IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 1026

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Judge John Cain, State Coroner
Deceased:	Jason Leslie Smith
Date of birth:	30 November 1973
Date of death:	3 March 2018
Cause of death:	1(a) Gunshot wound to the head
Place of death:	2 Oxford Street, Sunshine North, Victoria

INTRODUCTION

1. On 3 March 2018, Mr Jason Smith (**Mr Smith**), was 44 years old when he was found deceased on the kitchen floor of the residence he was living in on Oxford Street, Sunshine North. At the time of his death, Mr Smith was living with his uncle, Mr John Pozzebon (**Mr Pozzebon**) and other associates of Mr Pozzebon.

2. Mr Smith was raised in the Lalor area of Victoria by his mother and step-father and attended the Lalor Technical School until Year 10. After school, Mr Smith commenced an air-conditioning apprenticeship but did not complete the program and worked intermittently at various abattoirs.

3. Mr Smith had never married but fathered five children across three different relationships. Mr Smith had minimal contact with four of his children but regularly saw his youngest son who lived with Mr Smith's former partner, Ms Kelly Willan (**Ms Willan**).[1]

4. In late 2017, Mr Pozzebon invited Mr Smith to live with him in Sunshine North to provide him with long term accommodation as Mr Smith had been living in transient accommodation since the end of his relationship with Ms Willan in 2014.[2]

5. Mr Smith had become addicted to substances early on in his life and is reported to have started as a teenager and continued poly-substance abuse across his life. This led to issues with his finances and personal relationships.

THE CORONIAL INVESTIGATION

6. Mr Smith'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.

7. 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.

[1] *Coronial Brief*, Statement of June Munro dated 7 March 2018, 82-83; Statement of Kelly Willan dated 6 March 2018, 76-77
[2] Ibid

8. 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.

9. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Smith's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

10. This finding draws on the totality of the coronial investigation into the death of Mr Smith, including evidence contained in the coronial brief and further evidence obtained under my direction. 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. [3]

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

Circumstances in which the death occurred

11. In the lead up to the fatal incident, the available evidence suggests that Mr Pozzebon believed that Mr Smith owed him money for rent and that Mr Smith had stolen money from him.[4]

12. On the evening of 2 March 2018, Mr Pozzebon and his partner attended a local bar and Mr Pozzebon was reported to have consumed a large amount of alcohol. He returned home with his partner, Ms Sue Anderson (**Ms Anderson**) at around midnight that evening.[5]

13. At about 12.20am on 3 March 2018, Mr Pozzebon reportedly left his room to go to the toilet and about this time, one of the male residents, Andrew Matus (**Mr Matus**), returned home and Mr Smith arrived home shortly after the male resident.[6]

14. Mr Pozzebon later admitted during an interview with Victoria Police that he went into Mr Smith's bedroom and the two of them had an argument about money. Mr Pozzebon asked where his overdue rent was, and was heard by Mr Matus saying to Mr Smith, '*where's my*

[3] 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.
[4] *Coronial Brief*, Statement of Sue Anderson dated 14 March 2018, 54-55
[5] *Coronial Brief*, Statement of Sue Anderson dated 3 March 2018, 48
[6] Ibid

rent, where's my rent, where's the money you owe me.' Mr Smith said he would have the rent money soon. Mr Matus then heard Mr Pozzebon say that he had had enough of this. Mr Matus then heard Mr Pozzebon leave the house through the back door.[7]

15. Mr Matus went into the kitchen and spoke briefly with Mr Smith. Mr Matus returned to his room. Shortly afterwards, he heard Mr Pozzebon re-enter the house through the back door.

16. In that brief intervening period, Mr Pozzebon had left the house and proceeded to the shed at the rear of the property where he retrieved his .22 calibre rifle and ammunition. He also attached a silencer to the barrel of the rifle and returned inside the house through the back door.[8]

17. Mr Pozzebon confirmed later that he went up to Mr Smith in the kitchen and began yelling at him about the money Mr Smith owed him and about everything Mr Pozzebon had done for Mr Smith's family. Mr Pozzebon sounded angry and aggressive during the argument, which was overheard by Mr Matus in his room.[9]

18. Mr Pozzebon further confirmed that he raised the rifle and placed it close to the head of Mr Smith, pulled the trigger and shot him in the head. Mr Smith reportedly fell to the floor. At this time, Mr Matus heard a noise which sounded to him like a thud. Mr Matus walked from his room into the hallway. He could see Mr Smith lying on the floor in the kitchen, surrounded by blood. Mr Pozzebon was standing in the middle of the kitchen to the right of Mr Smith, holding a rifle in his hand. Mr Matus immediately fled the scene, fearful of being shot by Mr Pozzebon. He went to the Sunshine Police Station and reported the event.[10]

19. Mr Pozzebon confirmed later that he returned to his bedroom, where Ms Anderson was, with the rifle. Mr Pozzebon told Ms Anderson not to go to the kitchen as it was a 'bloodbath'.[11] Ms Anderson went to the kitchen and found Mr Smith lying on the floor. Ms Anderson told Mr Pozzebon to get rid of the rifle and he confirmed that she was safe and he wasn't going to shoot her. Ms Anderson then had a cigarette outside the house in the front yard whilst Mr Pozzebon returned to the garage and put the rifle in its bag on a trailer inside the garage.[12]

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[7] *Coronial Brief,* Statement of Andrew Matus dated 3 March 2018, 41
[8] *Coronial Brief,* Transcript of Police interview with John Pozzebon dated 3 March 2018, 273-275
[9] *Coronial Brief,* Statement of Andrew Matus dated 3 March 2018, 41-42
[10] Ibid, 42-43
[11] *Coronial Brief*, Statement of Sue Anderson dated 3 March 2018, 49-50
[12] *Coronial Brief,* Transcript of Police interview with John Pozzebon dated 3 March 2018, 284-285

20. At the time Mr Pozzebon was in the garage storing his rifle, a friend of his, Mr Raymond Lane, was driving past the house and saw Ms Anderson in the front yard. He stopped and spoke to her and she told him what happened. Mr Lane approached the front door and Mr Pozzebon appeared from inside the house. Mr Lane asked what Mr Pozzebon had done and he replied, '*I've had enough of the Smitties'*, an apparent reference to Mr Pozzebon's former wife's side of the family.[13]

21. Victoria Police members from the Critical Incident Response Team arrived shortly at around 1.44am and found Mr Pozzebon on the footpath drinking from a bottle of apple cider. Mr Pozzebon was arrested without incident. Ambulance paramedics and other Police members then entered the premises and found Mr Smith lying on his back in the kitchen. The paramedics checked for signs of life and pronounced Mr Smith deceased at 1.50am.[14]

22. On 18 December 2019, in the Supreme Court of Victoria, Mr Pozzebon was found guilty of the murder of Mr Smith and he was sentenced to 26 years imprisonment with a non-parole period of 19 years.[15]

Identity of the deceased

23. On 7 March 2018, Jason Leslie Smith, born 30 November 1973, identified via fingerprint identification comparison.

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

Medical cause of death

25. Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 3 March 2018 and provided a written report of his findings dated 12 September 2018.

26. Dr Lynch noted the following:

    (a) The projectile entered the left temporal skin, temporalis muscle and skulls (with internal bevelling) and passed through the left temporal lobe, midbrain and right temporal lobe resulting in a partial exit in the right temporal bone.

[13] *Coronial Brief*, Statement of Ray Lane dated 3 March 2018, 64
[14] *Coronial Brief*, Statement of Jiri Patrasek dated 10 March 2018, 102-103; Statement of Victoria Police CIRT Member dated 6 March 2018, 125-126
[15] *R v Pozzebon* [2019] VSC 631, 16

(b) The range of the wound is distant. This was based on pathological classification of range based on the absence of blackening, muzzle imprint or stippling (tattooing) at the entry site.

(c) Natural disease was noted in the form of a heart weight at the upper limit of normal, scarring of the heart muscle, abnormal thickening of the mitral valve chordae, pulmonary emphysema and chronic hepatitis C.

27. Toxicological analysis of post-mortem samples identified the presence of amphetamines, cannabinoids, benzodiazepines, methadone, cocaine metabolites, morphine and codeine. None of these detected substances were at levels that suggest a connection to the mechanism of death in this case.

28. Dr Lynch provided an opinion that the medical cause of death was '1(a) Gunshot wound to the head'.

29. I accept Dr Lynch's opinion.

FURTHER INVESTIGATIONS AND CPU REVIEW

Family violence investigation

30. As Mr Smith's death occurred in circumstances of recent family violence, I requested that the Coroners' Prevention Unit (**CPU**) [16] examine the circumstances of Mr Smith's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[17]

31. Mr Smith's relationship with Mr Pozzebon met the definition of 'family member' under the *Family Violence Protection Act 2008* (Vic) (**the FVPA**).[18] The fatal incident involved an assault by Mr Pozzebon towards Mr Smith which meets the definition of 'family violence' in the FVPA, specifically the act of shooting Mr Smith in the head to cause his death.

[16] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[17] The VSRFVD provides assistance to Victorian Coroners to examine the circumstances in which family violence deaths occur. In addition the VSRFVD collects and analyses information on family violence-related deaths. Together this information assists with the identification of systemic prevention-focused recommendations aimed at reducing the incidence of family violence in the Victorian Community.

[18] Section 8(1)(c) of the *Family Violence Protection Act 2008*

32. An in-depth family violence investigation was conducted in this case and I requested materials from several key service providers that had contact with Mr Smith and Mr Pozzebon prior to Mr Smith's death.

33. The available evidence suggests that Mr Pozzebon had a history of perpetrating family violence against current and former partners, in the form of emotional/psychological abuse and threats.[19] This included threatening his current partner with a gun.[20]

34. There is no indication in the available evidence however, that Mr Pozzebon perpetrated family violence against Mr Smith prior to the fatal incident, aside from one potential incident where Mr Pozzebon was reportedly verbally abusive towards Mr Smith in approximately mid-January.[21]

35. The information and records provided to the Court by various services that had contact with Mr Smith and Mr Pozzebon did not evidence any family violence that was disclosed to services prior to the fatal incident.

36. As a result of sustaining a head injury in his workplace in 2012, Mr Pozzebon was unable to continue working and his wife separated from him at the time. Mr Pozzebon was treated by various medical practitioners using Citalopram to improve his mood and anxiety. Mr Pozzebon was reported by family members to have suffered from increasing emotional instability following the 2012 head injury.

37. Mr Pozzebon's former partner indicated that his behaviour had changed, and he became more aggressive after sustaining the head injury.[22] A review of Mr Pozzebon's medical records from his treating General Practitioner did not identify any indications that this increase in aggression was disclosed to his treating practitioner proximate to the fatal incident.[23]

Firearms and Mr Pozzebon's acquired brain injury

38. At the time of the fatal incident, Mr Pozzebon had a valid firearm license and had lawfully acquired six firearms which were registered in his name and stored in his residence a gun safe in his garage.

[19] *Coronial brief*, Statement of Sue Anderson dated 3 March 2018, 50, 53-55; Statement of Susan Pozzebon dated 7 March 2018, 86-87, 90; Appendix G – Transcript of Audio Recording, 232-233, 244, 247
[20] *Coronial brief*, Appendix G – Transcript of Audio Recording, 244
[21] *Coronial brief*, Statement of Andrew Matus dated 3 March 2018, 45.
[22] *Coronial brief*, Statement of Susan Pozzebon dated 7 March 2018, 86-87.
[23] Sunshine City Medical Centre, Medical records of John Pozzebon.

39. I received firearms records from the Victoria Police Licensing and Registration System which showed that Mr Pozzebon had last renewed his firearms license on 29 January 2016 and ticked yes to having been *treated for psychiatric, depression, stress or emotional problems* ***and*** *stroke or head injuries*" located on the renewal application form.[24] Mr Pozzebon supplied a letter from his former treating neuropsychiatrist dated 8 February 2013 to support his application for renewal.[25] There is no conclusive evidence that the then treating neuropsychiatrist supported Mr Pozzebon retaining his firearms license as the support letter was not addressed to the License and Regulation Division of the Victoria Police and did not mention his suitability to hold a firearms license.

40. During Mr Pozzebon's criminal trial, a forensic psychologist reviewed Mr Pozzebon's mental health status and confirmed that there was a deterioration of symptoms following Mr Pozzebon's head injury in 2012[26] and that the only situational stressor in addition to persistent mental health symptoms at the time of the fatal incident was intoxication from alcohol consumption on the day of the fatal incident.[27]

41. Many mental health conditions and acquired brain injuries may deteriorate overtime and this can increase the risk posed to the community if individuals with such conditions aren't treated regularly and, where the risk is high, have their firearms license suspended.

42. I requested that the CPU review data relating to homicides between 1 January 2010 and 1 January 2020 involving firearms where the offender had a known mental health condition.[28] This revealed 98 homicides during that period where a firearm was the murder weapon. Of the 98 cases identified, at least 28 cases involved an offender who had a known or suspected mental health condition.

[24] Category A and B Longarms Renewal Application Form completed and signed by Gioni Pozzebon on 29 January 2016

[25] Support letter from Dr Mark Walterfang dated 8 February 2013

[26] Dr Aaron Cunningham psychological report dated 7 October 2019, 4

[27] Ibid

[28] The Victorian Homicide Register (VHR) is a state-based suicide surveillance system that contains detailed information on people who die by homicide and the circumstances surrounding their death. The VHR uses enhanced data (pertaining to stressors, service contacts and legal system contacts), this enhanced data is coded into the VHR after the coronial briefs of evidence are received and the Coroner has made a determination regarding circumstances of death. Data was extracted from the Victorian Homicide Register, data includes both open and closed cases and the data set is from 1 January 2010 to 1 January 2020.

43. This issue has arisen in previous coronial investigations relating to suicide by firearm and I reference two former coronial findings including the investigations in the deaths of *Raymond Cox COR 2014 2220* and *Peter Quin-Conroy COR 2010 3294*.

44. In the coronial investigation into *Peter Quin-Conroy COR 2010 3294*, Mr Quin-Conroy had a history of major depression which he was being treated for by his General Practitioner (**GP**) and a consultant psychiatrist. The GP provided Mr Quin-Conroy with a letter of support for him to use in his firearm license renewal application. The case went to inquest and the Honourable Coroner Spooner heard evidence from the treating consultant psychiatrist who indicated that he would have recommended that Mr Quin-Conroy instead surrender his firearms due to his mental health conditions. The recommendations coming out of the inquest into Mr Quin-Conroy's death included the following:

(a) implementing a variable period of licensing for individuals with mental health conditions;

(b) a requirement that all applicants provide a suitable medical report from a medical practitioner who is in an appropriate position to comment on their medical history;

(c) attached to the license application form, instructions for general practitioners about their roles and responsibilities in providing the medical report;

(d) establishing a medical review panel for applicants who are identified as potentially unsuitable to hold a license by virtue of the mental illness; and

(e) guidelines for GPs about when to report concerns of mental illness and the use of medical note alerts as a reminder that the patient holds a firearms license.

45. In response to the above recommendations Victoria Police developed a guide for health professionals, in consultation with the Royal Australian College of General Practitioners (RACGP). outlining what medical evidence is required to support a firearms license application and when a treating medical practitioner should report a patient who holds a firearms license and is unfit to have a firearms license. The most current version of this guide is the *Quick Guide: The Role of Health Professionals in the Firearms Licensing Process*.[29]

46. In the case of Coroner Spanos' investigation into the death of *Raymond Cox COR 2014 2220* – This was a similar case of suicide by firearm use involving an 84 year old who had

[29] Available online at: https://www.police.vic.gov.au/sites/default/files/2018-11/Role-of-the-Health-Professional_V2_Feb2016_0.pdf

Alzheimer's and multiple health conditions that made it unsuitable for him to hold a firearms license. His treating general practitioner assumed that he would cancel his firearms license and dispose of his firearms but this never happened and Mr Cox's lack of suitability to hold a license was never reported to Police. The deceased's wife tried to warn the police but they did not take action, instead insisting that the deceased self-report and surrender the firearms. Her Honour commented on her support of the new guide for health professionals and indicated her support for this guide to become more widely circulated and promoted amongst the medical profession.

FINDINGS AND CONCLUSION

47. Pursuant to section 67(1) of the Coroners Act 2008 I make the following findings:

    (a) the identity of the deceased was Jason Leslie Smith, born 30 November 1973;

    (b) the death occurred on 3 March 2018 at 2 Oxford Street, Sunshine North, Victoria from 1(a) Gunshot wound to the head; and

    (c) the death occurred in the circumstances described above.

48. Having considered all the available evidence, I am satisfied that no further investigation is required in this case.

49. I convey my sincere condolences to Mr Smith's family for their loss.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

Firearms licenses, mental health and previous related coronial findings

50. Firearms are regulated by the *Firearms Act 1996* (Vic) and the responsibility for regulating firearm license holders lies with the Licensing and Regulation Division of Victoria Police.

51. This case and other similar deaths investigated by this Court highlight the importance of having current medical evidence to support the holding of a firearms license. There is a need to properly manage risk and establish a regime of enforcement and regulation that reduces the risk to the community posed by individuals holding a firearms license who are being treated for mental health or health conditions that can deteriorate or change over time.

52. Firearm ownership comes with great responsibility and it is a firearm license holders' obligation to ensure their actions do not put themselves or others at risk. However, it is the ultimate responsibility of Victoria Police as the regulatory body to ensure that only appropriate individuals have access to firearms, especially in circumstances where an individual's health or mental health is compromised and the safety of the community is endangered.

RECOMMENDATIONS

53. Pursuant to section 72(2) of the Act, I make the following recommendations:

Recommendation One:

That Victoria Police review their current policies and procedures regarding firearms license applications and renewal applications. Specifically, that if an applicant declares that they are currently being treated for a medical issue (including mental health), the medical evidence provided to support such an application must be current and less than 3 months old. It must also be provided in the form of Appendix One to the *Quick Guide: The Role of Health Professionals in the Firearms Licensing Process* to ensure that health professionals understand why the medical report is being provided with respect to the suitability of an individual to hold a firearms license.

Recommendation Two:

That if a firearms license holder is being treated for a condition that is subject to change as indicated in a medical report supporting their continual access to firearms, Victoria Police should consider implementing a variable period of review for such firearms license holders to ensure that they continue to provide regular medical advice as to the appropriateness of the individual being licensed to possess and use a firearm.

54. 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.

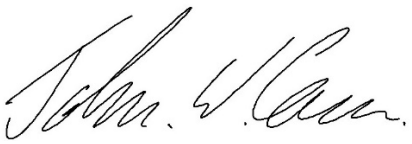
55. I direct that a copy of this finding be provided to the following:

Ms June Munro, Senior Next of Kin

Mr Shane Patton, Chief Commissioner of Police, Victoria Police

Detective Acting Sergeant Tom O'Loughlin, Coroner's Investigator

Signature:



JUDGE JOHN CAIN

STATE CORONER

Date: 13 April 2021

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.