IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 5884

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

*Section 67 of the **Coroners Act 2008***

INQUEST INTO THE DEATH OF CHRISTOPHER WINSBOROUGH GEORGE

Deceased:	Christopher Winsborough George
Date of birth:	13 June 1990
Date of death:	22 November 2018
Cause of death:	I(a) Gunshot wound to the head
Place of death:	28 Taig Road, Axedale, Victoria, 3551
Findings of:	Coroner Jacqui Hawkins
Delivered on:	18 July 2019
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street Southbank, Victoria, 3006
Counsel Assisting the Coroner:	Ms Jo Wilson, Principal In House Solicitor, Coroners Court of Victoria

CORONER HAWKINS:

SUMMARY OF INQUEST

1. On 22 November 2018, Christopher George sent a series of text messages to his friend and threatened to take his own life. Police were notified and attended his home address at 28 Taig Road, Axedale. At some stage during the afternoon, whilst police were attempting to communicate with Mr George, who had previously obtained a firearm, shot himself causing fatal injuries.

2. A coronial inquest was held on 18 July 2019 to gain a better understanding of the circumstances surrounding Mr George's death.

BACKGROUND

3. Mr George was 28 years old when he died. He was the son of Sue and the late David George and the brother of Aleecya and Nick.

4. He left school in year 11, became a qualified carpenter and was studying for his builders' license.

5. Mr George had a past medical history of major depressive disorder, suicidal thoughts and self-harm. His General Practitioner, Dr Moe Zaw Lin referred Mr George to several psychologists, however he rarely attended his scheduled appointments.

6. In April 2014, Mr George consulted with Dr Surya Tipimeni, Consultant Psychiatrist, who diagnosed him with persistent mild depression and Cluster B personality, with a significant family history of suicide, namely the suicide of his father in 2003, when Mr George was aged 13. Mr George also attended a consultation with Dr Keflemariam Yohannes, in May 2014, who diagnosed him with major depressive disorder and persistent depressive disorder.

7. In approximately 2014 or 2015, following the breakdown of a long term relationship, Mr George began to regularly leave suicide notes around his then house in Sunbury, which were subsequently found by his mother.

THE PURPOSE OF A CORONIAL INVESTIGATION

8. Mr George's death was reported to the Coroner as it fell within the definition of a reportable death of the *Coroners Act 2008* (Vic) (**Coroners Act**). Specifically, pursuant to section 4(2)(a) as defined in the Coroners Act, the death of a person is reportable if the death appears to have been unexpected, unnatural or violent.

9. The role of a coroner is to independently investigate reportable deaths to establish, if possible, the identity of the deceased, the medical cause of death and with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The law is clear that coroners establish facts; they do not lay blame or determine criminal or civil liability.[1]

10. The cause of death refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

11. The circumstances in which death occurred refers to the context or background and surrounding circumstances of the death. It is confined to those circumstances that are sufficiently proximate and causally relevant to the death.

12. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[2] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

13. 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 prevention role.

14. Coroners are also empowered to:

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

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

    (c) 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.

15. 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

---

[1] In the coronial jurisdiction facts must be established on the balance of probabilities subject to the principles enunciated in *Briginshaw* v *Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[2] *Keown v Khan* (1999) 1 VR 69

Briginshaw v *Briginshaw*.[3] 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.

16. In writing this Finding, I do not purport to summarise all the evidence but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity.

CORONIAL INQUEST

17. The circumstances of Mr George's death require a mandatory inquest. Pursuant to section 52(2)(b) of the Coroners Act, a coroner must hold an inquest in circumstances where the death occurred in Victoria and the deceased was, immediately before the death, a person placed in custody or care. A "person placed in custody or care" is defined in section 3(1)(j) of the Coroners Act as "a person who a police officer is attempting to take into custody". The evidence is that on 22 November 2018, the police attended Mr George's home to conduct a welfare check to provide assistance and to potentially take him into custody for the purpose of having him admitted and assessed in hospital.

18. A coronial inquest was held on Thursday, 18 July 2019 to assist me to determine the identity of the deceased, the cause of death and the circumstances surrounding the death.

19. Victoria Police assigned Detective Sergeant Ivan Bobetic to be the Coroner's Investigator for the investigation into Mr George's death. Sergeant Bobetic conducted inquiries on my behalf and compiled the coronial brief which included witness statements and photographs.

20. At the inquest, Sergeant Bobetic gave *viva voce* evidence and outlined his investigation and the surrounding circumstances of Mr George's death.

IDENTITY OF THE DECEASED

21. Christopher George was visually identified by his mother, Sue George, on 29 November 2018. Identity was not in issue and required no further investigation.

MEDICAL CAUSE OF DEATH

22. On 26 November 2018, Dr Melanie Archer, Forensic Pathologist at the Victorian Institute of Forensic Medicine (**VIFM**) performed an autopsy on the body of Mr George and reviewed the Form 83 Victoria Police Report of Death, the post mortem computed tomography (**CT**) scan,

[3] (1938) 60 CLR 336

the Section 27 Form – Request by the Homicide Squad for an Autopsy to be conducted, scene photographs, preliminary examination report, VIFM contact log and Ambulance Victoria notes.

23. Dr Archer found a gunshot entrance wound to the roof of the mouth. The projectile passed through the floor of the skull anteriorly, with the projectile creating a wound track upwards and slightly backwards to the parietal region of the skull. The gunshot wound caused considerable damage to the brain, which Dr Archer considered would have resulted in rapid unconsciousness and death.

24. Toxicological analysis of post mortem blood detected the presence of sertraline which was consistent with therapeutic use and glucose was also detected.

25. Dr Archer provided an opinion that the medical cause of death was 1(a) GUNSHOT WOUND TO THE HEAD.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

26. The purpose of the inquest was to understand the circumstances which led to Mr George's death.

27. In early 2018, Mr George started a relationship with Sarah Bol, a friend he had known for about three years, eventually moving in together.

28. In May 2018, Mr George attended the Goonawarra Medical Centre and saw general practitioner, Dr Lin, who provided him with a prescription for sertraline, an antidepressant medication. Mr George's partner, Ms Bol, reported that he would occasionally forget to take his medication for a day or two, and would sometimes cease using his medication for periods of up to one month. Ms Bol stated that when Mr George did not use his medication, he would experience low moods, stress and suicidal ideation.

29. It appears that Mr George was struggling financially, and in order to save money, he and Ms Bol moved into his mother's home in early October 2018.

30. On the night of 19 or 20 November 2018, Mr George and Ms Bol argued. The following day, Ms Bol returned to her own family home to clear her head and reassess her relationship with Mr George. Ms Bol explained this to Mr George, who understood that she was leaving for a period of time.

31. Mr George and Ms Bol remained in contact by text message and Facebook and Mr George expressed that he thought that their relationship was over. Ms Bol reassured him that their

relationship would continue, but that she needed time. After approximately one day, Mr George began to express suicidal ideation and planning.

Day of the incident – 22 November 2018

32. At around midday on 22 November 2018, Mr George sent a text message to his mother and said that he had "*entered a spiral, can't get out, might not make it*", followed by a text message a short time later to reassure his mother that his mood had improved.

33. Mrs George received several text messages from Ms Bol around the same time, which stated that out of concern for Mr George, she had contacted the police and requested they attend the Axedale property to conduct a welfare check on Mr George. Ms Bol told Mrs George that Mr George had said that he had a gun. Mrs George thought that this was strange as she believed the guns owned by the family were in storage.

34. Mrs George finished work at approximately 1.00pm and drove to Axedale. She called Mr George and was on the phone to him when she arrived home to find police were already in attendance at the property.

Police response to the incident

35. At 12.50pm, police officers Leading Senior Constable (**LSC**) Dan O'Bree and LSC Karl Kerschbaumer received a request from the Emergency Services Telecommunications Authority (**ESTA**) to attend at 28 Taig Road, Axedale in relation to a male who had threatened suicide. They conducted a LEAP check on Mr George which did not reveal anything of note.

36. On the way to the job, LSC O'Bree telephoned Ms Bol who advised that Mr George had threatened to hang himself. According to LSC O'Bree, she did not disclose any information about any firearms or other dangers.

37. On arrival at the property in Axedale, at approximately 1.24pm, LSCs O'Bree and Kerschbaumer searched the property for Mr George and located him by looking through a window in a small metal shed. The police officers reported that Mr George was holding a firearm in his left hand. It was a longarm firearm and he was holding it by the middle section with the barrel pointed at the roof.

38. The two officers immediately retreated to a safe position behind a trailer, approximately 20 metres from the shed. LSC O'Bree requested Mr George to put the gun down and come out of the shed. LSC O'Bree told him that they were there to help him work through his problems.

Mr George did not reply. The two officers withdrew from the scene to the front of the property and requested police back up, whilst keeping watch of the shed.

39. LSC O'Bree contacted Mrs George and asked about Mr George's access to a gun. She advised that she thought they were at the gun dealer in Sunbury. Police attempted to contact Mr George on the phone, but he continued to not respond.

40. At 1.45pm, Sergeant Luke Kinder and Sergeant Greg Gentry arrived and took charge of the scene. Sergeant Kinder confirmed that the Critical Incident Response Team (**CIRT**) had been contacted and were on their way.

41. At 2.12pm, an arrest plan was discussed with all police members present. Duties were allocated, and contingency plans were discussed which included establishing a cordon and command post at O'Keefe Rail Trail and Taig Road, Axedale.

42. At 2.36pm, Senior Constable (**SC**) Chris Sommers, a CIRT Negotiator, who was on his way to the scene, attempted to speak to Mr George on the phone, but he refused. S/Sergeant Jo-Anne Jeffrey, who was with Mrs George, put her phone on speaker so that Mrs George could speak directly with SC Sommers. SC Sommers spoke with Mrs George who then relayed information to her son via the Facebook Messenger application. She confirmed that Mr George refused to speak to police and was in possession of a firearm. He told his mother that he felt trapped in the situation and that there was no way out. He said he was experiencing a depressive episode and had not been taking his prescription medication. His mother informed police that he was speaking calmly. He informed Mrs George that other factors that were causing him to be upset included his father's suicide, the fact that his firearms licence had not been renewed and his recent relationship problems with Ms Bol.

43. According to SC Sommers, communicating with Mr George via his mother was difficult because he could not hear Mr George's responses. This meant that police were unable to gauge his demeanour, tone or have an appreciation of the full conversation or the effectiveness of the strategies being used. Mr George continued to refuse to speak to police. In the circumstances, it was agreed to continue to allow Mrs George to speak to her son because it was apparent that she had established a good rapport, he was calm, and she had the added protection of the police presence if the situation were to change.

44. At approximately 3.30pm, SC Sommers sensed that Mrs George became more anxious and there was a sense of urgency in her voice. Mr George was encouraged to put the firearm down and walk out of the shed, unarmed, where he would be met by police. He refused to do this. Mrs George also told her son to put the gun down. A short time later the call ended after

59 minutes. Mrs George attempted to contact her son several more times however there was no response. She asked police if she could go to the shed and speak to her son, however due to the high risks involved, she was not permitted to do so.

45. At about this time, the shed door, which had been slightly ajar the whole time, was closed. At approximately 4pm, Sergeant Gentry, who was watching the shed, heard five rhythmic thumps, which he thought may have come from the direction of the shed. The sound reminded him of hammering, but it was difficult for him to establish the direction from which it had come.

47. At approximately 4.15pm, the CIRT arrived. Ambulance Victoria were requested to attend the scene and be on standby. At 5:05pm, S/Sergeant Rebecca Marshall, the CIRT Commander, arrived and took control of the scene. S/Sergeant Marshall said that she conducted multiple risk assessments and regularly communicated with other members about the plan. A 'Bearcat' armoured vehicle was placed in close proximity to the shed where Mr George remained. The CIRT plan was to negotiate from inside the armoured vehicle to ensure the protection and safety of the CIRT members if Mr George engaged the firearm.

48. Communication efforts continued, however the police did not receive a response from Mr George. SC Sommers attempted to communicate with Mr George for approximately one hour. During this period there were no movements inside the shed, no noises, no signs of life or any acknowledgement by Mr George.

49. At approximately 5:50pm, command and control of the scene was handed over to the Special Operations Group (**SOG**). Shortly after, the SOG deployed a 'RamCam' robot into the shed, which allowed a live stream of vision from within the shed. Police observed Mr George slumped on the ground next to a rifle and noted that blood had collected underneath his head and that he was obviously deceased. Police members entered the shed and secured the scene before allowing paramedics to enter, who subsequently pronounced Mr George deceased.

Coronial investigation

50. Due to the death occurring in police presence, the Homicide Squad attended the scene and later assigned the coronial investigation to Detective Sergeant Bobetic and he commenced compiling the coronial brief of evidence, including obtaining witness statements and photographs of the scene.

51. Mrs George stated that the family owned four firearms. The firearm found next to Mr George in the shed was a Stevens 56C .22 calibre rim fire rifle with a serial number P167. This

firearm was registered to Mr George. The firearm and an expired .22 calibre cartridge located at the scene were examined by LSC Paul Griffiths, a ballistics expert at the Victoria Police Forensic Services Centre. The expired round was found to have been fired from the rifle located at the scene.

52. Mrs George said that a number of firearms were passed down to her from her parents. She said that all the guns were registered to Mr George. She believed that the four firearms were securely stored in a gunsafe in the shed at her property in Sunbury. Mrs George said that there were two sets of keys and they were stored in boxes, but that she had misplaced them when they moved from Sunbury to Axedale.

53. Senior Sergeant Andrew Armstrong reviewed the records held by the Licensing and Regulation Division of Victoria Police and identified that on 22 November 2018, Mr George was the holder of a Category A & B firearm licence that had expired on 11 September 2018. The records confirmed that he had four firearms registered to him at the time. S/Sergeant Armstrong commented that when a firearms licence expires, and firearms are attached to that licence, a notification is made to the local Divisional Firearms Officer (**DFO**) who has the task of contacting the firearm's owner and ensuring that the firearms are either handed into the police station or ownership is transferred. A notification that Mr George's firearm licence had expired was made to the local DFO, SC Claus Othier, on 5 October 2018. However, due to a high workload, at the time of Mr George's death, SC Othier had not personally been in contact with Mr George.

54. In an email to the Coroners Court on Monday 20 May 2019, Mrs George advised that she and Mr George had submitted paperwork to transfer ownership of the firearms into her name, but the transfer had not been completed.

55. Having now considered all of the evidence I am satisfied that no further investigation is required.

FINDINGS

56. Pursuant to section 67(1) of the *Coroners Act 2008*, I make the following findings connected with the death:

    (a) the identity of the deceased was Christopher Winsborough George, born on 13 June 1990;

    (b) Mr George died on 22 November 2018, at 28 Taig Road, Axedale, Victoria, from 1(a) *Gunshot wound to the head*;

(c) in the circumstances described above.

57. There appears to have been multiple stressors present in Mr George's life in the years prior to his death including his father's suicide, mental ill health, previous suicidal thoughts, financial hardship and a relationship breakdown. Having considered all of the evidence, I am satisfied that Mr George intended to end his own life. I am unable to determine the approximate time Mr George took his life, however, I find that it was in the presence of Victoria Police.

58. Having reviewed and considered all of the evidence, I am satisfied that the Victoria Police response was reasonable and appropriate in the circumstances, particularly given Mr George was armed with a firearm and the risk that presented to Mrs George and the other police officers in attendance at the scene.

59. I wish to express my sincere condolences to Mrs George and her family. I acknowledge the unbearable grief and devastation that you have endured as a result of the losses of both your husband and your son.

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

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

Mrs Sue George;
Victoria Police, Professional Standards Command;
Victoria Police, Civil Litigation Division;
Information recipients; and
Detective Sergeant Ivan Bobetic, Coroner's Investigator, Victoria Police

Signature:

JACQUI HAWKINS
Coroner
Date: 18 July 2019