Forte (paracetamol and codeine). From January 2010, until late May 2012, he was also prescribed clonazepam at the same Clinic.[38]

61. From at least January 2010 to June 2012, Mr Patterson was simultaneously prescribed these same medications by his GP at the Alpha Medical Centre in Mill Park.[39]

62. Both GPs appear from the records to have ceased prescribing Mr Patterson fentanyl, zolpidem and clonazepam around June 2012. This corresponds with their receipt of correspondence from the Department of Health (as it then was) indicating that they had both simultaneously applied for a schedule 8 permits to treat Mr Patterson with Fentanyl and therefore their applications were refused.[40]

63. Mr Patterson's Rehabilitation Physician at the Epworth Rehabilitation Camberwell, Dr Stephen De Graaff, commenced prescribing fentanyl and clonazepam for the deceased instead at this time.

64. Medical Certificates submitted to the TAC by Dr De Graaff, who played a significant role in overseeing and coordinating Mr Patterson's care from 2004 onwards, indicate that Mr Patterson was suffering from depression, and had been for many years. Dr De Graaff's medical records contain numerous references to concerns about Mr Patterson's psychological state. However, at the time of his death, it does not appear that Mr Patterson was currently on any medication for this or receiving any other treatment for mental health issues.[41]

65. From the records available, it would appear that, at the suggestion of Dr De Graaff, Mr Patterson was referred by his GP to psychologist Dr Jackie Stanford in May 2007 and was seen by her approximately a dozen times. His treatment plan referred to mood fluctuations, ongoing pain, partial post traumatic stress disorder, and chronic adjustment disorder with

[37] Coronial Brief Neil Patterson pp 441 – 446.
[38] Coronial Brief Neil Patterson, Exhibit 14.
[39] Coronial Brief Neil Patterson, Exhibit 15
[40] Coronial Brief Neil Patterson p.404 -405 and 444-445.
[41] Coronial Brief Neil Patterson Exhibit 16.

depressed mood. Mr Patterson's treatment with Dr Stanford ceased when it was agreed that things were not progressing in terms of pain management strategies.[42]

66. Later in 2008, again at the suggestion of Dr De Graaff, Mr Patterson was referred by his GP to consultant psychiatrist Dr Graeme Kernutt. Over several appointments, Dr Kernutt struggled to develop rapport with Mr Patterson and found him uncooperative and closed, in part because he was suspicious and guarded as a result of his TAC claims. In a letter to Dr De Graaff, Dr Kernutt wrote that Mr Patterson "presents quite a challenge in terms of both diagnosis and psychiatric management." Dr Kernutt doubted that Mr Patterson was suffering from major depression or post traumatic stress disorder. He noted that Mr Patterson presented as a quite controlling man who readily became defensive and suspicious when questioned. Dr Kernutt stated that he could see "no indication for adding further psychotropic medication to his treatment", and that there was little he could offer Mr Patterson, if he was unable to be more forthcoming with information about his life and past. He also suggested that given the unusual nature of Mr Patterson's presentation and the fact that his second accident had involved a head injury, perhaps neuropsychological testing should be considered.[43]

67. On 19 July 2011, Mr Patterson's GP records indicate that he attended and reported having poor sleep, a depressed mood and that he was suffering from irrational fear and compulsive behaviour. The notes indicate that Mr Patterson was counselled regarding relaxation techniques and that a GP Mental Health Care Assessment & Plan was prepared. This has not been retained and/or provided with the GP record. The following month, on 22 August 2011, his GP prescribed Efexor-XR 75mg to treat Mr Patterson's depression.[44] Three weeks later in an assessment undertaken as part of his TAC claim, Mr Patterson reported that the medication was yet to have any impact on his mood.[45] There is nothing in Mr Patterson's GP records to indicate that a further prescription was ever written for this or any alternate anti-depressant medication.

68. In addition to this direct information about his mental health treatment history, Mr Patterson's medical records also contain a number of reports prepared at the request of his lawyers or at the request of the TAC, to assist them in making claim related decisions. Many of these reports raise concerns about Mr Patterson's mood and cognitive function. For example:

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[42] Coronial Brief Neil Patterson p.532.
[43] Coronial Brief Neil Patterson pp 553 – 534, 590, 603, 604 – 605, 614, 615, 505 – 506.
[44] Coronial Brief Neil Patterson p.413- 414.
[45] Coronial Brief Neil Patterson p.129.

a. At the TAC's request, Mr Patterson was assessed by consultant psychiatrist Dr David Weissman on 12 March 2008. Dr Weissman concluded that Mr Patterson seemed to be suffering from a moderate, reactive mixed depressive syndrome, with prominent frustration and disappointment as a consequence of his transport crashes. He further concluded that Mr Patterson had sustained and developed an adjustment disorder with anxious and depressed mood in this regard.[46]

b. Expert orthopaedic surgeons Mr Michael Shannon and Mr W. H. Huffam who assessed Mr Patterson at the request of the TAC in May 2008 and March 2011 respectively, both identified a psychological aspect to Mr Patterson's presentation. Mr Shannon, opined that Mr Patterson's incapacity related mainly to psychological factors and stated that his personal relationships were influenced significantly by his multiple psychological problems[47]. Mr Huffam stated that Mr Patterson appeared to be suffering from quite severe psychiatric dysfunction and commented that "further treatment of Mr Patterson would be best directed to his mental condition and pain management strategies." He also indicated that the possibility of organic brain damage should be considered and further neuropsychological testing undertaken. [48]

c. On 20 July 2010, consultant medico legal psychiatrist Dr Nigel Strauss assessed Mr Patterson at the request of his lawyers. Dr Strauss diagnosed Mr Patterson as suffering major depression and post traumatic stress symptoms. It was speculated that treatment with anti-depressants might be beneficial, however it was noted that Mr was not taking any at that time. Dr Strauss doubted that Mr Patterson had suffered a brain injury but nonetheless indicated that neuropsychological testing was warranted.[49]

d. On 1 June 2011 and 12 September 2011, again at the request of his own lawyers, Mr Patterson was assessed by Clinical Neuropsychologist Isabella Walters. Ms Walters described him as 'significantly depressed and taking several medications prone to cognitive side effects'. She noted that on a self report questionnaire of psychological symptomatology, Mr Patterson's symptoms of depression placed him in the 'Extremely Severe' range and his perceptions of stress in his life was in the Severe range. She expressed the view that Mr Patterson's cognitive dysfunction significantly limits his social, domestic and recreational potential. Ms Walters provided a recommendation to the TAC "to provide [Mr Patterson] with psychological services which address his

[46] Coronial Brief Neil Patterson p.586 – 594.
[47] Coronial Brief Neil Patterson p.517 – 523.
[48] Coronial Brief Neil Patterson p.435 -440.
[49] Coronial Brief Neil Patterson p.438 – 439.

psychological distress". In particular, she opined that Mr Patterson needed appropriately chosen, effective antidepressant medication.[50]

69. According to the TAC, none of these reports or assessments resulted in a direct request for the TAC to fund any psychological treatment.[51]

Transport Accident Commission

70. Both Mr Patterson and Ms Patterson had ongoing claims with the TAC. The history and status of these claims was set out in a statement provided by Mr Alan Woodroffe of the TAC.[52]

71. Mr Patterson had been involved in two separate crashes. At the time of his death, the TAC had paid out $83,401.86 and $180,270.24, respectively in relation to these crashes, in compensation towards medical costs, medication and psychological treatment. Through his legal representatives, Mr Patterson was in the process of negotiating a lump sum impairment benefit from the TAC in relation to the injuries sustained in the both crashes. His legal representatives had also commenced a damages action in respect of injuries sustained in the first crash.

72. Ms Patterson had been involved in three separate crashes. The records of the first crash, which occurred in 1983, are limited, however it appears a damages action was settled in 1990. In respect of the later two crashes, the TAC had paid $711.15 and $21,163.60, respectively, in compensation towards medical and rehabilitation costs incurred as a result of injuries sustained.

73. No formal complaints about the handling of their claims had been made by Ms Patterson or Mr Patterson through the TAC's formal complaint procedure. Only one minor matter had been raised by Mr Patterson (and resolved) under the TAC's dispute's protocol.

Statements from family and friends

74. Statements were obtained from Ms Patterson's family and friends which addressed, amongst other things, the dynamics and status of the couple's relationship and the history of Mr Patterson's threats and violence towards Ms Patterson.

75. In her statement[53], Megan described her father as a 'violent alcoholic'. She stated that she had witnessed Mr Patterson bash Ms Patterson and smash up the house. Ms Patterson reportedly told Megan that Mr Patterson had once held a knife to her throat because she would not tell him where she was going. Megan also claimed that her father had beaten her

[50] Coronial Brief Neil Patterson p.126 – 133.
[51] Coronial Brief Neil Patterson p.116 – 125.
[52] Coronial Brief Neil Patterson p.116 – 125.
[53] Coronial Brief p.98 – 103.

in the past and broken plates over her head. Megan stated that neither she nor Ms Patterson called the police because they were both too scared of reprisal.

76. In his statement[54], Darren Patterson describes his parents relationship as 'emotionally abusive...dad against mum'. Darren stated that Mr Patterson was controlling and would often degrade and isolate Ms Patterson. He stated that "it very rarely became physically violent."

77. According to Ms Patterson's sister, Ms Deborah Estlick[55], Ms Patterson was happy and outgoing during her younger years. This reportedly changed when she married Mr Patterson, who over a period of decades isolated Ms Patterson from her friends and family with the result that her personality slowly changed to become reserved and introverted'.

78. Ms Estlick stated that she suspected that "Neil had been hitting Leanne over a long period of time". Ms Estlick had witnessed cuts on her sister's face, bruises on her arms and on more than one occasion had seen Ms Patterson with a black eye. Ms Estlick felt Ms Patterson was too scared and intimidated to tell Ms Estlick how she was being bruised. Ms Estlick also stated that Ms Patterson could not go anywhere without Mr Patterson and on the occasions in which she did go somewhere on her own, Mr Patterson would constantly call and check up on her.

79. Ms Lindsay Burton, Ms Patterson's beauty therapist, noticed bruises and marks on Ms Patterson too. Ms Patterson explained these as being caused by a pet, or if they were burn marks, as being caused from the oven.

80. Ms Burton formed the impression Mr Patterson and Ms Patterson's relationship was over and that they slept in separate rooms. This was confirmed by Megan.[56]

81. As noted above, in one of the notes in Mr Patterson's hand writing located at the crime scene it is indicated that Mr Patterson believed and/or that Ms Patterson had disclosed that she had commenced an intimate relationship with her Chinese massage therapist. This was apparently not the first occasion on which Mr Patterson had made accusations of this nature. There was no evidence to support Mr Patterson's assertion. Her massage therapist denied that his relationship with Ms Patterson was anything more than a casual friendship[57] and Ms Patterson had not disclosed a relationship with him to any family members.

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[54] Coronial Brief p.104 – 106.
[55] Coronial Brief p.107 – 109.
[56] Coronial Brief p.113-115.
[57] Coronial Brief p.110-112.

FINDINGS PURSUANT TO SECTION 67 OF THE CORONERS ACT 2008

82. Section 67 of the Coroners Act provides that coroner investigating a death must find, if possible:

a. the identity of the deceased;

b. the cause of death; and

c. the circumstances in which the death occurred

With respect to those matters, based on the evidence gathered and set out above, I find the following.

83. The identity of the deceased was Ms Leanne Margaret Patterson, born 6 April 1960. She died as a result of a gunshot wound to the head. She was shot through the high temporoparietal region of the left side of the head with a .22 rim fire rifle registered in her husband Mr Neil Patterson's name.

84. At the time she was killed, Ms Patterson was lying sedated on a reclining lounge chair which she used as a bed, having consumed or been administered both zolpidem, for which she had a prescription, and clonazepam, for which she had no known prescription, but which her husband had been routinely prescribed for some years.

85. It is not known whether Ms Patterson self-administered these medications or was administered them overtly or covertly by another, notably her husband. Her daughter has expressed the strong view that these drugs were likely self administered given her previous observations of her mother's use of these medications, her discussion with her mother about their use, and her father's liberal distribution of his prescription medications to others.[58]

86. If, as indicated by the toxicology results, Ms Patterson was significantly sedated at the time of her death, this would have rendered her less likely to be able to carry out the coordinated activity of self inflicting a hard gunshot wound to the left side of the head with a long rifle measuring 605 millimetres from muzzle to trigger. However, this scenario can not be definitively excluded based on the autopsy or toxicology results in isolation.

87. Mr Patterson was shot twice in the head with the same rifle. The first bullet left a guttering wound but did not penetrate his skull. After incurring this injury, Mr Patterson walked around the house and possibly lay down in his bedroom, leaving a trail of blood. He then returned to the lounge room and while seated on the couch and shot himself again with the same rifle, this time fatally, through the forehead. The rifle was found between his legs and the two spent cartridges located at the scene had been fired from it.

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[58] Letter from Megan Patterson, received by email 15 July 2015.

88. At the time of his death, Mr Patterson had consumed alcohol, benzodiazepines and opiates. The combined effect of these drugs on his state of mind and consciousness can not be determined.

89. There is no evidence to indicate that any third party was present at the house at or around the time of the deaths and/or involved in the deaths of Ms Patterson and Mr Patterson in any way.

90. On the contrary, the evidence, particularly the notes that were left at the scene in Mr Patterson's handwriting and his unusual visit to his daughter on the evening of 6 January 2013, are sufficient to satisfy me that Mr Patterson intentionally shot Ms Patterson and then intentionally took his own life.

91. His purported motivations for doing so appear to be an erroneous perception that his wife was having an affair, frustration regarding his ongoing dealings with the TAC, and his, or at least his wife's ongoing struggle with chronic pain.

92. It is possible, given the toxicological findings and his prescription history, that his mood and/or cognitive function were affected at the time by his simultaneous consumption of alcohol, benzodiazepines and opiates. It is also possible, based on his medical history, that his behaviour was affected by mental health issues which had been noted, but not definitively diagnosed or treated, by the various medical practitioners involved in his assessment and care.

93. Ms Patterson was sedated at the time of her death and could have been suffering from a diminished conscious state.

94. There is no indication Ms Patterson and Mr Patterson discussed or planned a suicidal pact or mercy killing prior to the incident. On the contrary, the evidence indicates that the relationship between Mr Patterson and Ms Patterson was acrimonious and they were therefore unlikely to have acted in concert. There is very little evidence that Leanne ever expressed any suicidal ideation or intent. There is no evidence of her involvement in the planning for the deaths. Her final phone contact with family members was unexceptional. She did not attend at her daughter's address on 6 January 2013 to hand over money and other personal effects. She did not author any of the notes located at the scene, which purported to offer an explanation for the deaths and provide instructions to the couple's children. None of Ms Patterson's personal documents were arrayed on the bench, in the manner that Mr Patterson's documents were set out.

95. With respect to the timing of the deaths, Ms Patterson died sometime after she spoke to her father, Mr John Leavold, at 4.24pm on 5 January 2013 and before her body was discovered

at 1.45pm on 8 January 2013. Given that she did not attend her daughter's house with her husband on the evening of 6 January 2013 and that her husband was in possession of her phone at this point, in all the circumstances it appears likely that she was already deceased at this point. The inability of police to locate a third gun cartridge at the scene and the possibility that it was therefore disposed of off site, also suggests that Mr Patterson left the scene after he shot Ms Patterson, possibly when he visited his daughter.

96. Mr Patterson died sometime after leaving his daughter Megan's house (which was approximately an hour and a half from his own) at 7.30pm on 6 January 2013 and before his body was located at 1.45 pm on 8 January 2013.

97. Megan has expressed the strong view, based on her mother's unusual failure to respond to phone calls and texts, that Ms Patterson died some time on the evening of 5 January 2013.[59] While I understand and accept the basis for this view, I am not satisfied that the time of death can be expressed with greater precision. There may have been other explanations for Ms Patterson's failure to respond to her daughter, including, for example, her degree of sedation.

98. Ms Patterson's death occurred in the context of a long history of physical and emotional abuse by Mr Patterson which over time, in addition to physical injuries and property damage, had resulted in Ms Patterson withdrawing socially from friends and family. There is no evidence that Ms Patterson sought any kind of assistance in relation to family violence from community support services, the police or court system, or that such assistance was sought on her behalf. There is no evidence that Mr Patterson ever came to attention or was held to account, in any way, for the abuse he perpetrated. According to her daughter, Mr Patterson had created an environment of fear and control, such that Ms Patterson would never have contacted police.

99. Ms Patterson had ongoing and frequent contact with a variety of healthcare providers. Her experiences of family violence were never reported to or detected by any of these providers. The evidence indicates that over a period of time, Ms Patterson had become dependent on pain and sleep medications with significant cognitive side effects. This, together with her complicated general medical presentation, made it difficult for those involved in her health care to recognise and/or address the psycho-social issues inhibiting her ability to make and action decisions to improve her well being. In particular, Leanne's focus on finding the source of, and a fix for, her pain, appears to have diverted her doctors from a more probing

[59] Letter from Megan Patterson, received by email 15 July 2015.

examination of the psycho-social issues, including ongoing family violence that may have been contributing to her significant malaise.

COMMENTS

100. The broader purpose of coronial investigations is to contribute to the reduction of the number of preventable deaths through the investigation findings. This is generally referred to as the 'prevention' role. As part of that role, Coroners are empowered to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice.

101. As Ms Patterson's death occurred in the context of family violence, the evidence has been carefully reviewed with a view to:

a. capturing information which will provide a better understanding of the contributing factors and indicators of risk; and

b. identifying opportunities to more effectively detect and respond to the risk of family violence homicide.

102. Based on that review, and pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comments connected with the death. These comments are not intended to suggest that:

a. the responsibility for Ms Patterson's death rests with anyone other than Mr Patterson;

b. that an explanation or excuse for his actions can be found in aspect of his healthcare;

c. that there was a causative link between any of the matters commented upon and Ms Patterson's death.

GP detection of family violence

103. Ms Patterson had been under the care of general practitioner Dr Emmanuel Nnopu of Gateway Plaza Family Medical Practice, since 10 November 2010. Her records indicate that she attended regularly, at least monthly, but sometimes more frequently. A large number of these consults were for the purpose of renewing prescriptions for pain medication or obtaining referrals to investigate or treat her ongoing pain.

104. Ms Patterson did not disclose to Dr Nnopu a history of family violence. Her GP records indicate that she was also never directly questioned about whether she had experienced family violence, notwithstanding that her presentation included a number of relevant indicators.

105. Her husband accompanied her to a number of her appointments and because of her wrist injury often completed patient history/information forms on her behalf. Although this would have complicated any attempt to question Ms Patterson about her relationship, it also

potentially provided another possible indicator that family violence may have been occurring.

106. I requested clarification from Dr Nnopu about whether he had perhaps had discussions with Ms Patterson about these matters that were not recorded in his records or whether he had discussed with Ms Patterson the possibility of a referral to a psychologist to deal with her apparent psycho-social issues. Dr Nnopu replied that the deceased had severe pain and was managed as per her symptoms. He noted that he had referred her to the multidisciplinary Pain Management Clinic which included psychologists, psychiatrists, occupational therapists, physiotherapists and pain specialists. He did not indicate that he had ever questioned the deceased about the possibility that she had experienced or was at risk of family violence.[60]

107. It is well acknowledged that GPs have an important role to play in preventing and detecting family violence; responding to disclosures of abuse, and providing follow-up and support to patients experiencing the health effects of violence and abuse. The Royal Australian College of General Practitioners issues a Guide, now in its fourth addition, entitled "Abuse and violence: working with our patients in general practice" (also known as "the White Book.").[61] The White Book provides evidence-based guidance on appropriate identification and response in clinical practice to patients experiencing abuse and violence. It lists the potential presentations of intimate partner abuse which, relevantly to Ms Patterson, include: insomnia, depression, chronic back pain, frequent presentation, identifiable social isolation; and an overly attentive accompanying spouse.

108. The White Book directs general practitioners to ask patients, who are showing clinical indicators of the mental and physical effects of intimate partner abuse, about their experiences of abuse. Referencing supporting studies, the White Book notes that most women are, in fact, open to enquiry about intimate partner abuse and are significantly more likely to disclose if they are proactively asked by their doctor about the abuse. The White Books directs GPs as follows:

> *Studies show that there is a need for patients to be encouraged to discuss abuse and to see it as affecting their health. We need to have a high level of suspicion and to be able to ask direct questions in a sensitive way. There is insufficient evidence for screening in clinical settings, with the possible exception of antenatal care. However, there should be a low threshold for asking about abuse, particularly when underlying psychosocial problems are suspected.*

In that context, a list of possible questions to ask and statements to make is provided.

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[60] Letter from Dr Emmanuel Nnopu, dated 9 February 2015.
[61] Available online at: http://www.racgp.org.au/your-practice/guidelines/whitebook/

109. The information and advice contained in the White Book, is echoed in other guides and fact sheets available for GPs in Victoria for example: "Family Violence Risk Assessment and Risk Management Framework Practice Guide 1: Identifying family violence" and "Identifying and responding to family violence: a guide for general practitioners" produced by the Victorian Community Council Against Violence.

110. There are also a number of previous cases where Coroners have made comments about GPs and family violence.

111. Of course, it is very uncertain, in this case, whether Ms Patterson would have disclosed, if asked by her GP, that she had experienced family violence. Further, even if she had disclosed such a history or concerns for her safety, it is equally uncertain whether this would have led to further steps or engagement which might have decreased her risk of future harm.

112. Given this uncertainty and the educational resources already available on this issue, I do not consider that a recommendation on this matter is warranted in this case. However, I consider that it is important to reiterate that general practitioners, who are often a sole or primary point of service contact, have a very important role to play in detecting family violence and that an opportunity in that regard, however hypothetical or intangible, may have been lost in this case.

Coordination of care

113. Mr Patterson and Ms Patterson were both long term users of prescription medications. In particular, for a number of years preceding his death, Mr Patterson was taking benzodiazepines (clonazepam), opioids (fentanyl and codeine) and zolpidem. These medications can be habit forming and can have significant cognitive side effects, which may, particularly in combination with alcohol, affect mood and judgement.

114. It is not suggested that these medications were prescribed for Mr Patterson lightly. His medical records indicate that these medications were chosen in response to feedback from Mr Patterson regarding the ineffectiveness or adverse side effects of other medications or treatments.

115. However, there were a number of medical practitioners involved in Mr Patterson's care, who were not necessarily aware of each other's existence or role. Communication between them was dependent on an exchange of letters and, presumably, on Mr Patterson conveying information between practitioners.

116. The records indicates that this system was inadequate to maintain proper control over Mr Patterson's prescriptions and was vulnerable to subversion with the result that, up until six months before his death, he appears to have obtained certain medications in quantities not

known or intended by his medical practitioners and to have consumed them in combination with alcohol contrary to all advice.

117. What, if any role, Mr Patterson's use of these medications played in the deaths can not be determined, except to say that the already complex task of accurately diagnosing and effectively treating Mr Patterson's physical and mental health issues was not aided by his access to these medications in quantities not known or controlled by any one doctor.

118. It is for that reason that a number of coronial findings over the last three years have highlighted the need for a system of real time prescription monitoring to improve coordination of care in situations where multiple medical practitioners are engaged in prescribing a variety of changing medications for the same patient.[62]

119. In making this comment, I acknowledge that, while Ms Patterson appears to have been sedated with clonazepam and zolpidem at the time of her death and while Mr Patterson had also consumed a combination of alcohol, clonazepam, zolpidem and opiods, neither Mr Patterson nor Ms Patterson died as a direct result of drug toxicity. Further, at the time that Mr Patterson shot himself and his wife, it appears that only one doctor, his rehabilitation physician, was prescribing him clonazepam, fentanyl and zolpidem. Both of his GPs had ceased to prescribe these medications some months earlier.

Clear diagnosis and treatment of mental health issues

120. Mr Patterson did not have a clear mental health diagnosis at the time of his death. Many opinions had been proffered and the possibility of an underlying brain injury had also been repeatedly raised. All the doctors who assessed and/or treated Mr Patterson were forced to do so in a vacuum. They had no or very limited information from family and friends, they appear to have been rarely furnished with a complete record of previous reports and assessments, and Mr Patterson was unwilling to speak about matters beyond his crashes and their direct impact on him. Furthermore, the majority of the assessments conducted on Mr Patterson were for the purposes of evaluating: the reasonableness of his claims for treatment and medication; his ability to return to work; and his eligibility for an impairment benefit. This undoubtedly impacted on Mr Patterson's openness and presentation at these consultations.

121. While Mr Patterson appears to have left several medical practitioners with a feeling of disquiet about the status of his mental health, nobody appears to have had the relationship or

[62] See for example the list of previous findings referenced at paragraph 26 of finding with Inquest into the Death of Paul Kanis, COR 20120367, delivered by Coroner Jacinta Heffey on 17 December 2014.

leverage with Mr Patterson necessary to convince him to effectively address his mental health issues, whatever their precise origin or nature.

122. There is evidence that Mr Patterson's mood was monitored by his medical practitioners on an ongoing basis. However, over a period of many years he consistently reported at consultations that, despite various interventions and medications, he was without any significant improvement physically and mentally. In that context (i.e. a reported history of unrelenting, unresponsive chronic pain and associated despair), it may have been difficult to detect any escalation in the severity of his psychological distress. Certainly, no concerns about a marked change in Mr Patterson's presentation and associated risks were noted by his GP or rehabilitation physician when they saw him in the weeks preceding his death.

123. I consider that Mr Patterson may have been suffering from an undiagnosed mental health disorder and that the fact that it was not definitely diagnosed and effectively treated that disorder may have increased the risk that Mr Patterson posed to both himself and his wife. However, even non-diagnosis and non-treatment in this sense, while regrettable, cannot be attributed to any specific shortcoming in his medical care.

Firearm Licensing

124. At the time of Ms Patterson's death, Mr Patterson had two firearms registered in his name. He had been holder of a category A and B long arm licence since 31 December 1975, with his most recent licence issued in 2008. On that basis, any issues identified with the licensing process clearly were not temporally proximate to the death. Nonetheless, the fact remains that a firearm was the means utilised by Mr Patterson to realise his homicidal and suicidal intentions and reducing access to means has long been considered an important aspect of harm prevention strategies. On that basis I make the following observations.

125. Possession and use of firearms in Victoria is regulated under the *Firearms Act 1996 (Vic)* (the Firearms Act). The Firearms Act provides for a firearms licensing system, administered by the Licensing and Regulation Division (LRD) of Victoria Police on behalf of the Chief Commissioner of Police. The provisions of the Firearms Act are designed to ensure, inter alia, that:

a. only those who can demonstrate a specified category of need for possessing a firearm should be licensed to have one; and

b. the Chief Commissioner only issues a licence where he or she is satisfied that:

   i. the applicant is a fit and proper person;

   ii. the applicant can possess, carry and use a firearm without being a danger to public safety or peace; and

iii. the issue of license is not against the public interest.

Genuine reason for applying for a licence

126. Pursuant to section 10 of the Firearms Act, a category A or B long arm firearm licence should only be issued to a person who can demonstrate that the firearm is required for: sport or target shooting; hunting; primary production; the occupation of security guard or prison guard; or an official, commercial or prescribed purpose or for a purpose authorised by an Act or regulations.

127. Mr Patterson had no apparent need of a firearm. He was unemployed, lived in a suburban, residential property, and was not a member of any shooting club. His family did not recall him using the guns he owned and the second rifle located by the police in the firearms safe at the property was described as in new condition.[63] Nonetheless, Mr Patterson declared in Part 2 of his Licence Renewal Application, that the licence was required for "hunting".[64]

128. Subsection 10(2)(b) of the Firearms Act lists the types of evidence that must be submitted to support a claim that a licence is required for "hunting". Mr Patterson relied on 10(2)(b)(v) which states that an applicant may demonstrate that a licence is required for hunting by "providing written permission to hunt pest animals on Crown land, from the Secretary to the Department of Natural Resources and Environment or from any person nominated by the Secretary to give that permission". Mr Patterson obtained such a letter and attached it to his application.

129. The issue with this subsection is that it does not appear that permission is in fact required to hunt pest animals on Crown Land - a current firearms licence is all that is necessary. As a result, the relevant Department[65] will issue a letter to a person, for the purposes of satisfying section 10(2)(b)(v) of the Firearms Act, upon request and payment of a small fee. There is no apparent scrutiny or screening.[66]

130. The result, in practice and as demonstrated in Mr Patterson's case, appears to be that the current firearms licensing scheme does not necessarily limit firearm possession to those with a demonstrated, specified need, but rather limits possession to those with a self declared (but otherwise unsubstantiated) specified need.

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[63] Coronial Brief Neil Patterson pp 5 and 105.
[64] Coronial Brief Neil Patterson p.81.
[65] I understand that the current Department is the Department of Environment, Land, Water & Planning.
[66] Hunting and Game Management Action Plan, p. 14 available at:
http://www.depi.vic.gov.au/__data/assets/pdf_file/0005/281624/Hunting-and-Game-Management-Action-Plan.pdf

131. I invited the Chief Commissioner of Police to comment on this observation. In a statement provided in reply dated 6 August 2015, Senior Sergeant (Snr Sgt) David Pinner of the Licensing and Regulation Division of Victoria Police, stated that:

> *In circumstances where the governing legislation clearly specifies that written permission from the Secretary to hunt pest animals on Crown Land is sufficient documentary evidence to demonstrate a reason for applying for a Category A or B Longarms licence, it is not the general practice of the Chief Commissioner of Police to require further evidence from an applicant demonstrating their interest in hunting or to investigate the circumstances of the applicant to determine whether they hold such an interest. To do so would place a heavy burden on the resources of the LRD given the volume of licence applications and renewal applications received each year.*
> *However, if the LRD were to receive information that an applicant sought a licence for a reason other than the reason stated in their application, then the applicant may be required to provide further information in relation to their circumstances and/or their application for a licence or licence renewal may not be granted.*

132. No criticism can be levelled at the LRD for administering a firearms licensing regime in compliance with the terms of the Firearms Act. Nonetheless, I consider that it is still appropriate to comment that in practice, and as demonstrated by this case, the requirements of the Firearms Act sometimes create little more than a veneer of rigour to the licensing regime.

Disclosure of mental health issues

133. The other aspect of Mr Patterson's licence application which warrants comment is the documentation that was required to address any concerns that may have arisen from Mr Patterson's mental health issues.

134. In his most recent licence renewal Application (made in July 2008), Mr Patterson had self-disclosed, in response to a direct question in the application form, that he had been treated for "psychiatric, depression, stress or emotional problems" since his last license renewal application.[67] This did not automatically render him ineligible to hold a license. Although, it raised the possibility that he might not be a fit and proper person to hold a firearms licence and that his possessing a weapon may be a safety risk.

135. Having made this declaration in his application, Mr Patterson was required to attach a letter from his treating doctor endorsing his suitability to hold the license. The endorsement letter was authored by his GP and stated only that he was treating Mr Patterson for his back injury.[68] The letter made no mention of the nature of Mr Patterson's psychiatric or emotional problems, nor how they had been or were being managed. At the time of application, Mr Patterson was attending appointments with psychiatrist, Dr Kernutt. Prior to that he had

[67] Coronial Brief Neil Patterson p.82.
[68] Coronial Brief Neil Patterson p.84.

attended several sessions with psychologist Dr Stanford. He was also under the supervision of rehabilitation physician Stephen De Graaff, at whose direction the referral to both Dr Kernutt and Dr Stanford had been made. There was no mention of these other members of Mr Patterson's treating team in the endorsement letter, and no indication that they had been consulted or provided an opinion on the license application.

136. Nonetheless, the brief letter provided appears to have been sufficient to have satisfied the Chief Commissioner of Police that, notwithstanding Mr Patterson's generically declared mental health issues, it was appropriate to renew his firearm licence.

137. I also invited the Chief Commissioner of Police to comment on these observations. In reply Snr Sgt Pinner of the LRD of Victoria Police advised of a number of significant changes in the application process where an applicant has a known mental health issue. These include:

a. The publication of revised Standard Operating Procedures which specify the matters which must be addressed in a report from a medical practitioner provided in support of an application; and

b. The introduction of a publically available guideline document for health professionals which is designed to assist health professionals in understanding their role in the firearms licensing regime, including by providing direction on the type of information that is required to be included in a medical report provided in support of an application;

c. The introduction of a standing instruction that the Senior Sergeant attached to the LRD must assess any applications where the applicant disclosed that they have suffered from a mental health problem, with a view to ensuring a more consistent approach to assessing application across the LRD;

d. The introduction of a practice of requesting that an applicant provide a report from a relevant qualified psychologist (and not just a general practitioner) where there are suitability concerns relating to mental health issues raised by their application;

e. An increased amount of liaison between the LRD and Police Medical Officers which includes advice to assessors to approach the Police Medical Officer for comment and advice where a medical report is not clear on its face and/or requires any degree of interpretation for a lay person to understand;

f. The introduction of variable licensing periods for individual's with mental health issues so as, where appropriate, the applicant is subject to reassessment more often; and

g. The introduction of the use of special conditions for individual with mental health issues in certain circumstances.

138. Snr Sgt Pinner indicated that if a renewal application, such as that submitted by Mr Patterson in July 2008, was received today, it would be expected that an assessor at the LRD would not accept a medical report of the type provided as sufficient evidence of his medical suitability to hold a licence. This is because it does not state the specific nature of the mental condition suffered as required by the current Standing Operating Procedures. He further indicated that as a result of the publication of the Guideline document for health professionals, it would be expected that the medical report would contain more detailed information, such as the nature of the condition and its treatment, including medication and likely impacts.

139. I am pleased to note the many improvements that have been introduced to the process for assessing suitability to hold a firearm licence where a person has a known history of mental ill health. These changes may not have impacted on the ultimate outcome of Mr Patterson's license renewal application in 2008. However, had the current assessment process, with its greater level of scrutiny, been in place in 2008, the community could at least have been assured that the decision to renew Mr Patterson's licence, at the time it was made and irrespective of the tragedy that followed, was an appropriately considered and informed one from a mental health perspective.

Police response to Megan Patterson's call

140. Megan Patterson called police between 6.30 and 7.00a.m on the morning of 7 January 2013 because she was concerned about her parents. The evidence indicates that Ms Patterson was likely already deceased at the time the call was received.

141. The call was diverted from Port Arlington Police Station, which did not open until 8.00am, to the Geelong Police Station where it was answered by SC Pikkert. Megan advised SC Pikkert that she was worried about her parents as she was unable to get in contact with them and had been trying to call her mother throughout the night. She advised that her father had visited her home the previous evening and had left envelopes with her and her brother's names on them with money inside. Megan described the visit as very unusual.

142. SC Pikkert asked Megan why she didn't go and check on her parents. Megan explained that she lived in Melbourne and they were in Indented Head. Megan sought her advice.

143. SC Pikkert advised Megan that she could call the nearest police station, Port Arlington, and get them to do a welfare check on her parents if that is what she wanted. She advised that it opened at 8.00am and provided the number. SC Pikkert asked Megan how worried she was for her parents. Megan replied that she had rung her brother overseas to tell him what was going on. Megan reported that she was pretty worried as it was really unusual for her Dad to

come all the way to her house to do that. SC Pikkert then advised Megan that if she believed that it was more urgent, she could contact the Bellarine Police Station and request them to do a welfare check because they were already on duty. The number was provided.

144. SC Pikkert was not made aware of a history of family violence between Megan's parents. She was not made aware of any general health or mental heath concerns in relation to either parent. She was not made aware that Mr Patterson had two licensed firearms.

145. SC Pikkert did not ask Megan direct questions about the basis of her concern for her parents, beyond the information volunteered about her father's unusual visit and her inability to contact them overnight. In particular, SC Pikkert did not ask any questions about whether there was a history or risk of family violence or mental ill health.

146. I understand from SC Pikkert's supplementary statement and the submissions made on her behalf[69] that, in questioning Megan about why she had not attended her parents' house herself and about her level of worry for her parents, SC Pikkert's intention was to give Megan an opportunity to talk further about the reasons for her concern. SC Pikkert stated that, in asking these questions, she was seeking to gather information that would assist her in assessing whether there was a need for immediate police attendance.

147. While I accept that this may have been her intention, I consider that ideally a member in SC Pikkert's situation would also ask more directed questions to assist the caller in providing information which may be pertinent to the member's assessment of the appropriate response. Where a caller has expressed concern for both their parents following an unusual visit from their father the previous evening and an inability to contact either parent overnight, I consider that it would be appropriate, for example, to question the caller directly about any history of family violence and mental ill health in order to explore the basis of and context for the concern. I acknowledge that, in this case, it is not clear whether further directed questions would have necessarily elicited any additional information.

148. As I see it, this view is consistent with the advice received from the Chief Commissioner of Police that members are expected to approach all reports and requests made to police from members of the public by:

a. Obtaining information from the reporting person about the nature, reason and background for the request; and

b. Based on that information and having regard to all of the circumstances (including but not limited to resourcing issues and the relative urgency of actioning the report), make a

[69] Letter from Russell Kennedy Lawyers dated 19 October 2015.

decision as to the most appropriate strategy or course of action to adopt in response to the request.[70]

149. The Chief Commissioner of Police has submitted that as a result of significant developments and improvements made to Victoria Police family violence policy and procedure in recent times, the vast majority of police members are now generally more aware of the need to pro-actively consider and respond to reports made by members of the public that may potentially involve family violence. It was indicated that with these improvements it would now be expected that a member in SC Pikkert's position would question Megan about any history of family violence as part of the risk assessment and this would be factored into account as to the appropriate course of action to take.[71]

150. Based on the information that *was* provided to her, SC Pikkert made an assessment that the attendance of Victoria Police organised by her, either via 000 or some other means, at Ms Patterson's address was not required at that time. This assessment was made in a context in which SC Pikkert did not understand Megan to be requesting police attendance for a welfare check. SC Pikkert understood Megan to be seeking advice only. It was in response to that general advice request that information was provided about contacting Port Arlington Police Station for a welfare check or, if she thought it was more urgent, Bellarine Police Station. SC Pikkert stated that she was left with the impression that Megan would call one of those two police stations in the next hour or so because she did not request anything further of SC Pikkert. The way in which the call ended SC Pikkert did not think that Megan was dissatisfied with that outcome. [72]

151. I have already noted above that there is a difference in recollections about this telephone conversation. Megan recalled in her statement that she had said she would like a welfare check done, that she had been asked how urgent it was and was told that there was no one to do it. She recalled that she was then told to contact the local police station at Port Arlington. Megan felt belittled and rejected and couldn't face calling Port Arlington Police Station.

152. I did not call either Megan or SC Pikkert to give oral evidence because I considered that it was unlikely, given the passage of time and the nature of the disparity in their recollections, that it would be satisfactorily resolved. Further, I was mindful that the evidence indicated that Ms Patterson was likely already deceased at the point the phone call was made.

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[70] VGSO letter, para 11.
[71] VGSO letter, para 34 -35.
[72] Supplementary Statement of SC Pikkert at [5].

153. In all the circumstances, I consider that the most appropriate comment I can make is that it is regrettable that there appears to have been such a misunderstanding between the parties to the call about its purpose and resolution.

154. I had foreshadowed to all interested parties that I was minded to make a recommendation that where a person contacts a police station out of hours to express concern for the safety or welfare of another, and that call is diverted to a second, open station, Victoria Police should assess the call in the ordinary manner, determine whether police attendance is warranted (including for the purpose of a welfare check) and ensure that a job is created and allocated accordingly.

155. There was no objection to a recommendation in these terms from the Chief Commissioner of Police. It was indicated that it is not inconsistent with Victoria Police Policy and Procedure which accepts that it not the responsibility of a person making a report to police to phone around or phone back in order to coordinate a response in circumstances where police attendance is warranted.

156. Notwithstanding the suggestion that a recommendation as proposed may be somewhat redundant, I consider that there is still utility in clearly iterating the appropriate response to a call made to police in circumstances such as the present. I have therefore made a recommendation in terms similar to those foreshadowed.

RECOMMENDATIONS

Pursuant to section 72(2) of the *Coroners Act 2008*, I make the following recommendations connected with the death:

Chief Commissioner of Police

1. I recommend that Victoria Police members should be advised that where a person contacts a police station out of hours to express concern for the safety or welfare of another, and that call is diverted to a second, open station, Victoria Police should:
   a. assess the call in the ordinary manner, including by obtaining information from the reporting person about the nature, reason and background for the report or request;
   b. determine whether police attendance is warranted, including for the purpose of conducting a welfare check; and
   c. if it is assessed that police attendance is warranted, ensure that a job is created and allocated accordingly, without requiring the caller to phone around or phone back to coordinate a response.

Pursuant to section 73(1) of the ***Coroners Act 2008***, I order that this finding be published on the internet.

I extend my sincere condolences to the family and friends of Ms Leanne Patterson.

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

Mr Darren Patterson, Senior Next of Kin

Ms Megan Patterson, Senior Next of Kin

Chief Commissioner of Police

Senior Constable Pikkert

Dr Emmanuel Nnopu

Detective Senior Constable Liana Goonan, Victoria Police, Coroner's Investigator

Signature:

JUDGE IAN L. GRAY
STATE CORONER
Date: 16/11/15.