IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 3645

**FINDING INTO DEATH FOLLOWING INQUEST**

*Form 37 Rule 63(1)*
*Section 67 of the **Coroners Act 2008***

**Inquest into the death of Gwen Adeline Smith**

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| Delivered on: | 7 May 2021 |
| Delivered at: | Coroners Court of Victoria,<br>65 Kavanagh Street, Southbank |
| Hearing dates: | 7 May 2021 |
| Findings of: | Judge John Cain, State Coroner |
| Counsel assisting the Coroner: | Nicholas Ngai, Family Violence Senior Solicitor |
| Catchwords: | Suspected homicide, no one charged with an indictable offence in respect of a reportable death, mandatory inquest. |

**HIS HONOUR:**

## BACKGROUND

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

2. 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.

3. 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.

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

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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

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]

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

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[6] *Coronial Brief,* Statement of May Ryan dated 26 July 2018, 41
[7] Ibid
[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

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]

## THE PURPOSE OF A CORONIAL INVESTIGATION

13. Mrs Smith's death constitutes a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as Mrs Smith ordinarily resided in Victoria[19] and the death appears to have been unexpected and violent.[20]

14. Pursuant to section 52(2) of the Act, it is mandatory for a coroner to hold an inquest if the death occurred in Victoria and a coroner suspects the death was as a result of homicide and no person or persons have been charged with an indictable offence in respect of the death.

15. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[21] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[22]

16. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[23] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[24] or to determine disciplinary matters.

17. The expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

18. For coronial purposes, the phrase "*circumstances in which death occurred*,"[25] refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

19. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by

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[17] *Coronial Brief,* Statement of Nicole Sparrow dated 10 October 2018, 33
[18] Ibid
[19] Section 4 *Coroners Act 2008*
[20] Section 4(2)(a) *Coroners Act 2008*
[21] *Coroners Act 2008* (Vic) s 89(4),
[22] *Coroners Act 2008* (Vic) preamble and s 67.
[23] *Keown v Khan* (1999) 1 VR 69.
[24] *Coroners Act 2008* (Vic) s 69 (1).
[25] *Coroners Act 2008* (Vic) s 67(1)(c).

the making of recommendations by coroners. This is generally referred to as the Court's "*prevention*" role.

20. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;[26]

    (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice;[27] and

    (c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[28] These powers are the vehicles by which the prevention role may be advanced.

21. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[29] In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[30] 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 that they caused or contributed to the death.

**IDENTITY OF THE DECEASED PURSUANT TO S.67(1)(a) OF THE ACT**

22. On 25 July 2018, Gavin Minns visually identified the deceased to be his grandmother, Gwen Adeline Smith, born 28 July 1926.

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

**MEDICAL CAUSE OF DEATH PURSUANT TO S.67(1)(b) OF THE ACT**

24. 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 4 December 2018.

25. Dr Archer commented on the following:

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[26] *Coroners Act 2008* (Vic) s 72(1).
[27] *Coroners Act 2008* (Vic) s 67(3).
[28] *Coroners Act 2008* (Vic) s 72(2).
[29] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[30] (1938) 60 CLR 336.

(a) there was a single gunshot entrance wound to the right side of the head, with the wound track through the brain extending backwards and slightly upwards. There was no exit wound and bullet fragments were recovered from within the cranial cavity; and

(b) 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.

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

***I(a) Gunshot wound to the head***

27. Toxicological analysis of post-mortem specimens revealed the presence of therapeutic concentrations of the antidepressant doxepin and no alcohol.

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

## CIRCUMSTANCES IN WHICH THE DEATH OCCURRED PURSUANT TO S.67(1)(c) OF THE ACT

29. 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 her colleague Ms Cheryl Malloch. Mr Minns and Mrs Sanders were also present during this assessment.[31]

30. Ms Sparrow reported that during the assessment she had '*got the impression that [Mr Smith] was concerned he was losing his independence*',[32] 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.[33] 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.[34]

31. 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.[35]

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[31] *Coronial Brief,* Statement of Nicole Sparrow dated 10 October 2018, 33
[32] Ibid, 34
[33] Ibid
[34] Ibid
[35] *Coronial Brief,* Statement of Kerryn Sanders dated 25 July 2018, 22

32. 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.[36] 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.[37]

33. Following attempts to enter the house, Mrs Holloway was able to gain entry and located Ms Smith deceased in her bed.[38] Mrs Holloway advised Mrs Sanders to call the ambulance as Mrs Smith was unresponsive.[39] 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.*'[40]

34. Mrs Sanders exited the house and called emergency services to attend.[41] 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.[42]

35. The Police did not identify any signs of struggle, forced entry or of apparent third-party involvement.[43]

**COMMENTS**

36. 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.

37. 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 she did not end her own life.

38. 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'[44] under that Act. Moreover, Mr Smith's actions in fatally shooting Mrs Smith constitutes 'family violence'.[45]

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[36] *Coronial Brief,* Statement of Kerryn Sanders dated 25 July 2018, 22; Statement of Gavin Minns dated 25 July 2018, 16
[37] *Coronial Brief*, Statement of Linda Holloway, 36
[38] Ibid.
[39] *Coronial Brief,* Statement of Kerryn Sanders dated 25 July 2018, 23; Statement of Linda Holloway, 36
[40] *Coronial Brief*, Statement of Gavin Minns dated 25 July 2018, 16.
[41] *Coronial Brief,* Statement of Kerryn Sanders dated 25 July 2018, 23-24
[42] *Coronial Brief,* Statement of Detective Senior Constable Josh Coy dated 2 November 2018, 47
[43] *Coronial Brief,* Statement of Detective Senior Constable Josh Coy dated 2 November 2018, 47-50

39. In light of Mrs Smith's death occurring under circumstances of family violence, I requested that the Coroners' Prevention Unit (CPU)[46] examine the circumstances of Mrs Smith's death as part of the Victorian Systemic Review of Family Violence Deaths (VSRFVD).[47]

40. 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.

41. At the time of 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.

*Homicide-suicides in advanced age couples*

42. 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.

43. 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.[48]

44. 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

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[44] Family Violence Protection Act 2008, section 9
[45] Family Violence Protection Act 2008, section 8(1)(a)
[46] 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
[47] 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
[48] Australian Government-Australian Institute of Criminology, *Murder-suicide in Australia,* No. 176 2008 <https://aic.gov.au/publications/cfi/cfi176>

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.

45. 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.*'[49] 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.

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

**FINDINGS AND CONCLUSION:**

47. Having held an inquest into the death of Mrs Smith, I make the following findings, pursuant to section 67(1) of the Act:

    a) The identity of the deceased was Gwen Adeline Smith, born on 28 July 1926;

    b) That 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) That the death occurred in the circumstances set out above.

48. I convey my sincerest sympathy to Mrs Smith's family.

49. Pursuant to section 73(1) of the Coroners Act 2008, I order that this finding be published on the internet.

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

    **Ms Maree Ryan, Senior Next of Kin**

[49] 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 inquest. 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.