IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2020 0820

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Caitlin English, Deputy State Coroner
Deceased:	Mark Edward Elliott[1]
Date of birth:	24 January 1962
Date of death:	13 February 2020
Cause of death:	1(a) Shotgun wound to the neck
Place of death:	Victoria

[1] This Finding has been de-identified to protect the identity of the deceased's family members.

INTRODUCTION

1. On 13 February 2020, Mark Edward Elliott was 58 years old when he took his own life. At the time of his death, Mr Elliott lived in Victoria with his family.

THE CORONIAL INVESTIGATION

2. Mr Elliott's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent, or result from accident or injury.

3. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

4. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

5. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Elliott's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence. Although approached to provide statements, Mr Elliott's family declined.

6. This finding draws on the totality of the coronial investigation into Mr Elliott's death, including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

[2] 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.

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

Identity of the deceased

7. On 13 February 2020, Mark Edward Elliott, born 24 January 1962, was visually identified by his son.

8. Identity is not in dispute and requires no further investigation.

Medical cause of death

9. Forensic Pathologist, Dr Joanna Glengarry, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection on 17 February 2020 and provided a written report of her findings dated 18 February 2020.

10. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or any commons drugs or poisons.

11. Dr Glengarry provided an opinion that the medical cause of death was *"1(a) Shotgun wound to the neck"*.

12. I accept Dr Glengarry's opinion.

Circumstances in which the death occurred

13. As noted, Mr Elliott's family declined to provide statements to the coroner's investigator to assist my investigation. For this reason, I have received limited information about Mr Elliott's life and his frame of mind in the months leading to his death and the circumstances surrounding his death. However, I am satisfied that Mr Elliott was a prominent and successful lawyer who subsequently became involved in protracted and complex legal proceedings that affected his work and reputation, which must have in turn affected his mental health to some extent. There is no need for me to detail the intricacies of those proceedings here, but I will provide a brief summary to illustrate the enormity of the stressors affecting Mr Elliott at the time of his death.

14. Mr Elliott was the managing director of Elliott Legal, which specialised in class actions, and the managing director of Australian Funding Partners, which funded class actions. Mr Elliott oversaw the class action by some 16,000 investors against Banksia Securities, which settled for $64 million in 2018. Mr Elliott subsequently became involved in protracted legal proceedings regarding an application for Australian Funding Partners to be reimbursed for

legal costs and litigation funding commission. The Supreme Court subsequently appointed a contradictor to review the fees and the conduct of Mr Elliott and others who had worked on the class action. In December 2019, discovery was ordered which required the parties to produce relevant documents for the proceeding. On 10 February 2020, Mr Elliott instructed his lawyers that he had limited documents to discover because he had deleted most of his emails in line with his long-standing practice. On 12 February 2020, the contradictor asked for this information to be included in an affidavit to be sworn by Mr Elliott.[3] After Mr Elliott's death, proceedings were briefly adjourned. However, over the following months after Mr Elliott's death, the Supreme Court heard evidence and was satisfied that Mr Elliott and others had engaged in unconscionable conduct and deliberately misled the court regarding the basis of the legal fees incurred. The Honourable Justice John Dixon subsequently ordered damages to be paid by Australian Funding Partners and others to members of the group proceeding.[4]

15. While I have no information regarding Mr Elliott's mental state in the months and weeks leading to his death, his doctor provided a statement which set out the following.

16. On 7 January 2020, Mr Elliott attended his general practitioner, Dr Luke Dunne, at Epworth Freemasons in East Melbourne. He requested a repeat prescription for zolpidem[5] to assist with jet lag in anticipation of an upcoming trip to the United States. Dr Dunne subsequently prescribed 14 tablets with one repeat.

17. Mr Elliott returned to Dr Dunne on 4 February 2020 after returning from his trip. He informed Dr Dunne that he had lost the tablets and the prescription repeat and requested another prescription for future travel. Dr Dunne subsequently prescribed another 14 zolpidem tablets with no repeats and a prescription for antibiotics for a lingering respiratory infection. They also discussed Mr Elliott's high blood pressure readings and a plan was put in place for Mr Elliott to attend a cardiologist.

18. Dr Dunne explained that Mr Elliott had safely used sleeping tablets in the past and had been advised that they should not be combined with alcohol or other drugs under any circumstances. Dr Dunne stated Mr Elliott had never mentioned any work-related or other stress and had never reported any mental-health related symptoms. Dr Dunne advised that according

[3] *Bolitho v Banksia Securities Ltd (No 18) (remitter)* [2021] VSC 666.
[4] Supreme Court of Victoria, Summary of Judgment, *Bolitho v Banksia Securities Ltd (No 18) (remitter)* [2021] VSC 666, 11 October 2021.
[5] Zolpidem is a medication primarily used for the short-term treatment of sleeping problems.

SafeScript, there was no record of the replacement prescription provided on 4 February 2020 ever being dispensed by a pharmacy. The prescription provided on 7 January 2020 was dispensed at a pharmacy on the same day.

19. In the early hours of 12 February 2020, Mr Elliott was transported via ambulance to the Royal Melbourne Hospital with a decreased level of consciousness, which was attributed to excessive alcohol ingestion. His blood alcohol concentration level was measured at 0.12%. Mr Elliott reported to hospital staff that he had consumed alcohol, then a hypnotic, and further alcohol for insomnia. He was subsequently discharged at 11.00am the same day. It remains unclear how much medication Mr Elliott ingested and his intentions.

20. On the morning of 13 February 2020, Mr Elliott reportedly left the family home and drove to the family farm. Mr Elliott's family became concerned about his whereabouts and his sons went to the property to look for him.

21. His son subsequently found his father deceased at the southern boundary of the property. He had sustained a large wound to the right side of his neck. It appeared he had taken his own life with one of his firearms. Emergency services were contacted at 4.47pm and ambulance paramedics subsequently confirmed death.

22. Victoria Police found no evidence to indicate that any other person was involved in Mr Elliott's death.

23. I am satisfied that at the time of his death, Mr Elliott's mental health was affected by ongoing legal proceedings regarding his conduct in the Banksia Securities class action, which may have led to a recognition or suspicion that he would likely lose his career and be liable for significant damages. The same litigation was a significant factor in the death of another lawyer involved with the case.

FINDINGS AND CONCLUSION

24. Pursuant to section 67(1) of the Act I make the following findings:

    (a) the identity of the deceased was Mark Edward Elliott, born 24 January 1962;

    (b) the death occurred on 13 February 2020 in Victoria, from shotgun wound to the neck; and

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

25. Having considered all of the evidence, I am satisfied that Mr Elliott intentionally took his own life.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

1. The Victorian Suicide Register (**VSR**) is a database containing detailed information on suicides that have been reported to and investigated by Victorian Coroners between 1 January 2000 and the present.

2. The VSR indicates the annual frequency of suicides occurring in the state of Victoria has been steadily increasing for the past decade, from 550 deaths in 2011 to a peak of 731 deaths in 2020.[6]

3. The annual Victorian suicide rate for the period 2011 to 2019 ranged from 9.9 suicides per 100,000 people in 2011 to 11.0 suicides per 100,000 people in 2017.[7]

4. I note that the Coroners Prevention Unit[8] has identified 25 suicides of legal professionals in Victoria between 2011 and 2021.[9] This comprised of 15 males (60.0%) and 10 females (40.0%). The highest proportion of suicides were reported among those aged between 45 to 54 years with 10 suicides (40.0%). This was followed by the 55 to 64 group with nine suicides (36.0%), all of whom were males.

5. The primary purpose of gathering suicide data in the VSR is to assist Coroners with prevention-oriented aspects of their suicide death investigations. VSR data is often used to contextualise an individual suicide with respect to other similar suicides; this can generate insights into broader patterns and trends and themes not immediately apparent from the individual death, which in turn can lead to recommendations to reduce the risk that further such suicides will occur in the future.

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[6] Coroners Court Monthly Suicide Data report, November 2021 update. Published 22 December 2021.
[7] The annual suicide rate is the annual suicide frequency expressed as a proportion of the population in which the suicides occurred. The most common calculation for a crude rate is to divide the frequency of Victorian suicides by the overall population of Victoria in that year, then multiple by 100,000 (to produce the suicide rate per 100,000 people). For example, in 2011 there were 550 Victorian suicides and the population of Victoria at that time was estimated to be 5,537,817 people, so the rate was (550 ÷ 5,537,817) × 100,000 = 9.9 suicides per 100,000 people.
[8] The Coroners Prevention Unit (**CPU**) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.
[9] 2021 is year-to-date frequency to 30 September.

6. So much is still unknown about suicide and every suicide occurs in unique circumstances to a person's history and life experience. Through recording information about each individual suicide in the VSR, such as the method used as well as information about the health and other services with whom the person had contact, and then examining what has happened across time and across people, the VSR data can lead to new understandings of how people who are suicidal might better be supported in our community.

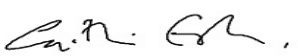
I convey my sincere condolences to Mr Elliott's family for their loss.

I am satisfied publication of this finding is in the public interest. Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Senior next of kin
[Specified family members]
Dr Luke Dunne
Senior Constable Jack Henderson, Victoria Police, Coroner's Investigator

Signature:



Caitlin English, Deputy State Coroner

Date: 23 February 2022

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.