IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 002220

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	Paresa Antoniadis Spanos, Coroner
Deceased:	Raymond John Cox
Date of birth:	28 September 1929
Date of death:	3 May 2014
Cause of death:	Gunshot Wound to the Head
Place of death:	Merton, Victoria

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of RAYMOND JOHN COX without holding an inquest:

find that the identity of the deceased was RAYMOND JOHN COX born on 28 September 1929

and that the death occurred on 3 May 2014

at 234 Strathbogie Road, Merton, Victoria 3715

from:

I (a) GUNSHOT WOUND TO THE HEAD

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Mr Cox was an 84 year old man who resided with his wife of some 30 years, Margaret Cox, on a rural property in Merton, Victoria. He is survived by six children from his first marriage, Debra, Sandra (Sam), Gavin, Leonie, Larissa and Benjamin and two children from his marriage to Mrs Cox, Ryan and Erica. Prior to retiring Mr Cox worked as an aeronautical engineer who was also known to be an inventor and innovator. Mr Cox was described as a highly intelligent man who was incredibly persistent and persevering, however, often focussed on the negative side of things, being a "glass half empty" sort of fellow.[1]

2. Mr Cox had a family history of Alzheimer's disease and a past medical history of hiatus hernia,[2] ischaemic heart disease,[3] bile reflux,[4] dry eyes, hypercholesterolaemia,[5] hypertension,[6] lumbosacral spondylosis,[7] bilateral macular degeneration,[8] osteoarthritis,[9] seborrhoea blepharitis,[10] hypocalcaemia,[11] B12 deficiency,[12] left impaired hearing, depression, type 2 diabetes mellitus,[13] and Alzheimer's disease (Alzheimer's).[14]

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[1] Coronial Brief of Evidence, Statement of Margaret Cox.

[2] A hiatus hernia is a condition where part of the stomach pushes up through the diaphragm muscle.

[3] Ischaemic heart disease is known as damage or disease in the heart's major blood vessels.

[4] Bile reflux occurs when bile (a digestive liquid produced in the liver) backs up (reflexes) into your stomach and the tube that connects your mouth and stomach (oesophagus). Bile reflux may accompany acid reflux, the medical term for the backwash of stomach acids into your oesophagus.

[5] Hypercholesterolaemia is the medical term for high amounts of cholesterol in the blood.

[6] Hypertension is commonly referred to as high blood pressure.

[7] Spondylosis changes in the spine are frequently referred to as osteoarthritis. For example, the phrase "spondylosis of the lumbar spine" means degenerative changes such as osteoarthritis of the vertebral joints and degenerating intervertebral discs (degenerative disc disease) in the low back.

[8] Macular degeneration is also known as age-related macular degeneration. It is the leading cause of worldwide blindness in the elderly, and is a bilateral ocular condition that affects the central area of retina known as the macula.

[9] Osteoarthritis is a type of arthritis that occurs when flexible tissue at the ends of bones wears down.

[10] Seborrhoea blepharitis is a common type of chronic inflammation of the margins of the eyelids with adherence of dry scales and often associated with seborrheic dermatitis of the scalp and face.

[11] Hypocalcaemia is a condition in which the blood has too little calcium.

[12] Vitamin B12 deficiency can lead to anaemia and neurologic dysfunction. A mild deficiency may not cause any discernible symptoms, but as the deficiency becomes more significant, symptoms of anaemia may result, such as weakness, fatigue, light-headedness, rapid heartbeat, rapid breathing and pale colour to the skin.

[13] Type 2 diabetes mellitus is a chronic condition that affects the way the body processes blood sugar (glucose).

[14] Alzheimer's disease is a progressive disease that destroys memory and other important mental functions. It usually starts slowly and then worsens over time. It is the cause of 60% to 70% of cases of dementia.

3. For years, Mr Cox held a Category 'A' Long Arm Victorian Firearms Licence, having a semi-automatic 0.22 calibre rifle (semi-automatic rifle) and a Stirling Model 14 0.22 calibre bolt action rifle (bolt action rifle) in his possession. In or around 2006, during a gun amnesty, Mr Cox handed in his semi-automatic rifle, however retained the bolt action rifle. Mrs Cox stated that her husband's retention of the gun generated many arguments between them, as she did not like guns, and did not see the reason for him to have one in his possession.

4. In March 2011, Mr Cox was admitted to Mansfield District Hospital with septicaemia.[15] Following the event he was noted to have some cognitive impairment and was subsequently referred to the Cognitive Dementia and Memory Service (CDAMS) at North East Health Wangaratta.[16]

5. In June 2012, as a result of recommendations made by CDAMS, Mr Cox started taking an antidepressant. At the time he denied depressive symptoms, however, on review the following month he reported feeling better, with Mrs Cox also indicating that he was happier.

6. In August 2012, Mr Cox was diagnosed with Alzheimer's disease. He was acutely aware of the disease process as he had watched his mother succumb to it in a nursing home after initially being cared for by his father at home. Mr Cox commenced treatment for Alzheimer's a short time later, however, according to his General Practitioner, Dr Graham Slaney, his memory and cognition steadily declined thereafter. Mr Cox was aware of his deterioration and was distressed by it,[17] leading him to say to his wife "*You're not going to put me into one of those places*" in reference to being placed in an aged care facility, and "*I'll kill myself first*".[18] Mrs Cox believed her husband was terrified about what would happen as his Alzheimer's deteriorated.

7. According to Dr Slaney, on 15 October 2012, he reviewed Mr Cox and had a conversation with him about his driver's licence and his firearms licence. Dr Slaney, gave Mr Cox explicit instructions not to drive and not to use any firearms and to avoid other risky activities such as cleaning the gutters. Dr Slaney stated that at the time he had expected that Mrs Cox would have voluntarily handed in her husband's firearms licence and driver's licence.

8. Sometime in 2013, Mrs Cox became concerned about her husband's mental state, identifying that he was "depressed and angry about his Alzheimer's diagnosis and the deterioration in his mental acuity".[19] She felt unsafe about her husband having possession of a firearm, believing

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[15] Coronial Brief of Evidence, Statement of Dr Graham Slaney.
[16] Ibid.
[17] Statement of Dr Graham Slaney, dated 8 July 2015.
[18] Coronial Brief of Evidence, Statement of Margaret Cox, dated 6 May 2014.
[19] Statement of Margaret Cox, dated 26 October 2015.

that he "might inadvertently harm himself or someone else". Mrs Cox recalled that on one occasion she saw him stumble in the yard while holding a loaded firearm and that he had "no insight into issues of safety around the use of the firearm, nor his own impaired decision-making ability or physical frailty".[20] On discussing her concerns with her children, they strongly advised her to seek assistance from the police to surrender Mr Cox's firearm.

9. According to Mrs Cox, a short time after this conversation with her children, she attempted to obtain assistance from the police to remove Mr Cox's firearm from their premises. Mrs Cox went to Mansfield Police Station where she explained the situation, expressed her concerns about having a firearm in the house and enquired about how to relinquish it, volunteering to bring the firearm to the police station.

10. In response, Mrs Cox was told that if she brought the gun in she could be charged with illegal possession of a firearm as she was not the licence holder, so she could either have Mr Cox hand the gun in himself or have the police come to their property and seize it. Knowing that her husband would not hand the gun in himself (having told her that "*it's mine and no one has the right to take it off me*")[21] and not wanting to agitate him any further as his behaviour had become quite difficult to manage with explosions of temper and frustration,[22] Mrs Cox locked the gun in the gun cabinet and hid the key in a jewellery bag she kept on the upper shelf of their bathroom. According to Mrs Cox, her husband was unaware of where she had hidden the key.

11. Sometime after Mrs Cox's enquiry at Mansfield Police Station, she discussed the situation with Dr Slaney during one of her own consultations. Dr Slaney recalled the conversation, stating that Mrs Cox had spoken to him about her attempt to relinquish her husband's gun and the fact that she now had the gun locked in the gun cabinet, with the key in a place that Mr Cox could not access.[23]

12. During a consultation on 20 December 2013, Mr Cox told Dr Slaney that his depressive symptoms had been worsening over the previous months, with tearful episodes and lowered mood. At the consultation Mrs Cox also expressed concerns, confirming her husband's symptoms and mood change. Dr Slaney increased Mr Cox's antidepressant.[24]

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[20] Statement of Margaret Cox, dated 26 October 2015.
[21] Ibid.
[22] Statement of Margaret Cox, dated 26 October 2015.
[23] Statement of Dr Graham Slaney, dated 8 July 2015.
[24] Mr Cox's antidepressant (citalopram) dose was increased from 10mg to 20mg on 20 December 2013.

13. At a subsequent review on 8 January 2014, Dr Slaney noted that despite a steady decline in memory and cognition,[25] Mr Cox's mood had improved significantly, with him reporting experiencing no dark thoughts, being less sleepy during the day, no longer tearful, and smiling.[26]

14. On 24 April 2014, Mr Cox again presented to Dr Slaney for review, where he saw that despite Mr Cox's memory and cognition appearing to have further deteriorated, his mood appeared to be good and he seemed to be generally happier.[27] At this consultation, Dr Slaney found no evidence of depression in Mr Cox, and no indication that he had suicidal thoughts or intent.[28]

15. In a conversation with his wife on 2 May 2014, Mr Cox said that he had gotten his gun out of the cabinet, loaded it, and then lay on the floor, putting the gun in his mouth before pulling the trigger. According to Mrs Cox, her husband said that the gun had not gone off and that he had "*known for ages how to get into the gun cabinet*".[29] After this disclosure, Mrs Cox checked the gun cabinet, only to discover that it was still locked with the key nowhere in sight. She assumed that her husband had imagined the scenario, as he had imagined an unknown woman about whom he had recently become "obsessed" and was trying to find in order to help her.[30]

16. On 3 May 2014, at around 7:00am, Mr Cox woke up and brought his wife a cup of tea. According to Mrs Cox, he appeared to be happy and got back into bed, falling asleep until receiving a phone call from the doctor around 9:00am. A short time later Mrs Cox left home to pick up her prescription medication from Mansfield, telling Mr Cox that she would return in about an hour and a half.

17. Upon her return, Mrs Cox noticed that the front door was locked. This was unusual as the couple never locked the front door. On walking around the back of the house, Mrs Cox found her husband slumped in a lounge chair on the back verandah with his gun between his legs, blood in sight and a note clipped to the chair. She immediately called 000.

18. While waiting for an emergency response, Mrs Cox went into the bedroom where the gun cabinet was and saw that it was open. She checked the jewellery bag in the bathroom and saw that the keys were still there before noticing a pair of tweezers on the floor near the gun cabinet which she thought her husband had used to pick the gun cabinet lock.

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[25] Statement of Dr Graham Slaney, dated 8 July 2015.
[26] Coronial Brief of Evidence, Medical Record entry of Dr Graham Slaney's consultation with Raymond Cox.
[27] Statement of Dr Graham Slaney, dated 8 July 2015.
[28] Ibid.
[29] Coronial Brief of Evidence, Statement of Margaret Cox.
[30] Ibid.

19. A short time later Victoria Police members arrived, as well as a neighbour and an off-duty Mobile Intensive Care Ambulance (MICA) paramedic who checked Mr Cox for signs of life. Within minutes Ambulance Victoria paramedics also arrived at the scene. They pronounced Mr Cox deceased at 12:42pm.

20. Leading Senior Constable Stuart Pritchard of Mansfield Police attended and commenced a coronial investigation, later compiling the brief of evidence on which this finding is largely based. On arrival, LSC Pritchard saw that Mr Cox was deceased, and that he had clipped a suicide note to the chair he was sitting on. Scene examination revealed a spent 0.22 calibre casing on the concrete about one metre from Mr Cox's feet and another one of a different variety on the grass about four metres away. LSC Pritchard opined that the location of the two spent casings suggested that Mr Cox had fired two rounds while standing or moving around on the verandah, before sitting in the chair where he was ultimately found. He also thought that the two different types of 0.22 calibre rounds suggested that Mr Cox had fired them in order to decide which type to use.

21. Forensic Pathologist, Dr Jacqueline Lee of the Victorian Institute of Forensic Medicine, reviewed the circumstances of the death as reported by police to the coroner, post-mortem computer assisted tomography scanning of the whole body (PMCT) and performed a post-mortem examination of Mr Cox's body. Dr Lee advised that PMCT showed metal objects/projectile in the head and natural disease in the form of coronary artery calcification.[31]

22. On examination, Dr Lee noted that Mr Cox's hands were bagged for gunshot residue testing. Testing was not undertaken after a pragmatic assessment by police was made that it was not necessary in the circumstances. Dr Lee identified a contact entry wound in the oral cavity,[32] and no other significant injuries on Mr Cox's body. Dr Lee noted the results of routine toxicological analysis of post-mortem samples which detected the antidepressant citalopram at a level of a therapeutic concentration of ~ 0.3mg/L in blood, consistent with normal therapeutic use and no alcohol or other commonly encountered drugs or poisons.[33]

23. Dr Lee advised that it would be reasonable to attribute Mr Cox's death to *gunshot wound to the head,* without the need for an autopsy.

24. In light of the difficulties reported by Mrs Cox when she made enquiries of the police about relinquishing the firearm, I requested further investigation by Victoria Police. My request was

[31] Coronary artery calcification is a risk factor for adverse outcomes in the general population and in patients with ischaemic heart disease.
[32] Intraoral refers to within the mouth.
[33] Citalopram (otherwise known as escilatopram) is a medication that is indicated for the treatment of depression. Dr Slaney prescribed that Mr Cox take 20mg in the evening on 20 December 2013. The script was issued for this dose with 5 repeats.

addressed in the first instance to LSC Pritchard on 22 December 2015, wherein I asked him to obtain a statement from the Officer in Charge of Mansfield Police Station, addressing Mrs Cox's statement of 26 October 2015 and asking them to search all hard copy and electronic records, day books, watch-house keeper's books, the law enforcement assistance program (LEAP), and to produce any records relating to an attendance by Mrs Cox about relinquishing her husband's firearm. I was notified by LSC Pritchard that he had placed my request in S/Sgt Holland's in-tray at the station on 23 December 2015.

25. On 30 December 2015, S/Sgt Holland responded by email advising that she would "see what she could find" in regard to my request.[34] On 5 January 2016, S/Sgt Holland corresponded with the Court advising that she had searched the computer system without success and that she was awaiting responses from enquiries made with police members who still worked at the station. On 18 March 2016, court staff sought an update from S/Sgt Holland. On 13 April 2016, S/Sgt Holland provided a verbal update ahead of a written statement of 21 April 2016.

26. In her written statement S/Sgt Holland explained that the conversation that Mrs Cox had with police at the Mansfield was difficult to verify or refute as a search of the electronic records on the police station's computer general drive, Station Books (which is a record of correspondence in/out), the Divisional Intelligence Unit, Traffic Incident System, Attendance Register (attendance in custody), VicRoads records and VicPol Name database revealed nothing to assist with my enquiry apart from Mr Cox's storage inspection file, driver licence details and record of firearms licence held.[35] S/Sgt Holland added that while Mrs Cox's enquiry may have been recorded by a member in their notebook or daybook, as seven members had since left the station having either retired, been transferred to other stations or taken extended sick leave since the (approximate) date in question, she was unable to either confirm or refute Mrs Cox's account.[36]

27. Senior Sergeant Andrew Armstrong of the Licensing and Regulation Division of Victoria Police also provided a statement in response to my request.[37] S/Sgt Armstrong provided a fulsome nine page response and seven page attachment "Quick Guide: The Role of Health

[34] Email Correspondence from Senior Sergeant Lynette Holland, dated 30 December 2015.
[35] Email Correspondence from Senior Sergeant Lynette Holland, dated 21 April 2016.
[36] Ibid.
[37] The request was a formal Form 4 request made pursuant to section 42 of the Act asking (a) whether there is a policy governing the police member's response to Mrs Cox's enquiry about relinquishing her husband's gun [the gun]; (b) whether the advice Mrs Cox received from the police member was accurate/in accordance with policy; (c) if there is no relevant policy governing the situation, whether the advice Mrs Cox received was likely to be of the type ordinarily offered by police members presented with similar enquiries; (d) if there is no relevant policy governing the situation, an indication of what information – as a matter of best practice – Victoria Police would expect its members provide if presented with similar enquiries to that made by Mrs Cox; (e) whether Victoria Police is presently engaged in developing or reviewing any policy or procedures that are applicable to this or a similar situation, and if so, details of this process and its outcome; and, (f) any other matter relevant to enhancing the interests of public safety in this area.

Professionals in the Firearm Licensing Process" [the Guide]. In brief, S/Sgt Armstrong advised that –

a. It is correct that a person cannot relinquish a firearm that is registered to another person. In the first place, it is the property of the other person. Moreover, it is an offence for a person to possess, carry or use a firearm without a licence, or to fail to store it in the manner prescribed.[38]

b. Police do have the power to seize a registered firearm from a licence holder in certain circumstances. Relevantly, a delegate of the Chief Commissioner of Police may suspend a person's firearms licence and seize their firearm if there are grounds to believe (amongst other things) that the person has failed to store the firearm as required and/or is no longer a fit and proper person to hold the licence.[39]

c. It is not entirely clear what Mrs Cox told the police member about her husband's mental state when she enquired about relinquishing the firearm. However, if she had raised specific concerns about the impact of his mental state on his suitability to hold a firearms licence, it would have been entirely appropriate (and expected) for that member to raise those concerns with a supervisor of the rank of Sergeant or above who was able to direct that their licence be suspended and their firearms seized pending further investigation. If the supervisor formed the view that the person may not have been a fit and proper person to hold a firearms licence, an investigation would have ensued and as part of that investigation, the License & Regulation Division [LRD] would be notified.

d. Generally, when the LRD is notified that an existing licence holder may no longer be suitable to hold a licence, it will undertake a review which *may* involve directing that the person's licence be suspended and their firearms seized and inviting them to make written submissions on the proposal to cancel their licence.[40]

e. Where the concerns about suitability are based on the mental health of the licence holder, it is the *practice* of the LRD to require the licence holder to provide a medical report from a qualified medical practitioner familiar with the licence holder's condition that must clearly state whether, in the medical practitioner's

[38] Section 6, 121 and Schedule 4 of the ***Firearms Act 1986.***
[39] Sections 47 and 49 of the ***Firearms Act 1986.***
[40] Section 47, 48 and 49 of the ***Firearms Act 1986***.

opinion, they are a fit and proper person to be in possession of firearms and that they pose no threat to themselves or the community.[41]

28. S/Sgt Armstrong further advised that the Guide attached to his response was developed by a working group formed in response to Coroner Heather Spooner's recommendations in her finding into the death of Peter Quin-Conroy[42] and was issued in December 2014, some eight months after Mr Cox's death. The purpose of the Guide is to assist both police members and health professionals in understanding the role of health professionals in the licensing process.[43] The Guide is accessible to police members on the Victoria Police intranet, is publically accessible on the internet, and has been distributed to medical practitioner representatives from the organisations involved in the document's development to raise awareness amongst the profession.[44] The LRD also provide the Guide to licence holders where a medical report is required as part of the review process.[45]

29. In addition to the promulgation of the Guide, S/Sgt advised of a number of other changes to the firearms licensing process where there are known suitability concerns relating to mental health issues.[46]

CONCLUSION

30. I find that Mr Cox, late of 234 Strathbogie Road, Merton, Victoria, died at the same location, on 3 May 2014, and that the cause of his death was gunshot wound to the head. The available evidence supports a finding that the major stressor for Mr Cox was his increasing debility as

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[41] According to S/Sgt Armstrong, this is a discretionary practice of the LRD on behalf of the Chief Commissioner of Police and is not a specific legislative requirement under the ***Firearms Act 1986.***

[42] COR 2010 3294.

[43] Statement of Senior Sergeant Andrew Armstrong, dated 1 September 2015. The Guideline Document provides an understanding of the type of medical information Victoria Police requires in the instance health professionals are prompted to provide medical reporting regarding a person's suitability to hold a licence; a medical report template to use when completing a report; information regarding how and when to voluntarily report a patient to Victoria Police whom they deem unsuitable to hold a firearm licence; advice regarding how Victoria Police used the information provided by health professionals and what action is taken once a report is received; and the process of reporting along with the protections in place for health professionals.

[44] The Victorian Department of Health (as it was then styled), the Royal Australasian College of General Practitioners, the Royal Australian and New Zealand College of Psychiatrists, the Victorian Institute of Forensic Medicine.

[45] Statement of Senior Sergeant Andrew Armstrong, dated 1 September 2015.

[46] Ibid. The additional changes include the introduction of a standing instruction that a Senior Sergeant attached to the LRD must assess any licence applications or renewal applications where the applicant's mental health may affect their suitability to hold a licence. This instruction aims to ensure a more consistent approach to assessing applications across LRD; the introduction of a practice of requesting that an applicant provide a report from a relevant qualified psychologist (and not just a general practitioner) where there are auditability concerns relating to mental health issues; an increased amount of liaison between the LRD and Police Medical Officers. Assessors are advised to approach the Police Medical Officer for comment and advice where a medical report is not clear on its face and/or requires any degree of interpretation for a lay person to understand; the introduction of the use of variable licensing periods for individuals with mental health issues. Licences can and are issued for shorter periods of where deemed appropriate which means that the applicant is subject to reassessment more regularly; and the introduction of the use of special licence conditions for individuals with mental health issues in certain circumstances.

he aged, in particular his diagnosis of Alzheimer's disease. I am satisfied given the lethality of the means he chose and the note he left, that Mr Cox intended to take his own life.

31. I find that the weight of evidence supports a finding that during 2013, Mrs Cox approached the police at Mansfield for advice/assistance to relinquish her husband's firearm. However, Mrs Cox's account as to when she did so is vague as to timing and this has made it difficult to establish the identity of the police member to whom she spoke, to determine the purport of their discussion and to evaluate any advice given to her. While I make no adverse finding against Victoria Police in this regard, the approach from Mrs Cox was a potential opportunity for intervention by the police to consider Mr Cox's suitability to continue to hold a firearms licence and/or to retain a firearm in his possession.

32. Similarly, had the Guide been available at the time, it may have provided clearer guidance to Dr Slaney about his ability to intervene by reporting a change in Mr Cox's medical condition to Victoria Police of his own motion and potentially triggering a review of his suitability to continue to hold a firearms licence.[47]

I direct that a copy of this finding be provided to the following:

The family of Raymond Cox

Dr Slaney

Leading Senior Constable Stuart Pritchard, Mansfield Police Station

Ms Rose Singleton, Victorian Government Solicitor's Office

Senior Sergeant Belinda Bales, Victoria Police, Civil Litigation Unit

Signature:

PARESA ANTONIADIS SPANOS
CORONER
Date: 28 June 2018

Cc: Manager, Coroners Prevention Unit

[47] Under the heading, *"When should a health professional make a report to Victoria Police on their own motion?"* the Guide provides – "As licences are renewed between three and five years, any change in the medical condition of a firearm licence holder should be brought to the attention of Victoria Police. It is for this reason that health professionals should be continually mindful of the firearm licensing regime in Victoria. Victoria Police has an expectation that health professional will notify Victoria Police if they feel a patient is not suited to possess firearms where they suspect the patient: Is a firearm licence holder; or Has or is intending to apply for a firearm licence."