IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 3644

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:	Arthur John Smith
Date of birth:	28 September 1926
Date of death:	Between 24 July 2018 and 25 July 2018
Cause of death:	1(a) Gunshot wound to the head
Place of death:	229 Smiths Road, Parwan, Victoria

INTRODUCTION

1. Mr Arthur John Smith (**Mr Smith**) was a 91-year-old man who resided at 229 Smiths Road, Parwan, Victoria with his wife, Gwen Adeline Smith (**Mrs Smith**). Mr and Mrs Smith had three daughters and at the time of their deaths were great grandparents to nine great grandchildren.

2. Mr Smith was born in Mount Cottrell and after completing his schooling, he joined the Airforce until the end of the Second World War. After leaving the Airforce, Mr Smith took up farming and was working on a share farm until he met Mrs Smith and they bought their own farm in Parwan.

3. Mrs Smith was born in Bacchus Marsh and after completing her schooling, she worked in various jobs including at a private hospital until she met Mr Smith around 1950 and they were married. The couple bought a 300-acre farming property where they resided until the fatal incident.

4. After settling into their new farm home in Parwan, Mr and Mrs Smith went on to have three daughters; Ms Jenifer Fraser (Ms Fraser), born in 1954, Ms Carolyn Smith, born in 1956, and Ms Maree Ryan (Ms Ryan), born in 1958.[1]

5. In 2001 and 2016 respectively, Mr and Mrs Smith's two eldest daughters, Ms Fraser and Carolyn Smith, both tragically passed away due to complications related to Multiple Sclerosis.[2]

6. After leaving home, Mr and Mrs Smith's remaining daughter, Ms Ryan, moved to New South Wales permanently.[3] The passing of her daughters and the subsequent suicide of Carolyn's husband significantly impacted upon Mrs Smith, and in 2008 she was diagnosed with depression and prescribed anti-depressants, which she took up until the time of her death.[4] Mrs Smith was also seeing a psychiatrist from 2008 until he passed away in January 2018.[5]

7. The available evidence suggests that in the years prior to the fatal incident, Mr and Mrs Smith had struggled financially and with the upkeep of their property and home, due to their age and the condition of the property.[6] Their daughter, Ms Ryan, had offered to relocate Mr and Mrs Smith to NSW, where she resided, however they had refused.[7]

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[1] *Coronial Brief,* Statement of Kerryn Sanders dated 25 July 2018, 22
[2] Ibid
[3] *Coronial Brief,* Statement of May Ryan dated 26 July 2018, 42
[4] *Coronial Brief,* Statement of Dr. Santino Bronchinetti, 68
[5] *Coronial Brief,* Statement of Kerryn Sanders dated 25 July 2018, 21
[6] *Coronial Brief,* Statement of May Ryan dated 26 July 2018, 41
[7] Ibid

8. Approximately two years prior to the fatal incident, Ms Ryan had placed a deposit on a unit within an aged care facility, however, Ms Ryan later found out that Mr and Mrs Smith had stopped the process and did not wish to move from their home.[8] Ms Ryan also proposed that the couple move elsewhere however, they reportedly did not want to move and stated that 'they *always found change and moving too difficult.*'[9] Ms Ryan states that Mr and Mrs Smith '*were always asking me why I was there and that I was interfering.*'[10]

9. Prior to their deaths, Mr and Mrs Smith received significant support and assistance from their grandchildren, Mrs Kerryn Sanders (**Mrs Sanders**) and Mr Gavin Minns (**Mr Minns**).[11] Mr Minns worked on the farm and both Mr Minns and Mrs Sanders attended the home of Mr and Mrs Smith almost daily.[12]

10. Prior to her death, Mrs Smith's general health was reported to be '*in reasonable health for her age*'[13] with her main health issues relating to the management of her depression, high blood pressure and cholesterol levels.[14] Mrs Smith saw her local doctor approximately every three months for the treatment of these conditions.[15]

11. On 26 June 2018, Mr Smith underwent a heart valve replacement at St. Vincent's Hospital and was discharged home on 1 July 2018. On the 6 July 2018, Mr Smith was readmitted to hospital due to complications, which led to a further stay at a rehabilitation facility with concerns that Mr Smith was having trouble coordinating.[16] On 23 July 2018, Mr Smith was discharged again and returned home with Mrs Smith.

12. On 21 July 2018, St Vincent's Hospital made a referral to My Aged Care requesting that they undertake an assessment of Mr and Mrs Smith and determine what in home supports could be arranged for the couple.[17] In the referral, it was noted that Mr Smith had expressed concern that due to his health issues, he would be forced off his farm and into care.[18]

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[8] Ibid
[9] Ibid
[10] Ibid
[11] *Coronial Brief,* Statement of Gavin Minns dated 25 July 2018, 16; Statement of Kerryn Sanders dated 25 July 2018, 21
[12] Ibid
[13] *Coronial Brief,* Statement of Dr. Santino Bronchinetti, 68
[14] Ibid
[15] Ibid
[16] *Coronial Brief,* Statement of May Ryan dated 26 July 2018, 43
[17] *Coronial Brief,* Statement of Nicole Sparrow dated 10 October 2018, 33
[18] Ibid

THE CORONIAL INVESTIGATION

13. 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.

14. 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.

15. 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.

16. 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.

17. 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. [19]

[19] 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.

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

Circumstances in which the death occurred

18. On 24 July 2018, Ms Nicole Sparrow, a Home Support Assessor with My Aged Care, attended the home of Mr and Mrs Smith in the company of colleague Ms Cheryl Malloch. Mr Minns and Mrs Sanders were also present during this assessment.[20]

19. Ms Sparrow reported that during the assessment she had '*got the impression that [Mr Smith] was concerned he was losing his independence*',[21] but that the general theme of the meeting had been positive, with both Mr and Mrs Smith appearing appreciative of the supports enabling them to continue to reside in their home.[22] Ms Sparrow and Ms Malloch reported that when they had left the home they had believed that Mr and Mrs Smith had been accepting of the proposed plan and noted that they did not hold any overall concerns for the pair.[23]

20. Following the meeting, Mrs Sanders and Mr Minns remained with Mr and Mrs Smith for a period of time before leaving the property. Mrs Sanders commented that Mr and Mrs Smith had appeared appreciative of the plan made for in home supports.[24]

21. On 25 July 2018, Mr Minns arrived at the Smith's property at 5.00am and started his farm duties until his sister, Mrs Sanders attended the property at around 10.00am.[25] Shortly thereafter a local neighbour, Ms Linda Holloway, arrived at the Smith's property and informed Mr Minns and Mrs Sanders that she had been attempting to contact Mr and Mrs Smith to no avail.[26]

22. Following attempts to enter the house, Mrs Holloway was able to gain entry and located Ms Smith deceased in her bed.[27] Mrs Holloway advised Mrs Sanders to call the ambulance as Mrs Smith was unresponsive.[28] Mr Minns then entered the home located Mr Smith face down on the floor next to the bed, sighting the '*butt of a firearm underneath him.*'[29]

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[20] *Coronial Brief,* Statement of Nicole Sparrow dated 10 October 2018, 33
[21] Ibid, 34
[22] Ibid
[23] Ibid
[24] *Coronial Brief,* Statement of Kerryn Sanders dated 25 July 2018, 22
[25] *Coronial Brief,* Statement of Kerryn Sanders dated 25 July 2018, 22; Statement of Gavin Minns dated 25 July 2018, 16
[26] *Coronial Brief,* Statement of Linda Holloway, 36
[27] Ibid.
[28] *Coronial Brief,* Statement of Kerryn Sanders dated 25 July 2018, 23; Statement of Linda Holloway, 36
[29] *Coronial Brief,* Statement of Gavin Minns dated 25 July 2018, 16.

23. Mrs Sanders exited the house and called emergency services to attend.[30] Ambulance paramedics were first to arrive at around 11:15am and found the deceased bodies of Mr and Mrs Smith in the master bedroom. The Police arrived shortly after at 11:35am to commence their investigations.[31]

24. The Police did not identify any signs of struggle, forced entry or of apparent third-party involvement.[32]

Identity of the deceased

25. On 25 July 2018, Gavin Minns visually identified the deceased to be his grandfather, Arthur Smith, born 28 September 1926.

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

Medical cause of death

27. Dr Melanie Archer, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, performed an autopsy on the body of Mrs Smith and provided a written report of her findings dated 21 December 2018.

28. Dr Archer commented on the following:

    (a) There was a single gunshot entry wound to the right temple, with no exit wound. The wound track went backwards and slightly upwards to terminate in the left side of the brain. The main bullet fragment was recovered from inside the skull at the left upper occipital region;

    (b) The entrance wound in this case was *'contact / near contact'* due to sooting of the skin surface and subcutaneous tissues, and absence of stippling. This means that the gun muzzle is most likely to have been either loosely in contact with, or within a couple of centimetres of the deceased's scalp;

    (c) extensive skull fractures were associated with the entrance wound and there was disruption of a large portion of the right cerebral hemisphere, which would have resulted in rapid unconsciousness and death;

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[30] *Coronial Brief,* Statement of Kerryn Sanders dated 25 July 2018, 23-24
[31] *Coronial Brief,* Statement of Detective Senior Constable Josh Coy dated 2 November 2018, 47
[32] *Coronial Brief,* Statement of Detective Senior Constable Josh Coy dated 2 November 2018, 47-50

(d) There was no evidence of further significant trauma at autopsy or on the post mortem CT, including no skeletal fracture. Minor bruising to the left toe, left middle toe and left elbow were seen, along with old abdominal bruising. There was no evidence of defence type injuries; and

(e) There was significant cardiac disease, including cardiomegaly (an enlarged heart), aortic valve replacement, and right coronary artery stenting. The deceased also had cardiac amyloidosis, which is deposition of amyloid protein in the spaces between heart muscle cells. There are several forms of amyloidosis, and this is favoured to represent the '*senile*' form, which commonly accompanies aging. The deceased's heart weight of 533 g was in excess of the 95th percentile for a man of his height and weight. His risk factors for cardiomegaly were hypertension, cardiac amyloidosis, ischaemic heart disease and valvular heart disease.

29. Dr Archer concluded that a reasonable cause of death was:

I(a) Gunshot wound to the head

30. Toxicological analysis of post-mortem specimens did not reveal the presence of alcohol or common drugs or poisons.

31. I accept the cause of death proposed by Dr Archer.

FURTHER INVESTIGATIONS AND CPU REVIEW

Family violence investigation

32. On the basis of the physical evidence as well as Dr Archer's opinion, I am satisfied to the coronial standard that Mr Smith was capable of the actions necessary to cause Mrs Smith's death and that he then turned the firearm on himself and intentionally took his own life.

33. For the purposes of the *Family Violence Protection Act 2008*, the relationship between Mr and Mrs Smith was one that fell within the definition of 'spouse'[33] under that Act. Moreover, Mr Smith's actions in fatally shooting Mrs Smith constitutes 'family violence'.[34]

[33] Family Violence Protection Act 2008, section 9
[34] Family Violence Protection Act 2008, section 8(1)(a)

34. In light of Mr and Mrs Smith's death occurring under circumstances of family violence, I requested that the Coroners' Prevention Unit (CPU)[35] examine the circumstances of their deaths as part of the Victorian Systemic Review of Family Violence Deaths (VSRFVD).[36]

35. The available evidence suggests that Mr Smith exhibited behaviours that aligned with more traditional gender roles and beliefs of their generation. There was no evidence however to suggest that there were concerns of family violence between Mr and Mrs Smith in the lead up to the fatal incident.

36. At the time of Mr and Mrs Smith's death, the services that were involved with the couple were primarily focused on their health needs and there were no prevention opportunities identified in the provision of these services.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was Arthur John Smith born 28 September 1926;

    (b) the death occurred sometime between 24 July 2018 and 25 July 2018 at the 229 Smiths Road, Parwan, Victoria from I(a) Gunshot wound to the head; and

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

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

39. 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.

[35] The Coroners Prevention Unit is a specialist service for Coroners established to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety

[36] 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

40. The unexpected, unnatural and violent death of a person is a devastating event. Violence perpetrated by an intimate partner is particularly shocking, given that all persons have a right to safety, respect and trust in their most intimate relationships.

Homicide-suicides in advanced age couples

41. The available evidence in this case suggests that in the lead up to the fatal incident, Mr and Mrs Smith experienced a number of significant relationship stressors including finances and debt, their daily care needs with advanced age and the stress over maintaining their large farm property. Mr Smith had expressed clear indications that he wanted to stay at home and both he and Mrs Smith cancelled previous plans made by their daughter to have them move into supported residential accommodation.

42. Research into intimate partner homicide-suicides has identified a unique set of characteristics regarding homicide-suicides amongst elderly couples. Findings indicate that individuals amongst this population have often been married for many decades, may have been suffering from a significant illness at the time of the fatal incident and may have been experiencing financial problems and/or social isolation.[37]

43. Mrs Smith's murder, and the subsequent suicide of Mr Smith, appear to have several characteristics consistent with the category of homicide-suicides. Mr and Mrs Smith were an elderly couple who had been married for many years and Mr Smith's health had also been rapidly declining in the months and weeks leading up to the fatal incident.

44. Research highlights that in cases such as these, the act of homicide and suicide may be consensually agreed upon, '*whereby there has been an agreement that this course of action is preferable to living with a debilitating illness or unfavourable living conditions.*'[38] Police investigations into the death of Mr and Mrs Smith, however, found no indication that Mrs Smith was aware or agreeable to Mr Smith's actions.

45. 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.

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

Ms Maree Ryan, Senior Next of Kin

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[37] Australian Government-Australian Institute of Criminology, *Murder-suicide in Australia,* No. 176 2008 <https://aic.gov.au/publications/cfi/cfi176>

[38] Roger Byard, '*Murder- Suicide; An Overview*', Forensic Pathology Reviews (2005) Vol 3, 345.

Detective Senior Constable Josh Coy, Coroner's Investigator

Signature:

JUDGE JOHN CAIN

STATE CORONER

Date: 7 May 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.