MAGISTRATES COURT
TASMANIA

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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 others by direction of the Coroner pursuant to s57(1)(c) of the Coroners Act 1995)

I, Olivia McTaggart, Coroner, having investigated the death of PQ

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

a) The identity of the deceased is PQ

b) PQ was born 7 October 1968 in Sydney and was aged 51 years at the time of his death. His parents were ST and VD he had one sister. His parents divorced when he was five years of age, after which his father played no further role in his life. His mother's partner, YE, became PQ's step-father. PQ lived by himself on his 100-acre rural property in Hamilton in the Central Highlands of Tasmania. He worked as a handyman and carpenter and, prior to his death, he was employed casually as a labourer at Willow Court. PQ was in a significant relationship with UG from about 2004 until their separation in late 2018. PQ and UG have two children together.

PQ began abusing alcohol from the age of 14 years and continued to drink heavily until his death. YE described his stepson as suffering alcoholism and outlined in his affidavit the very large quantities of alcohol PQ would regularly consume. PQ's medical records indicate a diagnosis of depression as early as 1983. In 2014, he began attending a general practitioner at Davey Street Medical Centre and was prescribed medication, desvenlafaxine, to treat his depression. It appears that PQ used this medication until well into 2018. The general practitioner's notes record that in September 2019, the desvenlafaxine prescription for PQ was ceased and was not replaced with another anti-depressant. I cannot discern any reason for this change in the medical notes. PQ also had a long history of back issues, pain and numbness caused by a prolapsed

disc. It appears that he used alcohol to attempt to alleviate the symptoms. In March 2019, he re-injured his back after falling down the stairs at his home.

PQ had held a firearms licence since 1997. It was granted by Firearms Services (part of Tasmania Police) for the purposes of primary production, recreational hunting and vermin control. The firearms licence was renewed by Firearms Services every five years – in 2002, 2007, 2012 and 2017.

On 15 November 2019, VD and YE (PQ's mother and stepfather), travelled to Tasmania from their home in Queensland to stay with PQ. The purpose of the trip was to help PQ deal with his worsening depression and also to help renovate the barn on the property.

On the morning of 9 December 2019, PQ became extremely upset after he missed a call from his employer asking him to work. YE said that he was inconsolable because he felt he had let his employer down. YE comforted him and PQ remained at home that day working on the barn.

In the afternoon of the same day, VD and YE decided they would return to Queensland after Christmas as they thought they had been disturbing PQ's life. When they told PQ of their plans, he became very upset and refused to talk to them. VD and YE then went upstairs into their bedroom. A few minutes later, they heard a loud bang, which, at first, sounded like a door slamming. After waiting about 15 minutes, YE went to look for PQ as he was concerned for his welfare. YE located PQ laying in a downstairs rear storage room, apparently deceased. It appeared to YE that PQ had shot himself in the chest. He immediately alerted VD and then called 000 for assistance.

Police officers arrived and located PQ, deceased, on the floor in a small rear storage room. He was lying face-up and appeared to have a single gunshot wound to his chest. Laying at his feet was a .357 Magnum calibre Amadeo Rossi lever action rifle, one of the seven firearms lawfully registered to PQ.

A thorough police investigation was undertaken regarding the circumstances of PQ's death. Upon the evidence in that investigation, I am satisfied that PQ deliberately discharged the firearm into his chest with the intention of ending his life. There are no suspicious circumstances. Blood samples taken from PQ's body identified a very high blood alcohol concentration of 0.197 g/100 mL, indicating that he had consumed a large amount of alcohol before his actions.

c) PQ's cause of death was self-inflicted chest injuries due to a gunshot wound to chest.

d) PQ died on 9 December 2019 at Hamilton in Tasmania.

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

- Tasmania Police Report of Death for the Coroner;
- Life extinct and identification affidavits;
- Opinion of the state forensic pathologist regarding cause of death;
- Toxicology report of Forensic Science Service Tasmania;
- Medical records for PQ from Davey Street Medical Centre;
- Affidavit of VD, mother of PQ;
- Affidavit of YE, PQ's stepfather;
- Affidavit of HQ, sister of PQ;
- Affidavit of RK, brother-in-law of PQ;
- Affidavit of UG, former partner of PQ;
- Affidavits of four attending and investigating police officers, including Ballistics Section and Forensic Services officers, together with photographs; and
- Firearms Services records.

Comments and Recommendations

It is plain upon the evidence that PQ had a very long history of depression and alcoholism. No doubt by his own choice, these conditions were not sufficiently treated. In particular, he had not taken anti-depressant medication for at least several months before his death. It appears that his mental state was deteriorating during this time. His suicide was not a surprise to his family members.

His general practitioner's records clearly notes PQ's depressive condition but do not record the contents of any discussion between PQ and his general practitioner about his mental state, the only exception being a notation in 2016 that PQ did not wish to reduce his desvenlafaxine medication as he "felt awful" when he did so the previous year.

When PQ renewed his firearms licence in 2002, 2007, 2012 and 2017 in each of the renewal applications, he was required to provide a declaration that the information in the application was correct. On each occasion, he answered "no" to the question of whether he suffered

from any mental disability. Although the question is somewhat ambiguously worded,[1] his answer was arguably incorrect in that he suffered a depressive condition. The renewal application forms did not, at that time, require any answer to a question relating to whether an applicant had ever required treatment for alcohol or mental/emotional problems.[2] However, in 1997, on his *original* application for a firearms licence, he answered "no" to the direct and unambiguous questions of whether he had suffered mental/emotional problems and alcohol-related problems respectively. These answers were almost certainly incorrect, even at that time.

Therefore, for a period of 22 years, Firearms Services was not aware of relevant information regarding PQ's mental state in its assessment that he satisfied the criteria of being a fit and proper person for the granting of and continued renewal of his licence. I commented, relevantly, in a recent finding concerning a suicide by firearm that alcohol intoxication and addiction are associated with loss of judgement, loss of inhibition and poor decision-making - all factors that impede the ability to exercise reasonable control over a firearm.[3]

Firearms Services did not seek a report from PQ's medical practitioner at the point of granting his applications. Presumably, this was because there appeared to be no reason to embark on further enquiries. Had Firearms Services sought information from PQ's medical practitioner at any point in the 22-year period, it may have become aware of PQ's depression and alcohol abuse. In such a case, it would have been able to then properly investigate those matters and make an informed decision based upon sound information as to whether PQ was a fit and proper person.[4]

Coroners regularly encounter suicides by firearm where the registered firearms holder has continually supplied false or misleading information in successive applications regarding the absence of mental health and alcohol issues. Untreated alcoholism and mental health conditions are, unfortunately, encountered in suicide investigations generally. Often, those conditions have worsened over the years for the individual concerned.

It may be appropriate for Firearms Services to consider seeking medical information with respect to long-term firearms licence holders at appropriate intervals to verify the

[1] Note the finding of Coroner McKee in *Nicholas Johnson,* 21 May 2021, dealing with this issue.

[2] The current renewal forms now require an answer to these questions and if the answer is "yes" then the applicant must produce a report from his/her treating doctor.

[3] *GW* 2022 TASCD 634

[4] Section 29 (2) of the *Firearms Act* 1996 specifies the matters to be taken into account in assessing whether a person is a fit and proper person. Section 29B permits the Commissioner to obtain further information, including a report from a medical practitioner or psychologist about the applicant's mental health.

declarations made in an application and to ensure that the licence holder remains a fit and proper person.

Although I have made comments, I do not make any formal recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I extend my appreciation to investigating officer Constable Craig Keogh for his investigation and report.

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

Dated: 10 May 2023 at Hobart in the State of Tasmania.

Olivia McTaggart

Coroner