IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 007361

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	AT
Date of birth:	1982
Date of death:	20 December 2024
Cause of death:	1a : GUNSHOT INJURY TO THE HEAD
Place of death:	Lang Lang Victoria 3984
Keywords:	Suicide; Firearm; Family violence

INTRODUCTION

1. Victoria's firearms licencing regime is lax given the destruction potential of the regulated equipment, but unfortunately it is victims and survivors who frequently suffer the consequences of this, rather than firearms owners themselves.

2. On 20 December 2024, AT was 42 years old at the time of his passing. AT resided in Lang Lang, Victoria, 3984 with his partner, CK and their four children.

3. AT was born in Belgrade, Serbia and migrated with his family to Australia in 1988. AT completed his secondary studies in Hampton Park and enrolled with the Australia Defence Force (**ADF**) when he turned 18 years old. AT remained with the ADF for two years before leaving and completing a Diploma of English and Education.

4. AT worked as an Engineering teacher at Chisholm Tafe before joining Ringwood Secondary College in 2020. AT met his partner, CK in 2003 and the couple had three children together and CK had an older son from a previous relationship.[1]

5. AT was reported to have started using Ketamine when his mother passed away in 2010 and his substance abuse issues escalated during the COVID pandemic period in Victoria. AT was being treated by a clinical psychologist in June 2019 and was diagnosed with Adjustment Disorder and Depression. AT attempted to reduce his Ketamine use over the years and seek treatment but his behaviour continued to worsen in the lead up to his passing.[2]

6. In October 2024, AT was involved in a family violence incident with CK that was witnessed by their children.[3] A report was made to Child Protection services who investigated and required AT to complete a drug and alcohol test. AT remained sober during this period and Child Protection closed the investigation.[4]

THE CORONIAL INVESTIGATION

7. AT'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.

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[1] *Coronial Brief*, Statement of CR.
[2] Ibid.
[3] Department of Families, Fairness and Housing L17 portal and Child Protection records.
[4] Ibid.

8. 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.

9. 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.

10. Victoria Police assigned Senior Constable Kayla Gardner to be the Coronial Investigator for the investigation of AT's death. The Coronial 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.

11. This finding draws on the totality of the coronial investigation into the death of AT 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.[5]

12. In considering the issues associated with this finding, I have been mindful of AT's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

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

Circumstances in which the death occurred

13. On 19 December 2024, AT was reported to have been drinking heavily as he was celebrating a family tradition taking his children to church, then visiting his father and his brother's grave.[6] At around 10:00 pm, AT started having a heated argument with CK about separation. CK had

[5] 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.

[6] *Coronial Brief*, Statement of CK.

wanted to separate since October but AT had refused and this caused significant friction between the couple.[7]

14. CK confirmed that the argument between the couple continued escalating and that AT said he would sleep in the shed. CK went upstairs to a loungeroom area to rest. AT was heard re-entering the house after about 15 minutes and approached CK holding a handgun in his hands.[8] AT was reported to be yelling, “look at me” whilst holding the gun to the side of his head. CK pulled a blanket over her head in fear that she would be shot and within seconds she heard a gunshot. CK lifted her blanket and saw AT slumped back into the couch with blood coming from his head.[9]

15. CK’s children came out of their bedrooms and she told her oldest to call emergency services while she took the two youngest children to a neighbour’s house nearby for safety. CK’s oldest son was performing cardiopulmonary resuscitation on AT whilst her second oldest was on the phone with a triple zero operator.[10]

16. I commend the family for their courageous attempts to both aid their stricken father and protect the younger siblings.

17. Ambulance paramedics arrived first on scene and unfortunately were unable to revive AT who was pronounced deceased before police arrived at 1:17 am.[11]

Identity of the deceased

18. On 20 December 2024, AT, born 1982, was visually identified by their partner, CK.

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

Medical cause of death

20. Forensic Pathologist Dr Hans de Boer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 23 December 2024 and provided a written report of his findings dated 24 December 2024.

[7] Ibid.
[8] Ibid.
[9] Ibid.
[10] *Coronial Brief*, Statements of DT and WD.
[11] *Coronial Brief*, Statement of First Constable Kayla Gardner.

21. Dr de Boer's findings at external examination and full body post-mortem CT scan were consistent with the reported circumstances, with an entry gunshot wound in the right temple and an exit gunshot wound in the left temple region. The features of the entry wound indicate a close contact between the muzzle of the gun and the head. There was also evidence of extensive fracturing of the skull and damage to the brain. There were no other remarkable findings.

22. Toxicological analysis of post-mortem blood samples identified the presence of ethanol (~0.18g/100mL), Oxycodone (~0.09 mg/L) and trace amounts of Paracetamol.

23. Dr de Boer provided an opinion that the medical cause of death was 1(a) GUNSHOT INJURY TO THE HEAD and I accept his opinion.

FURTHER INVESTIGATIONS

Firearms licensing in Victoria

24. At the time of the fatal incident, AT had a valid firearms license for Longarms (Category A & B) and a General Category Handgun (Category H).[12] He had five firearms registered to him which were all recovered during the police investigation, this included two handguns, two rifles and one air rifle.

25. In Victoria, Firearms license holders are generally granted a license through the Victoria Police – Licensing and Services Division (LRD) for 5-year periods.[13] AT's handgun license was due to expire on 27 July 2026 and his long arm license on 26 January 2028 . To renew a license, an applicant must declare, without being required to substantiate a double negative proposition that they do not possess any of the attributes incompatible with being a "fit and proper" person to control a gun, including whether they have:[14]

    a) any history of irresponsible handling of firearms;

    b) been deemed to be a "prohibited person";[15]

[12] Category A & B Longarm licenses covers airguns, rimfire rifles (non-semi automatic)
[13] Section 39(1) of the *Firearms Act 1996* (Vic).
[14] Note that official form, the website guidance and the legislation do not seem to fully marry up: VP Form 304A; Victoria Police website page https://www.police.vic.gov.au/firearm-licence-eligibility-requirements#fit-and-proper-persons and Section 17 of the *Firearms Act 1996* (Vic). For the purposes of this Finding, I have extracted the Victoria police website guidance.
[15] Section 3 of the *Firearms Act*.

c) findings of guilt for crimes of violence;

d) not proven to be of good character;

e) a criminal history associated with firearms (e.g. armed robbery, assault with a weapon, attempted murder and murder);

f) provided false or misleading information to the police in a firearms matter;

g) a record of physical or mental illness which medical evidence suggests an applicant should be excluded from owning or using firearms;

h) a record of drug or alcohol misuse which medical advice suggests an applicant should be excluded from owning or using a firearm; or

i) failed to possess sufficient knowledge and competency in the carriage and use of firearms (e.g. have not completed or failed the Victorian Firearms Safety Course).

26. Slightly askance from this website guidance, the current form for firearms license renewal requires an applicant to tick a box as to whether in the last five years they have been "treated for… Mental health concerns including depression, stress or emotional problems … [or] Alcohol or drug related problems?"[16]

27. The available evidence suggests that AT was diagnosed with multiple mental health and substance abuse issues in 2017 and 2019. AT was also subject to inpatient admission for mental health treatment at a hospital in August 2021.[17]

28. In records provided to the Court by LRD, it is evident that AT had failed to disclose his relevant mental health treatment and substance abuse history on his firearm renewal applications lodged in November 2022 and May 2023, despite the fact that these treatments were within the five-year declaratory window at that time.

29. It is a recognised issue in the current firearm licensing system that applicants only self-report conditions that might excluded them. There is no current capacity for checking the mental health or substance abuse background of firearm license applicants. This investigation and other past coronial investigations[18] have identified this deficiency where decision makers do

[16] VP Form 304A.
[17] *Coronial Brief*, Statement of Dr Sylia Anthony (Monash Health).
[18] Relevant previous coronial investigations COR 2018 001026; COR 2010 003294; COR 2022 000532 and COR 2017 4175.

not have relevant information available to them to make decisions that affect the safety of the community.

30. Following the recent 14 December 2025 Bondi Beach mass shooting event, there has been national momentum to reform firearm legislation and regulation across Australia. In New South Wales, the *Terrorism and Other Legislation Amendment Bill 2025* (passed in New South Wales Parliament on 24 December 2025) requires changes to:

    a) Individual license holders to have no more than four firearms registered at a time with exemptions for primary producers (previously 16 firearms).

    b) Magazines and belt fed ammunition to be reduced in capacity or restricted; and

    c) Safe storage inspection before issuing a permit and gun club membership for all license holders.

31. On 22 December 2025, the Victorian Premier announced that the appointment of former Police Commissioner Ken Lay to undertake a Rapid Review of firearm laws in Victoria.[19] On 25 May 2026, the Victorian Government released the findings of the review and provided a response confirming that of the 16 recommendations, the government accepted 15 but notably rejected the proposal to cap the ownership limits of Category A and B firearms.[20]

32. In particular, Recommendation 7 of the Rapid Review suggests strengthening oversight across the full licence lifecycle. This could include renewal requirements, fit and proper person assessments, genuine need assessments, training and ongoing monitoring - to support early identification and management of risk.

33. The Rapid Review further suggests that to achieve this objective, consultation should be undertaken with relevant agencies, to establish a clear and secure reporting pathway to enable medical practitioners, including GPs and psychologists, to notify Victoria Police where a licence holder's health condition may impact their ongoing fitness to hold a licence. This however fails to consider that medical practitioners have no access to information confirming which individuals have a firearms license beyond an individual volunteering this information. It would be more appropriate and less resource intensive to consider placing the onus on firearm license/renewal applicants to provide medical evidence supporting their eligibility as

[19] Available online at: https://files.justice.vic.gov.au/2026-05/Rapid-Review-Victoria-Firearm-Laws.pdf

[20] Available online at: https://files.justice.vic.gov.au/2026-05/Rapid-Review-Victoria-Firearm-Laws-Government-Response.pdf

a 'fit and proper person'. As the former State Coroner, Judge Cain, noted in his investigation into the death of *Jason Smith*,[21] any supporting medical reports submitted by a firearms license applicant should not only be compliant with the *Guide: The Role of Health Professionals in the Firearm Licensing Process* but also be less than three months old.[22]

34. Data provided by the Coroners Prevention Unit to the Rapid Review confirms that 342 suicide deaths involved firearms between 2016 and 2025.[23] This means that suicides by firearm were more than three times as frequent as firearm related assaults (104 deaths) and that firearm related suicides were more than four times as likely to occur in residential settings than non-residential locations, with that obvious implication that families and first responders bear the burden of witnessing these traumatic outcomes.[24]

Child Protection risk assessments and firearms

35. In the course of my investigation, it became apparent that a proximate family violence incident was reported to Child Protection on 6 November 2024. The family violence incident involving alleged physical violence from AT to CK and their adult children (non-adult children were witnesses).[25] This event occurred in the month prior to AT taking his life. Firearms access was not reported to Child Protection and none of the parties interviewed disclosed any threats of firearm use or past use. Child Protection investigated the allegations and performed a risk assessment using the Multi-Agency Risk Assessment and Management Framework (**MARAM**).[26]

36. The Child Protection investigation was closed as appropriate mitigation steps had been taken by AT and CK who indicated that they would be pursing marriage counselling and that further arguments would not occur when the children were present. The available evidence confirms that there was no prior history of family violence reported and no previous reports made to Child Protection other than the 6 November 2024 incident.[27]

37. The relevant MARAM practice guidelines and risk assessment training for Child Protection practitioners confirms that access to or use of firearms and weapons is an increased risk factor

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[21] COR 2018 001026.
[22] The Victoria Police guide for health professionals preparing a firearms license medical report is available online at: https://www.police.vic.gov.au/sites/default/files/2022-04/FirearmsQuickGuideHealthProfessionals.pdf
[23] Ken Lay AO APM, *Rapid Review of Victoria's Firearm Laws Final Report* (25 May 2026), available online at: https://www.justice.vic.gov.au/safer-communities/tackling-high-harm-crime/rapid-review-into-victorias-firearm-laws
[24] Ibid.
[25] Department of Families, Fairness and Housing – Child Protection records provided to the Court.
[26] Ibid.
[27] Department of Families, Fairness and Housing L17 portal records provided to the Court.

for family violence. However, the current practice and training does require practitioners to take proactive steps to check with Victoria Police whether an individual has access to firearms.

FINDINGS AND CONCLUSION

38. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[28] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

39. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was AT, born 1982;

    b) the death occurred on 20 December 2024 in Lang Lang, Victoria, 3984, from 1(a) GUNSHOT INJURY TO THE HEAD; and

    c) the death occurred in the circumstances described above.

40. Having considered all of the circumstances, I am satisfied that AT intentionally took his own life.

41. Given the manifest omissions in AT's License renewal application under the current system, I make no adverse comment about the individual decision making which led to the license being renewed. The system itself, however, unfortunately has the hallmarks of a 'rubber stamping' process, rather than a genuine vetting process around the use and control of dangerous equipment.

[28] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

RECOMMENDATIONS

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

(i) That the Victorian Government in considering the implementation of Recommendation 7 of the Rapid Review, consider legislative amendments that address the issue of self-reporting health conditions for firearm license applications and renewals. The onus should be placed on applicants to provide appropriate medical evidence confirming their suitability to apply for or renew their firearms license.

(ii) That the Department of Families, Fairness and Housing and Victoria Police work together to explore opportunities for updating information sharing protocols so that relevant firearm licensing data can be made available to improve risk assessments for Child Protection and family violence investigations.

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

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:

CK, Senior Next of Kin

CEO, Family Safety Victoria

Nicholas Cox, Civil Litigation Unit, Victoria Police

Assistant Commissioner Lauren Callaway, Victoria Police Family Violence Command

Hon. Anthony Carbines, Minister for Police

Hon. Lizzie Blandthorn, Minister for Children

Senior Constable Kayla Gardner, Coronial Investigator

Signature:

Coroner Simon McGregor

Date: 09 June 2026

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.