MAGISTRATES COURT of TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

(These findings have been de-identified in relation to the name of the deceased, family, friends and the others by direction of the Coroner, pursuant to Section 57 (1)(c) of the Coroners act 1995)

I, Stephen Carey, Coroner, having investigated the death of Mr J

Find that:

(a) The identity of the deceased is Mr J;

(b) Mr J died in circumstances described in this finding;

(c) Mr J died in November 2014 in Southern Tasmania;

(d) Mr J died as a result of a contact range gunshot wound to the head;

(e) Mr J was born in Tasmania and was aged 76 years at the time of his death;

(f) Mr J was a single man who was a disability pensioner.

Background:

Mr J was the youngest of 4 children. Two of three of his siblings are deceased.

Mr J commenced employment as a teenager and at age 18 was a bus driver, driving a school bus between Scottsdale and Bridport. When he was approximately 23 years of age he was involved in a motor vehicle accident when a car, driven by a driver affected by alcohol, crashed into him whilst he was working under the bonnet on the engine of the school bus. This accident caused the amputation of both his legs above the knee. He thereafter was admitted to a disability pension and save for another period of employment as a telephone switchboard operator for approximately 8 years, he remained on the pension until age 76.

Mr J lived at his final place of residence for approximately 40 years and, notwithstanding his physical disability, he remained independent and very active. He drove himself for the purposes of shopping and attending appointments and maintained his garden and home without external assistance. Part of his independence was that Mr J was reluctant to visit doctors and police investigations were unable to identify a general practice that he may have

visited in the years prior to his death. He did, however, remain in good health up until approximately 6 months prior to his death.

In July 2014 Mr J collapsed while he was out shopping and, as a result of this, he was conveyed by ambulance to the Royal Hobart Hospital. At that time Mr J was very reluctant to attend hospital and was in fact in his vehicle intending to drive away but was prevented from doing so by bystanders who were concerned as to his wellbeing.

When he was taken to the Royal Hobart Hospital he was noted to be a poor historian but did state that he had no regular doctor and he had not had any medical treatment for the previous 8 years, the last time being when he attended hospital suffering breathing difficulties. He remained in hospital as an inpatient for 4 days during which time he underwent diagnostic testing both in relation to his heart and his head. This testing identified that he had suffered no physiological event affecting his brain but that significant heart disease was identified.

Mr J refused to have more detailed cardiac examination or testing, in particular by angiogram and he was discharged from the hospital. Upon discharge he was provided with medication in relation to his heart disease and was advised that he was no longer fit to drive a motor vehicle due to this underlying heart disease. Subsequent to his discharge from hospital, friends and family noted that his physical and mental health appeared to deteriorate and he became withdrawn.

Circumstances Surrounding the Death:

Mr J had made known to friends and family that he did not want to go into a nursing home and, after his release from hospital, he was concerned about not being able to drive and arrangements were made with a friend, Mr G, for him to pay the household bills for Mr J, and also arrangements were made for his usual shop to do home deliveries of groceries.

Mr J indicated to friends, Mr G and Mr R, in the period after his release from hospital, his belief that he had a serious bowel condition, perhaps cancer. It would appear that, at this time, he was having digestion problems and it is noted in the hospital records on one occasion that blood was noted after a bowel movement. There is no medical evidence, however, of such a diagnosis being made and there is no indication upon the post-mortem examination that Mr J was in fact suffering cancer of the bowel. This appears to have been a self-diagnosis and a matter he had come to believe. He did, however, have confirmed ischemic heart disease, he was given medication, but apparently he did not take this in the manner instructed after his discharge from hospital.

Mr J's brother and friends note a significant change in his demeanour subsequent to his release from hospital. He is noted to have become more reclusive, he lost interest in his garden with a general lack of motivation to do things. His brother noted on the last occasion he stayed with him, a few weeks prior to his death, that Mr J's physical and mental condition appeared to be worsening. He appeared to have diminished his eating, he had stopped watching television, and did not engage readily in conversation. His brother suggested arranging for Mr J to see a doctor but this was resisted. His brother comments:

> "I must say that when I left his address that day he did not seem mentally well, he was not talking straight, more talking in riddles and not getting out what he actually wanted to say, I can't actually recall any of what he was saying at this time."

In November 2014, Mr G took his kayak across the road from his residence through Mr J's property to the beach, as had been a practice for some time, and whilst doing so he noticed that the daily papers for Saturday and Sunday were on Mr J's driveway. He then proceeded to use his kayak and returned at approximately 2:30pm. Given the papers were still in location on the driveway, which was unusual, he made investigations as to Mr J's welfare. He noted the curtains were closed which was not normal so he entered the house and noted Mr J on the floor with a rifle beside him. He immediately contacted police who attended at the address at approximately 2:50pm.

Upon entering the house police observed Mr J lying on his back on cushions on the floor. The body appeared to have been there for some time; the bruising on the front of his throat was advanced and the blood dried and discoloured. Initial enquiries revealed that Mr G recalled hearing a gunshot at approximately 10:00pm on the previous night. Further detailed police investigation identified no suspicious circumstances. The police investigation which included ballistic advice and also opinion from Dr Chris Lawrence, forensic pathologist, is consistent with the theory that Mr J has inflicted two wounds to himself. I am satisfied, based upon the police investigation that both wounds were inflicted by Mr J with the intention of ending his life.

It would appear that Mr J who, despite physical disability, had maintained an independent and active lifestyle, was worried about his possible loss of that independence and his inability to remain in his house as a result of his confirmed ischemic heart disease and his belief that he suffered bowel cancer. These matters have clearly caused him considerable concern and possibly led to significant mental illness in the form of a depressive illness which had manifested itself by the change in his demeanour and daily activities. Given his reluctance to seek medical assistance throughout his life, it is unlikely that even if Mr J realised the extent of his mental illness that he would have sought medical assistance. It is apparent from the investigation that those members of his family and friends who had contact with him, although noting the changes in his demeanour, did not believe that it was to the extent that Mr J might take action to end his life, and it is clear that he gave no indication about any such intention.

Comments and Recommendations:

The circumstances of Mr J's death do not require me to make any comments or recommendations pursuant to section 28 of the *Coroners Act* 1995.

Mr J did not hold a firearms licence and at the time of his death it was discovered that he was in the possession of five firearms, all of which were not registered. Given his age he may well have been of the view that he ought not to be obliged to adhere to the requirements of the *Firearms Act* 1996, but had his possession of a firearm, possibly unregistered, been made known to authorities, action may have been able to have been taken to remove those firearms from his possession. Such action would have, at least, removed an available means for him to end his life. Whether or not his death could have been prevented, I am unable to say, but at least with the removal of a means of self-harm,

the opportunity for intervention in respect of his physical and mental health may have been possible, and this may have avoided his death by suicide.

In conclusion, I convey my sincere condolences to the family of Mr J.

Dated: 29 July 2015 at Hobart in the state of Tasmania

Stephen Carey
Coroner