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 and family by the direction of the Coroner pursuant to s 57(1)(c) of the Coroners Act 1995)

I, Leigh Mackey, Coroner, having investigated the death of YZ,

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that

a) The identity of the deceased is YZ. He was 59 years of age at the time of his death. YZ was born in Zambia in 1964 to his parents ER and LM. In 1965 the family left Zambia via the east coast of Africa and moved to Australia, permanently settling in Tasmania.

YZ attended school until grade 10 when he then became an apprentice at Sheridan's Textiles. Once he completed his trade he travelled overseas for four years to the British Isles, Europe, a kibbutz in Israel and parts of Africa. He returned to Tasmania working in electrical repairs. In the course of that employment YZ often attended domestic sites to undertake the electrical repair of appliances. The work required that he undertake heavy lifting and assume awkward postures at times.

YZ suffered a workplace injury to the rotator cuff of his shoulder in 2022. Following that injury, he became anxious regarding the impact the injury had on his work capacity. The injury caused him pain and he experienced episodes of panic/anxiety whilst at work. Due to the ongoing impact of the injury, he retired from his employment in December 2022.

YZ was in a long term de facto partnership with HW, and they resided together at Glenlusk. HW was aware of YZ's shoulder injury and its impact on him not only in respect of his experience of pain and reduced function, but also on his

mental health. She describes him as having been a "*deep thinker*" and prone to "*ruminate*" and "*catastrophise*" with his main concern being his shoulder.[1]

She noted that he changed becoming more anxious in approximately August of 2022. YZ's anxiety worsened following his retirement from employment. He experienced a loss of self and purpose and struggled to occupy himself with meaningful activities. He explored options for engagement including volunteering but missed the value that he had previously derived from working. There was no evidence of relationship, financial or other issues that were impacting YZ at the time.

YZ was a recreational shooter. He held a firearms licence and kept three firearms and ammunition in accordance with his licence in a secured locker at his home;

b) On 4 July 2023 at approximately 8.00pm HW finished work and returned to the home she and YZ shared at Glenlusk. She found the home empty and a note left for her on the kitchen table from YZ telling her of his intention to kill himself. Concerned for his welfare, HW called Tasmania Police for assistance. Upon attending the home Police became aware that one of YZ's firearms was missing from his gun safe.

A search was conducted for YZ's location That search included mobile patrols around the Collinsvale, Glenlusk, and Molesworth areas. Marine units and the helicopter also assisted searching without result.

YZ's vehicle was missing from his home and on 5 July 2023 the make, colour and registration number of the vehicle was posted on social media with a request for public assistance to locate it. In response a member of the public contacted Police on that day advising of the vehicle's location. Police attended and found YZ deceased in the driver' seat of his vehicle. He was holding a firearm which was the weapon missing from his gun safe, and one shot had been fired into the lower part of his face. The evidence at the scene was consistent with YZ intentionally shooting himself. There was no evidence of the involvement of any other person in his death. YZ died as a result of a self-inflicted shotgun wound to the head;

c) YZ's cause of death was shotgun wound to the head; and

[1] Affidavit of HW 18 January 2024

d) YZ died between 4 and 5 July 2023 at Granton, Tasmania.

In making the above findings I have had regard to the evidence gained in the investigation into YZ's death. The evidence includes:

- The Police Report of Death for the Coroner;
- Affidavits confirming identity;
- Opinion of the forensic pathologist regarding cause of death;
- Affidavit of Mr McLachlan-Troup, Forensic Scientist;
- Medical Records;
- Affidavit of HW;
- Affidavit of ER;
- Affidavits of attending and investigating members of Tasmania Police; and
- Body worn camera footage of Tasmania Police Officers.

YZ's mental health history and treatment

Prior to 2022 YZ did not have any mental health history. On 24 November 2022 YZ consulted a General Practitioner and, for the first time, described symptoms of generalised worry/anxiety which were increasing together with episodes of panic. The record of that consultation reflects that he was "*worrying/catastrophising (his word) about physical health – musculoskeletal particularly and impact this will have on his carer role of mother and his partner also about work*".[2] He denied the experience of suicidal thoughts until at consultation with Dr Stearnes on 18 April 2023, he gave a history of being previously suicidal before increasing his dose of Lexapro but had no suidcial thoughts at that time.

Over this period YZ regularly consulted with two general practices, the Hopkins Street Medical Clinic (Hopkins) and the Gore Street Medical Practice (Gore), This came about as a result of a request he made to Dr Schwarz at Gore to see him on 24 January 2023 as his "*present Doctor doesn't seem to have the time or inclination to investigate any treatment options, other than prescription drugs*."[3] The response at Hopkins to YZ's experience of anxiety had been to prescribe and explore the efficacy of medication to treat his symptoms. The use of medication did not, however, provide symptomatic relief. There is no basis to criticise the prescribing practices of either Hopkins or Gore and the use of medication was reasonably indicated and appropriate in the circumstances. However, the use of two different general

[2] Hopkins Street Medical Clinic notes entry dated 24.11.22
[3] Gore Street Medical Records

practices carries with it a high risk of compromising treatment and care. YZ was expressly advised by Dr Stearnes at Hopkins, of the importance of consulting with only one medical practice regarding his mental health care. Whilst he continued to consult both practices, in this instance, the active involvement of Hopkins and Gore did not compromise his care. That care included the preparation of mental health care plans, referral for psychiatric assessment and psychological counselling and exploration of options to engage and occupy YZ.

YZ consulted with psychologist, Dr Stops, regularly from February 2023. He told Dr Stops that he had "*lots of suicidal thoughts*".[4] A suicide risk assessment was conducted and indicated YZ had "*some thoughts about how he might end his life*"[5], however he had no definite plans, "*no reported access to significant means*" and had not previously attempted to take his own life.[6] Clearly YZ did not disclose his access to firearms to his psychologist at that time nor do the medical records of both Hopkins and Gore record such disclosure by him to them. Dr Stop reported the history of suicidal thinking and the results of the risk assessment to Hopkins and Gore. The records of both practices do not record whether, in response to Dr Stop's report, the issues regarding suicidal thoughts and YZ's access to means to effect his own death were proactively explored further with him. Possibly this may have been due to YZ presenting with improving mental health at his subsequent consultations at both practices.

On 3 May 2023 YZ called Hopkins seeking a consultation and was advised that Dr Stearnes was "*fully booked*"[7]. He stated at that time that he was safe and options to seek assistance from other providers including hospital, and helpline services were given to him. YZ subsequently attended a review with Dr Stearnes on 9 May 2023 where he described having "*fleeting suicidal thoughts, no plan*", but overall improvement.[8] The history of experiencing fleeting suicidal thoughts was repeated at subsequent consultations. Despite the expression by YZ of suicidal thoughts, albeit fleeting, there is no record of exploring the issue further with him and specifically if he had the means to effect his death. It is noteworthy that the consultations around this time refer to an intent to holiday with his partner in Bali soon, and an upcoming psychiatric review at the Hobart Clinic. Both of which may have been reasonably considered as protective factors. A 22 June 2023 psychiatric report of Dr Kekulawala to Hopkins had noted YZ to be exhibiting, coherent and logical thought processes at that time, and that whilst he does experience suicidal ideation he had not contemplated "*concrete methods to end his life*".[9]

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[4] Letter, Dr Stops to Dr Schwarz and copied to Dr Stearnes dated 25 April 2023
[5] Medical Records Dr Darren Stops
[6] Medical Records Dr Darren Stops
[7] Medical Records Hopkins Street Medical Clinic
[8] Medical Records Hopkins Street Medical Clinic
[9] Medical Records Hopkins report Dr Kekulawala dated 21 June 2023

Dr Stops revisited the suicide risk assessment tool with YZ on 29 June 2023. The assessment placed the risk at the lower end of the scale with the intensity of the thoughts described as "*usually vague*". He was able to see a future with his partner, wanted to "*be here for mum*" and had no specific planning in place.[10] On 3 July 2023, YZ attended for a full skin cancer check which, given the future focussed nature of such a consultation, suggests his actions on the 4 July 2023 were not fully formulated at least on the day prior to his death.

The obligation to report

A medical practitioner and a registered psychologist are, amongst others, prescribed persons for the purposes of s148 of the *Firearms Act* 1996. As such, the doctors at Hopkins and Gore, Dr Stearnes and Dr Schwarz, who were involved in YZ's care, and Dr Stops, his psychologist, were each under an obligation to inform the Commissioner of Police if they formed a reasonable belief that YZ likely possessed or used a firearm and that possession or use would be unsafe because of his mental or physical condition or because he would be a threat to public safety.

With the benefit of hindsight, it is clear that YZ's possession of a firearm was for him unsafe given his mental condition. Had such a notification been given to the Commissioner of Police it is likely that the Commissioner would have taken action to suspend or cancel YZ's firearms licence and to seize his firearms. An obvious purpose of the statutory obligation to report under the *Firearms Act* 1996 is to protect those who suffer from mental illness from doing harm or effecting death to themselves or others given their ready access to firearms

As noted earlier in these findings whilst YZ did suggest at times that he thought of suicide the records of his health practitioners suggest that his level of risk was at the lower end of the scale. His plans were not formulated nor concrete and he presented as future focused acknowledging that he wished to be there for his partner and his mother.

In the assessments undertaken by Dr Stops, YZ was not completely truthful in the history he provided noting that he denied immediate access to the means by which he could end his life. He did in fact, by his possession of firearms in his home, have that access. It is unclear whether either doctor at Hopkins or Gore were aware that YZ held a firearms licence. Based on their records neither of them questioned YZ as to whether he held a firearms licence and/or was in possession of firearms. In any event had they been aware he was in possession of firearms it is unclear whether in light of how YZ was presenting at that time

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[10] SAFETool Triage; Continuum of Suicidal Thoughts Assessment 2 – 29 June 2023

and without the benefit of hindsight, he could have been reasonably considered to have reached the threshold for reporting under the *Firearms Act* 1996.

Comments and Recommendations

I extend my appreciation to investigating officer Constable Morgan Wright for her investigation and report.

The circumstances of YZ's death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995, however the circumstances of his death do cause me to remind health practitioners of the importance of inquiring as to the accessibility of firearms in patients expressing suicidal ideation noting the reporting obligations on health practitioners under the *Firearms Act* 1996.

I convey my sincere condolences to the family and loved ones of YZ.

Dated: 6 May 2025 at Hobart, in the State of Tasmania.

Leigh Mackey
Coroner