IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference:

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Coroner Paresa Antoniadis Spanos
Deceased:	Mr HP[1]
Date of death:	26 May 2019
Cause of death:	1(a) Gunshot injury to the head
Place of death:	Ballarat, Victoria

[1] This finding has been de-identified in accordance with the family's wishes

INTRODUCTION

1. On 26 May 2019, Mr HP was 50 years old when he died of a self-inflicted gunshot injury. At the time of his death, Mr HP was single and lived at Ballarat with his dog.

2. Mr HP was described as a friendly and sensitive man who enjoyed camping and spending time with his dog. At the time of his death, he was a kiln attendant at a clay brick manufacturer. He was said to have been dissatisfied with this job and appears to have experienced ongoing anxiety in relation to his work duties.

3. Mr HP was diagnosed with depression in 2010 at which time a psychiatrist prescribed duloxetine, which he continued taking until his death. After this time, Mr HP's mental healthcare was otherwise managed by his general practitioner, Dr John Emmanuel.

4. In terms of medical conditions, Dr Emmanuel identified that Mr HP's ongoing excessive alcohol use was a concern. Mr HP's alcohol abuse had led to heart issues and in 2017 he had a cardiac defibrillator inserted. While he had periods of abstinence, it appears he had no intention of abstaining from alcohol. Later, Mr HP also developed mild pancreatitis and type 2 diabetes.

5. In the lead up to his death, Mr HP experienced a number of stressors which appear to have adversely affected his mental health. These included his beloved mother's recent declining health, the receipt of an eviction notice, and a possibility that Mr HP's dog was ill. Mr HP's sister noted that during the year preceding his death, he became vocal about threats to take his own life.

THE CORONIAL INVESTIGATION

6. Mr HP'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.

7. 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.

8. 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.

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

10. This finding draws on the totality of the coronial investigation into Mr HP'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]

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

Identity of the deceased

11. On 26 May 2019, Mr HP was visually identified by his friend, who signed a formal Statement of Identification to this effect.

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

Medical cause of death

13. Senior Forensic Pathologist, Dr Burke, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection on 27 May 2019 and provided a written report of his findings dated 28 May 2019.

14. The post-mortem examination results were consistent with a close range/ contact gunshot injury to the right side of the head.

15. Toxicological analysis of post-mortem samples detected ethanol (alcohol at 0.17g/100mL), duloxetine (an antidepressant), and bisoprolol (used to treat hypertension). The level of bisoprolol was detected at a level consistent with therapeutic use, but the level of duloxetine was slightly elevated. However, I note duloxetine is subject to post-mortem distribution, which makes it difficult to conclude whether a prescribed or higher amount was ingested by Mr HP before death.

16. Dr Burke provided an opinion that the medical cause of death was *"1(a) Gunshot injury to the head"*.

[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.

17. I accept Dr Burke's opinion.

Circumstances in which the death occurred

18. In the late evening of 25 May 2019, Mr HP was involved in a motor vehicle collision. Initially, Mr HP drove away from the scene and was later intercepted by Victoria Police members nearby. A preliminary breath test was conducted which indicated Mr HP's breath contained alcohol. He was subsequently taken to Ballarat Police Station where a further test returned a blood alcohol content of 0.158 g/100mL. As this was a level over three times the legal limit for a fully licenced driver, he was required to immediately surrender his driver's licence and his vehicle was impounded.

19. Vitoria Police members drove Mr HP home at approximately 12.55am of 26 May 2019. First Constable Jason Allen stated that Mr HP did not say anything about suicide or self-harm at any stage during their interactions that evening.

20. At 1.49am, Mr HP sent a text message to his friend, stating that he would lose his job and home because of the earlier vehicle collision. He also expressed an intention to take his life, saying he would take His dog with him.

21. Mr HP's friend did not read the text message until later that morning at about 8.00am and upon doing so, immediately attended Mr HP's house. When Mr HP's friend arrived, he found Mr HP and Mr HP's dog both deceased on the bed and called 000.

22. Responding police members observed Mr HP to have a serious head injury and located a modified revolver (registered to Mr HP) under his body. They concluded that Mr HP had shot His dog before turning the gun upon himself. They also observed an unlocked and open firearms' safe in the living area. Two guns registered to Mr HP remained in the safe. Additional parts of a firearm and ammunition were located on a table nearby.

23. A handwritten note on a calendar entry dated 28 April 2019 indicated Mr HP had spoken to his mother and told her of his intention to take his own life.

24. Sergeant Steven Murphy, Coroner's Investigator, noted that it appeared Mr HP was experiencing increasing physical issues related to his alcohol abuse and had no psychosocial supports in place to help. He was essentially estranged from most of his family and had access to firearms. His various stressors were also mounting, and it appeared that this, coupled with his usual coping strategy of excessive alcohol consumption, may have resulted

in him impulsively choosing to end his own life. This is a sound analysis of the available evidence and I agree with his conclusion.

Mr HP's firearms licence

25. Enquiries revealed that Mr HP had been first issued a firearm licence in June 1993 for the purpose of hunting and that this licence had expired in June 2004.

26. In September 2017, Mr HP was issued with a Category A & B Longarm Licence, again for the 'genuine reason of hunting'. This licence was due to expire in September 2022. The genuine reason for hunting was supported by an authorised Department of Environment, Land, Water and Planning registration of interest. However, Mr HP was described as an animal lover by his friends who could not imagine him hurting any animal. One friend noted that Mr HP confided in him that he only ever shot at trees.

27. Senior Constable Kim Calvert-Crosby of the Victoria Police Regulation Support Unit confirmed there were no adverse notes listed against Mr HP to indicate any concerns were held by the police as to his suitability to hold a firearm's licence.

28. Sergeant Murphy noted that for all firearm applications, new and renewals, the applicant is required to detail if they have had any medical history in the preceding five years that may affect their suitability to obtain a Victorian Firearms Licence. Categories include mental health concerns including depression, and alcohol problems. In his August 2017 application, Mr HP indicated that he had no such medical history.

29. In her statement, Mr HP's sister expressed surprise that her brother was able to obtain a firearms licence and wondered who his referee was and who would have certified his suitability. She was of the opinion that he should have been required to submit a medical report for this purpose.

30. Dr Emmanuel confirmed that Mr HP had never disclosed in their discussion that he had access to firearms. His treating cardiologist, Dr Wayne Childs, was also unaware that Mr HP had a firearms licence or access to firearms.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was Mr HP;

(b) the death occurred on 26 May 2019 at Ballarat, Victoria;

(c) the cause of Mr HP's death was gunshot injury to the head; and

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

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

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

COMMENTS

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

What the statistics tell us

34. As part of my investigation, I requested the Coroners Prevention Unit[3] (**CPU**) extract data from the Victorian Suicide Register (**VSR**)[4] regarding firearm-related suicides.

35. The CPU's research revealed that between 1 January 2009 and 31 December 2020, 418 Victorians had taken their own life using a firearm. Annual frequency ranged between 26 such deaths (in 2011) and 41 (in 2012 and 2019).

36. In relation to whether these persons held a firearm licence, the data revealed that out of 306 firearm suicides between 2009 and 2017, 125 people (or only 40.8%) held a Victorian firearm licence at the time of death. However, interpreting this is somewhat challenging because in a roughly similar number of deaths (106, 34.6%) the firearm licence status of the deceased was unknown.

37. Of the 125 people who held a firearm licence, 46 (or 36.8%) had been previously diagnosed with one or more mental disorders.

38. The VSR indicates the annual frequency of suicides generally has been steadily increasing for the past decade, from 550 deaths in 2011 to a peak of 711 deaths in 2020, then 694 deaths in 2021.[5]

[3] The CPU is staffed by healthcare professionals, including practising physicians and nurses. Importantly, these healthcare professionals are independent of the health professionals and institutions under consideration. They draw on their medical, nursing, and research experience to evaluate the clinical management and care provided in particular cases by reviewing the medical records, and any particular concerns which have been raised.
[4] Victorian Suicide Register 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.
[5] Coroners Court Monthly Suicide Data report, March 2022 update. Published 20 April 2022.

Previous coronial findings and recommendations

39. I and other Victorian coroners have previously investigated firearm-related suicides where the deceased has held an extant licence on more than one occasion.[6]

40. Some of those findings have focussed on the failure of a medical practitioner to alert Victoria Police to the licensee's medical or mental health condition.

41. I note that the *Firearms Act 1996* allows health professionals to provide certain information to the Chief Commissioner of Police in relation to a person's suitability to hold a firearm, without attracting criminal or civil liability, provided that the information is provided in good faith. The Victoria Police Licensing and Regulation Division (**LRD**) has also developed a guide[7] for health practitioners regarding how to notify Victoria Police if they feel a patient is not suited to possess firearms if they suspect the patient is a firearm licence holder or has or intended to apply for a firearm licence.

42. However, in Mr HP's case, the available evidence supports a finding that his treating practitioners were unaware that he held a firearms licence or indeed that he had access to firearms. As Mr HP's sister identified, the focus then shifts to how Mr HP was able to obtain a licence given his previous mental health diagnosis.

43. The current licensing regime does not require an applicant to 'prove' they are a fit and proper person to hold a licence. Rather, an applicant is asked to provide a yes/no answer to a series of questions regarding their medical and mental health history. If the applicant answers 'yes' to any of these questions, they must then obtain a medical report from a treating medical practitioner outlining their suitability to hold a firearm licence and possess firearms.

44. As I have previously noted in the Finding into the death of Robert James Lawrence, the current paradigm for the granting of firearms licences relies too heavily on the applicant being entirely honest and disclosing information against their own interest when they apply for a firearms licence. It does not proactively assess an applicant's suitability in a positive sense, rather it assumes suitability from the absence of history indicating unsuitability – a glaring issue that has not escaped other coroners.[8]

[6] My investigations include: Finding into Death Without Inquest regarding Raymond Jon Cox, COR 2014 2220, published 28 June 2018; Finding into Death Without Inquest regarding Robert James Lawrence, COR 2016 4995, published 6 April 2020.
[7] Quick Guide (Firearms): Information for role of the Health Professionals, Victoria Police.
[8] See for example Finding into Death With Inquest regarding Peter Quin-Conroy, COR 2010 3294, delivered 5 March 2013; Finding into Death Without Inquest regarding Neil Robert Patterson, COR 2012 0123, unpublished.

45. In the Finding into the death of AS,[9] Coroner Rosemary Carlin highlighted that the fundamental position remains that the individual applicant must self-report his or her mental health, or other medical condition, before Victoria Police will seek a report from a health professional as to that person's suitability to hold a firearms licence.

46. Her Honour was not persuaded by the arguments against requiring all applicants for a firearms licence to provide a supporting medical report (that is, that patients would forgo appropriate medical treatment and that it would be unduly onerous for medical practitioners).

47. Her Honour noted while it would take longer for applications with a medical report to be assessed, it would ultimately identify previously under-reported medical conditions, which was a desirable outcome. As her Honour noted:

> *The real burden of such a requirement would fall on the applicants as they would need to obtain and submit the medical report. This is a small price to pay for the privilege of holding a firearms licence.*
>
> *…*
>
> *A requirement that all applications for licences or renewals be accompanied by a medical report would serve the dual purpose of reducing under reporting by applicants and alerting health professionals to the fact a patient holds a firearms licence, a significant piece of information in the treatment of the mentally unwell.*

48. Her Honour therefore made a recommendation that the Victoria Police LRD give further consideration to amending its firearm licence application process to require all applicants to submit a report from a treating health professional as to their fitness to hold a firearms licence.

49. In August 2016, Chief Commissioner Graham Ashton responded to the recommendation and noted that the *Firearms Act 1996* did not support a request for a medical report upon application and a legislative change would be required before the recommendation could be implemented.

50. I note that Part 2 of the current *Firearms Act 1996* sets out the requirements, including the provision of information, which applicants must adhere to when applying for a firearm licence. A medical report of fitness from a current treating medical practitioner accompanying the application is not required.

[9] Finding into Death Without Inquest regarding AS, COR 2014 4172, published 11 March 2016.

51. Given the annual frequency of firearm-related suicide has remained generally unchanged, I intend to make a recommendation that the Secretary, Department of Justice and Community Safety consider this issue, including possible amendments to the *Firearms Act 1996.*

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

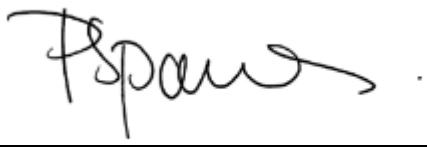
1. I recommend that the Secretary, Department of Justice and Community Safety consider the issues raised in this finding, including amending the *Firearms Act 1996* to require all firearm licence applicants to provide a medical report from a current treating medical practitioner setting out their medical history and factors relevant to their fitness/ suitability to hold a firearms licence and possess firearms.

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
Ms Rebecca Falkingham, Secretary, Department of Justice and Community Safety
Victoria Police Professional Standards Command
Victoria Police Licensing and Regulation Division
Sergeant Steven Murphy, Victoria Police, Coroner's Investigator

Signature:



Coroner Paresa Antoniadis Spanos

Date: 17 May 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