IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 000555

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Therese McCarthy
Deceased:	Mr J
Date of birth:	1945
Date of death:	29 January 2025
Cause of death:	1a: Gunshot wound to the chest;
Place of death:	Toongabbie, Victoria
Key words:	Suicide pending loss of mobility; chronic illness.

Background

1. Mr J, who was 80 years old when he died, lived alone on a property in Toongabbie with his dog and sheep. He was an active man who bush walked and hunted before he became unwell.

2. Mr J had little contact with his family and few friends. However, he had a positive relationship with his neighbour who assisted Mr J with activities of daily living due to his leg pain and mobility challenges. In around 2016, Mr J reconnected with Ms F, an ex-partner, and they remained friends until his death. Ms R also provided support to Mr J in many ways, helping his with his doctor's appointments, mail and finances and was the executor to his will.

3. He led a solitary life, and this meant that the effect of being housebound with his increasingly challenging illnesses weighed heavily upon him. Mr J suffered from many chronic illnesses including atrial fibrillation, chronic back pain and reflux. In 2019, Mr J underwent treatment for a rare cancer inside the blood vessels in his femur. This included surgery and radiotherapy. He continued to significant experience significant pain in his left leg and developed severe ulcers as a result of skin damage caused by the surgery and radiotherapy. This constellation of injuries affected his mobility and the blood flow between his legs and heart.

4. Mr J's healthcare was provided by Gippsland High Risk Foot (**HRF**) clinic through Latrobe Regional Hospital. For a period, Mr J received daily home care from Latrobe Community Health Services (**LCHS**), however approximately two months before his death this care was reduced to three visits a week. In the weeks preceding his death, LCHS staff became concerned about Mr J's mental wellbeing as he mentioned having suicidal thoughts but did not report to have a plan of self-harm.

5. In the months preceding Mr J's death, his leg became necrotic. Throughout his care, Mr J routinely refused surgical amputation of his leg and expressed concern over how he would cope in these circumstances. Mr J was concerned for his dog and sheep, and it was clear he thought his ability to continue to care for both would be impacted by the amputation of his leg.

6. On 3 January 2025, after nurses had visited him, police were called as he had mentioned suicide. However, police did not consider this threat to be genuine or at least, it did not reach the legal threshold for him to be taken for a mental health assessment. They gave him referrals to mental health support. An ambulance had also been called for him, but he declined to be transported.

7. Mr J's general practitioner Dr Aak Nyakwella Yor Akol who had treated Mr J for 14 years remarked upon the fact that Mr J had never presented to him as appearing to have mental health challenges and that he appeared well kept and his mood and affect did not appear low on 13 January 2025 when he last attended upon him.

8. On 24 January 2025, Mr J attended an appointment with a vascular surgeon who informed him that his leg needed to be amputated. After this appointment, he told nurses he would not be able to manage without his leg.

THE CORONIAL INVESTIGATION

9. Mr J'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.

10. I assumed carriage of the matter in July 2025 and have made the findings contained herein, following the retirement of Coroner Olle who previously had carriage of the matter.

11. 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.

12. 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.

13. Victoria Police assigned First Constable Nicholas Russell as to be the Coronial Investigator for the investigation of Mr J's death. The Coronial Investigator conducted inquiries on behalf of the Court, including taking statements from witnesses – such as family, neighbours, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

14. This finding draws on the totality of the coronial investigation into the death of Mr J 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.[1]

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

Circumstances in which the death occurred

15. On 29 January, a district nurse from LCHS arrived at Mr J's home to provide wound care, however when she opened the gate, she observed him in the garden, slumped over with a gun. She then called her supervisor who contacted emergency services. It is regrettable that emergency workers are so frequently faced with such confronting scenes.

16. Victoria Police members arrived shortly after and found a handwritten note in a nearby walking frame, believed to have been penned by Mr J, in which he indicated he had taken his own life. A further note was located in Mr J's kitchen which contained the words 'pain free at last'.

17. Ambulance Victoria paramedics declared Mr J deceased at 12.44pm.

18. There is no evidence to suggest that any other person was involved in the death.

19. I make no further findings with respect to the circumstances in which the death occurred, under section 67(2) of the Act, because I did not hold an inquest, and I find that:

    a) Mr J was not, immediately before his death, a person placed in custody or care; and

    b) there is no public interest to be served in making further findings regarding those circumstances.

Identity of the deceased

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

[1] 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.

Medical cause of death

21. Forensic Pathologist Dr Sarah Parsons from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 30 January 2025 and provided a written report of her findings dated 13 February 2025.

22. The post-mortem examination was consistent with the reported circumstances.

23. Toxicological analysis of post-mortem samples identified the presence of amitriptyline, nortriptyline, and bisoprolol but no other commonly encountered drugs or alcohol.

24. Dr Parsons provided an opinion that the medical cause of death was '*1(a) Gunshot wound to the chest*'.

25. I accept Dr Parsons's opinion.

Conclusion

26. Having considered all the circumstances, including the chronic illnesses suffered by Mr J including the prospect of the amputation of his leg, the lethality of the means chosen and the suicide note, I am satisfied that Mr J intentionally took his own life.

27. I accept the detailed report of Mr J's treating Doctor who opined that his mood and affect did not appear low. I acknowledge that Mr J found homes for his animals in preparation for ending his life.

28. I refer to the fact that Mr J was in constant pain. The content of his note: "*pain free at last*" can only be referrable to his informed decision to end his life in circumstances where he was, on the basis of the material before the court, unlikely to have been eligible for voluntary assisted dying. Whilst Mr J's quality of life had been impacted and significantly reduced by his chronic illnesses, his lack of terminal prognosis was a barrier to accessing the scheme. I conclude that Mr J took his own life in the circumstances.

29. I extend my sincere condolences to Mr J's friends, his carers and his community 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:

Senior Next of Kin

Executor

Latrobe Regional Health

Senior Constable Nicholas Russell, Coronial Investigator

Dr Aak Nyakwella Yor Akol

Signature:

Coroner Therese McCarthy

Date: 23 January 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.