QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Connon Kenneth PRESS**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Rockhampton
FILE NO(s):	COR 2012/1480
DELIVERED ON:	19 March 2015
DELIVERED AT:	Rockhampton
HEARING DATE(s):	17 December 2014, 16-18 March 2015
FINDINGS OF:	Mr Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: suicide, evidence, capacity to form intent, firearm, police investigation, scene preservation.

REPRESENTATION:

Counsel Assisting:	Mr Peter Johns
Ms Amanda Marsh:	Ms Joanne Madden, Solicitor
Commissioner of Police:	Mr Derek Kordick, instructed by Public Safety Business Agency
Queensland Ambulance Service:	Ms Louise Syme, Crown Law
Constable Justine Hartley:	Mr Troy Schmidt

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Introduction

Connon Press sustained a gunshot wound to his head while standing in the living room of his Mount Morgan home late on the morning of 28 April 2012. Present in the home at the time were his partner, his two young children and his brother's partner.

At the age of only 33 Mr Press was pronounced deceased prior to arrival at Mount Morgan Hospital. Initial investigations concluded that the death was a suicide and coronial findings were made without the holding of an inquest.

After considering an application by Mr Press' mother to the District Court, His Honour Judge Smith subsequently ordered that an inquest be held. These are the findings of that inquest. They:-

- establish the circumstances in which the fatal injuries were sustained; in particular whether Mr Press inflicted the gunshot wound himself (and if so, whether he did so intentionally) or whether a second party was involved;

- confirm the identity of the deceased person, the time, place and medical cause of his death;

- consider whether staff from the Queensland Ambulance Service (QAS) and Queensland Police Service (QPS) acted in accordance with their policies and procedures; and

- examine the adequacy of the investigation into Mr Press' death.

The investigation and path to inquest

On 5 March 2013 the Central Coroner, Mr David O'Connell, made findings with respect to the death of Connon Press. In doing so he rejected an application by Ms Janet Brighton, Mr Press' mother, for an inquest to be held.

An application was then made by Ms Brighton to the State Coroner pursuant to section 30(4) of the *Coroners Act 2003* (the Act) that an inquest be held.

This prompted the then State Coroner to conduct further investigations, in particular in relation to aspects of the autopsy report with which Ms Brighton was concerned. On 23 April 2013 then Acting State Coroner Clements wrote to Ms Brighton declining the application for an inquest.

On 16 May 2013 Ms Brighton applied to the District Court pursuant to section 30(6) of the Act seeking an order that an inquest be held into her son's death. The application was not opposed and on 2 July 2013 His Honour Judge Smith made an order in favour of the application.

In the reasons for his decision it is evident that His Honour considered the outcome of a number of similar applications to the District Court. After considering the affidavit material put before him His Honour concluded:

In my view, bearing in mind the following issues:

(a) the fact that two witnesses allege that there were two shots fired;

(b) there seems to have been no gunshot powder residue tests conducted;

(c) the fact it is alleged that the deceased was predominantly left handed

it seems to me that it is in the public interest to hold an inquest here.

It appears to be in the public interest for a coroner to inquire whether in this case the investigation by the police was an adequate one.

I do not express any concluded view on this question as that will be a matter for evidence to be lead at the inquest. But in my view the matter should be inquired into.

His Honour went on to consider the State Coroner's Guidelines. These are issued pursuant to the Act and deal, among other things, with the question of when an inquest should be held. His Honour stated:

It appears to me that a number of matters in the guidelines are applicable in this case namely:

(a) the family's right to know of the circumstances of the demise;

(b) issues of confidence in the police investigation; and

(c) the possibility of 3rd party involvement in the death

I have had due regard to His Honour's judgment in framing the scope of this inquest and in its conduct.

The inquest

A pre-inquest conference was held in Brisbane on 17 December 2014. Mr Johns was appointed counsel assisting and leave to appear was granted to Amanda Marsh (Mr Press' partner), Janet Brighton, the Commissioner of the QPS; the QAS and several police officers who were the subject of criticism by Ms Brighton.

The inquest was held in Rockhampton over three days commencing on 16 March 2015. Fourteen witnesses gave evidence and 66 exhibits were tendered. I am satisfied that all information relevant to and necessary for my findings was made available at the inquest.

The evidence

A large amount of information was contained in the exhibits and oral evidence. These reasons record only the evidence I believe is necessary to understand the findings I have made.

Social and medical history

Connon Kenneth Press was born on 11 August 1978. At the time of his death Mr Press was residing in Mount Morgan with his partner, Amanda Marsh. They commenced cohabiting in November 2009 and had two young children. He is survived by them, his mother, Janet, and two brothers, Albert and Arian.

At the age of three Connon underwent heart surgery and as he grew up was diagnosed as 'hyperactive'; later formalised as Attention Deficit Hyperactivity Disorder (ADHD). This clearly presented difficulties for his mother and it is apparent from the evidence before the court that she remained a supportive and caring mother, assisting Connon with his medical difficulties the best she could.

Connon's psychiatric difficulties developed over the course of his life to ultimately include formal diagnoses of Paranoid Schizophrenia, Polysubstance Dependence (in particular of amphetamines and cannabis); Anti-Social Personality Traits and episodic Amphetamine Induced Psychosis.

In her evidence to the inquest it was clear that Ms Brighton was not aware of the extent of her son's mental illness, at least in terms of formal diagnosis. She actively assisted in obtaining treatment for Connon and she knew he was being treated by consultant psychiatrist, Dr Lynne Steele. However, she thought this continued treatment was solely for the symptoms of ADHD and to deal with his offending behaviour.

This also meant that Ms Brighton was unaware of other aspects of Mr Press' mental state. This included what Dr Steele described in her evidence to the inquest as *chronic intermittent thoughts of suicide with numerous and multiple attempts of suicide since a child*. Methods included cutting his wrists, overdosing on prescription drugs and attempted hanging.

Dr Steele described the symptoms of Mr Press' paranoid schizophrenia as including auditory hallucinations and perceiving messages in external objects such as food servings. The hallucinations mainly related to conspiracies involving his partner.

None of this information was available to His Honour Judge Smith when he considered Ms Brighton's application for an inquest.

Dr Steele told the inquest that at sessions with Mr Press (the most recent on 19 March 2012) she would discuss management plans should he feel at risk of self-harm. She noted that Mr Press would always guarantee his safety to her despite these thoughts and expressed his desire to live because of his young family. Dr Steele acknowledged that Mr Press was committed to and protective towards his partner and children.

Ms Marsh also told the inquest that she was not aware of Mr Press' ongoing (though intermittent) thoughts of suicide. While she went with him to appointments with Dr Steele she was not a party to their discussions.

Ms Brighton was at pains in her evidence at the inquest to establish that Connon had 'never attempted suicide in front of her' though did not entirely dismiss that she was at least aware of one or more attempts at suicide when Connon was younger. She agreed that he had been admitted to a psychiatric hospital at Wacol in his youth following a court order.

Evidence that Connon had told police watch house staff of a previous suicide attempt was dismissed by Ms Brighton as Connon telling the police *what they wanted to hear*.

In the months leading to his death Mr Press was, according to Dr Steele, *suffering intrusive, compulsive thoughts to harm others which were long standing and chronic in nature*.

Mr Press guaranteed Dr Steele that he had no actual plans to harm others. He was disturbed by the thoughts and voluntarily sought treatment for them. This resulted in an increase, on 2 February 2012, of Mr Press' anti-psychotic medication. Dr Steele also added a prescription for the anti-depressant Prozac; the latter being helpful in some cases for obsessional, intrusive thoughts.

In addition to these medications Mr Press was given ongoing prescriptions for Methylphenidate for his ADHD. The fact that this drug was not present in his blood at the time of his death can be explained by Dr Steele's evidence that he was often not compliant with his medication regime.

On 19 March 2012 Mr Press presented to Dr Steele suffering from unresolved paranoid ideation despite the now high dose of the anti-psychotic drug Risperidone. Dr Steele decided to change Mr Press to a different anti-psychotic drug and increased his dose of Prozac.

Ms Marsh bore the brunt of the paranoid thoughts suffered by Mr Press. They primarily took the form of a delusional belief that Ms Marsh was cheating on him. He constantly checked her phone. On the day of his death he was convinced that she was making contact with others through an ear piece she was wearing for this purpose.

Ms Marsh told the inquest that Mr Press thought himself under surveillance by, for instance, 'cameras' installed in the smoke detectors at their house. These thoughts were correlated to Mr Press' use of amphetamines and consistent with the symptoms Mr Press had reported to Dr Steele.

In her affidavit to the District Court Ms Brighton contended that Mr Press had not taken amphetamines for three weeks prior to his death. It became evident at the inquest that this belief was based on little more than a promise Mr Press made to her three weeks prior to his death that he would stop taking these drugs for the sake of his family.

Ms Marsh told the court that the illegal drug use had in fact continued up until the day before Mr Press' death. Even when the family travelled to visit a friend

of Ms Marsh in Townsville earlier in April 2012 Mr Press had *found a way* to access amphetamines every day much to her distress. The account of Ms Marsh is entirely consistent with the post-mortem toxicology results which showed extremely high levels of methylamphetamine.

It is clear that Mr Press was much loved by Ms Marsh, Ms Brighton, his children, brothers and extended family. I extend my sincere condolences to each of them.

It is clear that Ms Brighton's grief at the sudden loss of her son is intense and has led to an apparent and largely understandable inability to accept key aspects of the events leading to the death. The unfortunate aspect of this is that her concerns have led to, what I find below are, entirely unfounded, and provably wrong, accusations of the utmost seriousness against Ms Marsh.

Events of 28 April 2012

It is unlikely Mr Press had slept at all on the night before his death. However, this was not particularly unusual and is a known symptom of amphetamine misuse.

A similar episode earlier in the week had resulted in Mr Press taking a significant overdose of Risperidone in an attempt to get to sleep. The unintended outcome of this was a reaction that involved lock-jaw which saw Mr Press attend hospital for treatment.

Ms Marsh said that when she woke on the morning of 28 April 2012 Mr Press was wide awake and told her he had not slept. As the morning wore on Mr Press was again acting on apparent paranoid and delusional thoughts.

He was insistent that Ms Marsh was wearing an earpiece and communicating with another man. She said that this was a common theme of his paranoia. In frustration this led to Ms Marsh continually showing him her ears. She also offered to have her hair cut to expose her ears if this would somehow allay Mr Press' concerns.

This resulted in an argument with raised voices. Ms Marsh said that arguments were more common when Mr Press was using amphetamines.

Also living at the residence was Karra Hare, the partner of Mr Press' brother, Arian. The verbal argument made her uncomfortable and she decided to go to her room and close the door. Ms Hare had lived with the couple for less than a week. She said that she was a 'stranger to them' and was minding her own business.

Ms Marsh says that Mr Press gained some insight into the nature of his behaviour, understanding that he needed to get some sleep. He decided to go for a ride on his motorcycle telling her that he would try to sleep on his return. Ms Marsh heard the motorcycle leave but then return a short time later.

She was sitting on the floor of their living room, changing their son's nappy, when Mr Press walked into the house. Ms Marsh saw that he was holding a gun. She had never seen the gun before. She had never seen Mr Press with a gun at any stage and did not know there was a gun of any sort in the house.

Ms Marsh told the inquest (as she had told police on the day) that Mr Press placed the gun to his head with his right hand and said *Do you reckon this works?* Ms Marsh responded *What the fuck?* at which time the gun discharged. Ms Marsh did not remember hearing a sound associated with the gun going off.

Mr Press fell with his head striking, and breaking, a glass TV cabinet. Ms Marsh screamed and immediately crawled on her hands and feet towards Ms Hare's room.

Ms Hare told the inquest that she heard raised voices followed by the smashing of glass. She heard nothing consistent with a gun shot. The smashing sound was enough for her to think she should see what was happening and when she opened her door Ms Marsh was immediately outside.

Ms Hare described Ms Marsh as hysterical; screaming and crying. Ms Marsh told Ms Hare that Connon had shot himself and that she did not know what to do.

Ms Hare instructed Ms Marsh to 'grab the kids and call an ambulance'. Ms Marsh called '000' and then relayed instructions to Ms Hare in relation to performing CPR while holding on to her youngest child, aged seven months.

Ms Hare's evidence was that she found Mr Press laying on his back with his hands to his side. He had a mouth full of blood but she could not immediately see where he had been wounded. Her evidence at the inquest was that as she rolled Mr Press onto his side in order to clear the blood from his mouth to enable resuscitation she saw the gun underneath him.

Ms Hare vividly recalled seeing hair and skin burnt onto the tip of the gun's barrel. She said that the gun was first moved by Ms Marsh to a point out of the immediate reach of the two young children who were nearby.

Ms Hare told the inquest that she later handled the gun on two occasions. The first was when she placed it on what she referred to as a 'podium' in order to ensure it was more certainly out of reach of the children. The second was when she handed it to a nurse who was with the ambulance officers at the scene.

Medical treatment

Ms Marsh had contacted '000' at 10:20am. The first paramedic to arrive at the scene was QAS officer Graham Roberts. He had been contacted at approximately 10:27am and arrived at the scene at 10:30am. He made the

decision to enter the property notwithstanding his knowledge that a gun had been involved and that police were yet to arrive.

Mr Roberts saw Ms Marsh standing at the top of the stairs holding a child and she guided him inside. There he saw Ms Hare performing CPR on Mr Press. He instructed her to continue while he began an assessment of Mr Press' injuries.

Mr Roberts was followed by another QAS officer, Mark Ricks who was dispatched at 10:30am and arrived minutes later.

Also sent to the scene was Nurse Narelle Matthews who had just commenced her shift at Mount Morgan Hospital. She travelled to the scene with the on call medical officer, Dr Joss O'Loan. They arrived around the same time as QAS officer Ricks.

The QAS officers and Nurse Matthews all give consistent accounts with respect to the scene confronting them and the whereabouts of Ms Marsh and Ms Hare.

It is clear from their evidence that when they arrived the gun used in the incident was positioned on top of a speaker. Ms Matthews then later observed the gun in a new position on the other side of the doorway (consistent with the versions of Ms Marsh and Ms Hare that it had been moved to a china cabinet).

As attempts to resuscitate Mr Press continued it seems that Ms Hare produced the gun and was asked by Ms Matthews to hand it over for safekeeping. This was done and Ms Matthews took possession of the weapon, placed it in a plastic bag, and later took it to Mount Morgan Hospital where it was handed to police by a QAS officer.

Ms Matthews also showed commendable initiative in obtaining plastic bags from Ms Marsh and later placing one over Mr Press' right hand with a view to preserving potential evidence. She did not place a bag over his left hand because she assumed that only the right hand was involved as the wound was to the right temple.

The continued attempts to resuscitate Mr Press, including intubation and the administration of adrenaline had failed to bring about any sign of life. In their evidence to the inquest both QAS officers said they held no hope for Mr Press' recovery but were directed by the doctor on scene to extricate Mr Press to the ambulance.

Ms Matthews' evidence was that when she and Dr O'Loan arrived at the scene it was 'uncontrolled and unsafe'. The QPS were not in attendance at that time. There were unknown persons arriving, children in attendance and she noted that the gun had been moved several times. The lighting inside the home was poor, making it difficult to assess Mr Press' condition.

Ms Matthews said that Karra Hare had told her 'Amanda said that Connon had shot himself'. However, not being aware of the circumstances of the shooting, her and Dr O'Loan's paramount consideration was safety. Accordingly, they made the decision to transfer Mr Press immediately to the hospital.

Dr O'Loan's clinical notes confirm that it was his decision to transfer Mr Press to the Mount Morgan Hospital. Resuscitation attempts continued while Mr Press was placed in the ambulance. It was there that QAS officer Roberts says a decision was taken by Dr O'Loan to cease the attempts to revive Mr Press before they had arrived at Mount Morgan Hospital. The doctor's clinical notes indicate a further formal assessment process occurred on arrival at Mount Morgan Hospital with Mr Press being declared deceased at 10:55am.

Police attendance

The first police officer on scene was Constable David Burton. He was later joined by another junior officer and CIB officer Detective Sergeant Scott Ingram.

Scenes of crime officer Senior Constable Justine Hartley attended the Bridge Street residence and took a series of photographs. Further photographs were taken of the seized weapon and of Mr Press' body. Senior Constable Hartley later swabbed the trigger and upper section of the handle of the gun as well as the spent cartridge. These swabs were sent for scientific analysis in Brisbane.

Another officer, Senior Constable Sheridan Simons attended the morgue later on 28 April 2012 and took samples from the hands of Mr Press for the purpose of detecting the presence of gun-shot residue (GSR). No other tests for GSR were carried out.

A local door knock was undertaken and recorded interviews were conducted with Ms Marsh and Ms Hare.

Detective Sergeant Ingram told the inquest that he had decided against GSR testing on any person other than the deceased based on his assessment of the scene and the information available to him on 28 April 2012.

Although he initially wanted to wait on the outcome of the autopsy examination before finalising his view, after interviewing Ms Marsh Detective Sergeant Ingram was reasonably satisfied that the injury had been self-inflicted. A GSR examination of Mr Marsh and Ms Hare, in his view, would not necessarily have assisted the investigation in any event.

As both women had admitted to handling the gun and were in contact with the deceased during the immediate aftermath of the shot such a test may have resulted in a 'false positive'.

Detective Sergeant Ingram was also aware that Ms Marsh had been ill and vomited in the aftermath of the shooting and would have washed her hands after doing so, impacting on any residue on her hands.

Detective Sergeant Ingram agreed with the principle that an investigator in his position should keep an open mind when confronted with a death caused by gun-shot occurring in the proximity of other people. He stressed that he had not closed off the possibility of the involvement of a second person until after the autopsy report but did not consider further GSR testing to have been necessary in this case.

Concerns of Ms Brighton and investigation findings

Ms Brighton raised many concerns with the circumstances of her son's death and the subsequent investigation.

The absence of GSR testing on the two women in the house is one of those and I will set out my views on this issue later in these findings. It is the most substantive issue raised by Ms Brighton. I do not consider it is necessary to address every other concern raised but will set out the way in which the investigation and inquest process dealt with those considered significant.

Ms Brighton and several other witnesses gave evidence that it was Mr Press' practice not to wear underpants or boxer shorts under his clothes. This was considered relevant as he was clearly wearing boxer shorts at the time of the autopsy.

It was not explained who might have been responsible for putting the boxer shorts on Mr Press post mortem or what possible motive they might have. In any event it was clear that none of those who gave evidence in this respect had lived with Mr Press for several years. Ms Marsh gave clear and compelling evidence setting out why Mr Press had adopted the practice of wearing boxers. This related to an increased and appropriate degree of modesty in the presence of his daughter.

Ms Brighton's application to the District Court contended that Mr Press was predominantly left handed. The affidavits from Mr Press' brothers attested to this while both containing the, rather significant, proviso that Mr Press wrote with his right hand.

In his evidence Arian Press acknowledged that Mr Press was able to carry out many other tasks equally well with his left or right hand. He described his brother as ambidextrous.

Ms Marsh told the court that in her experience Mr Press was predominantly, if not exclusively, right handed. The evidence was overwhelming that Mr Press might readily have used either hand to fire the gun used in his death. There is certainly no basis on which it could be found that the use of his right hand as contended by Ms Marsh, even if unusual, was particularly surprising.

The inquest received evidence from two residents of 31 Byrnes Street, Mount Morgan, who attested that they had heard two noises on the morning of 28 April 2012. They attributed the noises to gunshots.

The first, Leigh Mitchell, says that he reported the matter to the Mount Morgan police though there is no record of any such report with respect to this date. The Dee River separates his residence at 31 Byrnes Street from Mr Press' home, which was several hundred metres away. I do not consider that this evidence is of sufficient cogency to impact on my findings.

It is at odds with the credible evidence that the gun made little noise when discharged. Ms Hare's evidence was that she did not hear a gun shot from within the house. It is at odds with the strong evidence that only one shot was fired that arises from the account of Ms Marsh, the presence of only one shell and the absence of any apparent damage from a second projectile.

Even if it could be established that two shots were fired it would not necessarily implicate any other person in Mr Press' death. Clearly he could have fired a non-fatal shot, reloaded and fired a second, fatal shot. I do not find this happened at all. Rather, I emphasise that evidence of a second shot, even if able to be established, weighs very little on the basis for my findings.

The DNA sample taken from the upper part of the weapon's handle revealed a mixed profile of which the major profile was a match for Connon Press. The DNA sample taken from the trigger revealed only one DNA profile. This matched the DNA profile of Connon Press.

GSR samples taken from the hands of Mr Press were not definitive though revealed chemicals consistent with those expected to be produced by the firing of the ammunition in question. These were chemicals that Mr Press would not be expected to be exposed to given his usual day to day activities and there is a high likelihood of their being linked to the firing of a gun.

Further inquiries in relation to the gun were made by Detective Sergeant Ingram in the lead up to the inquest. These were made difficult by the absence of any serial number and the extensive modifications carried out on it.

I am satisfied that these investigations were taken to their logical conclusion. If the origin of the gun was more relevant to these findings the questioning of some witnesses at the inquest may have been more extensive. There were assertions made about its ownership which were met with denials. However, there was no utility in exploring this issue further. In these circumstances there is insufficient evidence upon which to make any finding in relation to the ownership or origin of the gun used by Mr Press.

As part of the investigations leading up to the inquest all Arunta telephone calls made between Ms Hare and Arian Press on and around 28 April 2012 were obtained and tendered. Rumours passed onto police that there may have been a video of the shooting posted to the internet were traced to a

prisoner who was then interviewed. This confirmed he had no direct knowledge of any such video and he refused to tell police the source of the rumour. Notwithstanding, QPS intelligence officers examined YouTube and other internet video sites without finding any such video.

An Arunta call at 10:33am on 28 April records Ms Hare telling Arian Press that 'Connon has just shot himself in the head'. A later call at 10:48 on 28 April 2012 records Arian saying to Ms Hare that Connon did not shoot himself and saying that Amanda was responsible. In response to this suggestion Ms Hare speculates that Amanda may have done it as the gun was not by his body. This is clearly inconsistent with her unprompted statement at 10:33am and the evidence she gave at the inquest that she found the gun underneath his body during CPR.

The autopsy

A full autopsy examination was conducted on the body of Connon Press on 3 May 2012 by an experienced forensic pathologist, Dr Nigel Buxton.

Dr Buxton noted a circular gunshot wound in the right temple with a diameter of approximately 5mm. He observed a grey shadow around the wound which he stated was *consistent with a muzzle imprint*.

Dr Buxton recorded the following observations in his report:

> *The skull showed a well-defined, clean puncture wound consistent with a 022" calibre entry wound. Bevelling of the fracture was internal. Over the left posterior temple region was a 0.22" exit wound with external bevelling. No other skull fractures noted.*
> *..*
> *The brain weighed 1420 grams and on sectioning showed the passage of a projectile with large true cavity formation from the right temple slightly postero-laterally exiting at the left posterior temple region. Extensive brain destruction was noted.*

Ms Brighton queried the finding of *extensive brain destruction* in the context of an apparently clearly defined projectile passage. At the inquest Dr Buxton explained that his observations were of extensive damage to parts of the brain around the 'true cavity'.

He told the court that this is a phenomenon regularly seen and is consistent with the damage caused by the gas which follows the passage of the projectile. Higher levels of gas entry can be expected the closer the weapon is to the victim when fired. Notwithstanding this damage (which became slightly less extensive in the soft tissue of the brain as the projectile travelled from right to left), sectioning of the brain was able to establish a single consistent path of travel between the entry and exit wound.

On reflection of the scalp Dr Buxton found a 0.22 calibre projectile trapped within the scalp aponeurosis. At the inquest he was asked whether it was unusual for the projectile to have had sufficient force to fracture the skull on

exit but remain trapped. He stated that this was not at all surprising given the low velocity of 0.22 rounds, the deceleration caused by the striking of the skull twice and the relatively strong muscle tissue around the area where the projectile was observed.

In his evidence Dr Buxton also noted that a needle had been inserted in the crook of Mr Press' right arm by medical staff for the purpose of inserting a cannula. Although he had not observed any needle marks consistent with recent drug use he noted that the size of the needle used by medical staff was usually larger than that used for the injection of drugs. It may, therefore, have the effect of masking any such signs of recent drug use. Photographs of Mr Press' body show the cannula in situ.

Dr Buxton concluded his report by stating:

> *Death in this patient is due to close contact gunshot wound to the head. The calibre of the projectile is 0.22 inch. The position of the entry gunshot wound is entirely consistent with a suicidally inflicted shot. There was no evidence that a second person played a physical role in this man's death.*

Dr Buxton issued an autopsy certificate listing the cause of death as:

> 1(a) Gunshot wound to head

Blood samples taken at autopsy were later tested. That testing revealed the presence of several drugs, most of which were consistent with the contents of medication prescribed to Mr Press.

The most notable findings of this toxicological testing were readings of amphetamine at a concentration of 0.09mg/kg and methylamphetamine at a concentration of 3.1mg/kg.

Ms Brighton contends that the toxicology results must be incorrect because they do not reveal any alcohol or cannabis – two substances Mr Press would consume daily. When questioned by Counsel Assisting Ms Brighton agreed that it would not have been at all unusual for Mr Press to only begin drinking alcohol in the afternoon. Although there was evidence from Ms Hare that she had smoked cannabis earlier in the week with Mr Press she did not state this had occurred in the days immediately prior to the death. Ms Marsh had not seen him use cannabis for several weeks.

During earlier coronial investigations an opinion was obtained in relation to the significance of the toxicology results. That opinion was provided by Dr Don Buchanan of the Queensland Health Clinical and Forensic Medicine Unit and remained unchallenged throughout the proceedings.

Dr Buchanan noted that while the presence of amphetamine might be consistent with legal prescription drugs, methylamphetamine is not available by prescription in Australia. He stated that:

Methylamphetamine undergoes N-demethylation to amphetamine, its major active metabolite (by-product). In view of the differences in concentrations between the amphetamine and the methylamphetamine in this case, it is most likely that the amphetamine present is a metabolite or by-product of the methylamphetamine.

Methylamphetamine can cause restlessness, confusion, anxiety, poor concentration, insomnia, a disturbed heart-beat, hypertension, hyperthermia, sweating and, in higher doses, hallucinations, circulatory collapse, convulsions and coma. Chronic abusers may develop paranoid psychosis.

The therapeutic range is said to be 0.01mg/kg to 0.05mg/kg but high levels can be reached without fatality. A level of 3.1mg/kg as in this case is an exceedingly high concentration, well above this range, and would be associated with poor concentration, confusion, anxiety and restlessness. Moreover, as the concentration is so high, it is likely he was a regular user, having become tolerant to the effects of the drug, necessitating greater doses to achieve the desired effects.

This concentration and level of use would have led to insomnia, which occurred in this case. This concentration is also very likely to have been a significant cause of his paranoid ideations.

Conclusions

I am satisfied to a very high level of confidence that Mr Press was the only person involved in his death.

I found Ms Marsh to be an impressive witness who was candid and resisted any attempt to gild her account of events in her own favour, even though there was an opportunity for her to do so. Her account is corroborated, insofar as it could be, by all others who were in or attended at the house that morning. She was clearly distraught and shocked at what had occurred.

The evidence is clear that the gun was fired at Mr Press from very close range – almost certainly while held against his head.

The inquest heard evidence from Dr Steele that Mr Press' mental state left him at a much higher risk of suicide than the general population. He had a history of significant suicide attempts and chronic intermittent suicidal ideation. Unlike his previous attempts, on this occasion he had access to a gun. This was a ready means of putting his ideations into effect. He was also likely to have been very severely affected by amphetamines.

In relation to this last point I have considered the possibility that Mr Press' death may have been accidental. In answer to questioning from Counsel Assisting, Dr Steele confirmed that the process of having and then acting on suicidal thoughts might readily occur notwithstanding a clearly disordered

thought pattern extending to psychosis. She was not surprised that Mr Press had taken his own life.

Dr Steele also gave evidence that the words used by Mr Press just prior to his death – *Do you reckon this will work?* – were a little unusual for someone committing suicide.

Dr Steele also agreed with counsel for Ms Marsh that if Mr Press was acutely psychotic on the morning of his death then his intent would be open to question, and that it was possible that he did not understand the consequences of his actions.

Clearly the latter is a possibility. I was unable to be satisfied about the origin of the gun. Therefore it is not clear whether Mr Press knew how it worked or whether it was loaded. The fact that only one shell was located would support the inference that it was loaded when he took possession of it.

Ms Marsh's evidence indicates that Mr Press was experiencing significant delusional thinking on the morning of his death. He was convinced that she was communicating with a third party via an ear piece. Her evidence was also that Mr Press was oriented to a future life with her and their children. He had recently given her a ring as a symbol of this long term commitment.

Post-mortem toxicology testing showed that Mr Press had fatal levels of methylamphetamine in his bloodstream. As Dr Buchanan, Clinical Forensic Medical Officer noted in his report[1], any person with a blood methylamphetamine of 3.1mg/kg would have developed disordered thinking with paranoid ideations resulting in actions that are unpredictable, impulsive and beyond the limits of normal behaviour expected of that individual. The effects would be amplified in an individual with Mr Press' symptomology.

In order to make a finding of suicide I am required to be satisfied that Mr Press acted intentionally, knowing the probable consequences.[2]

There was previously considered to be a presumption against suicide. It is now accepted that a finding of suicide can be made having regard to all the evidence on the balance of probabilities. However, a finding of suicide should not be made lightly.

Having regard to each of these considerations, it is my view that it is more likely that Mr Press was affected by symptoms of his mental illness and drug use to such an extent that he was not capable of acting intentionally with sufficient awareness of the probable consequences of his actions.

[1] Exhibit B3
[2] Clark v NZI Life Ltd [1991] 2 Qd R 11

Ms Brighton is understandably distraught and unable to understand why her son would do this when he was otherwise so committed to his family. On her account he planned to relocate with his children to Laidley.

Dr Steele told the inquest that much of Mr Press' distress arose from his clear devotion to his young family being incongruent with his addiction to illicit drugs and repeated periods of incarceration.

It seems that Ms Brighton is ascribing logical thought processes to someone who was clearly suffering a disordered, paranoid and likely psychotic mindset. She was clearly unaware of the extent of his mental illness. Her position that Mr Press was not taking drugs because he had promised her three weeks prior to his death that he would not, is misguided and clearly unsupported by the evidence.

I am satisfied that the decision to move Mr Press from his house to the ambulance is entirely immune from criticism.

Even if one medical officer may have decided that nothing further could be done prior to moving Mr Press, it does not follow that another reasonable medical practitioner could make a different decision.

I accept Ms Matthews' evidence that the scene was uncontrolled and unsafe. In this case resuscitation attempts continued after Mr Press had left the house. I am satisfied that it was an appropriate and reasonable decision to make by Dr O'Loan. No criticism can be levelled at the QAS officers involved who properly followed the directions of Dr O'Loan.

The basis of Ms Brighton's criticism for moving her son out of the house is linked to the potential loss of forensic evidence. It is not clear that any evidence of significance was lost. His body had already been extensively moved during the attempts to resuscitate him. The potential that his life might be saved clearly took priority over the preservation of the scene.

I am satisfied that the investigation into Mr Press' death was appropriately extensive and thorough. Another investigator might have sought to conduct GSR testing on Ms Marsh or Ms Hare. Even if such a test were to be positive it would not have in fact changed the outcome of the investigation. All other criticisms made by Ms Brighton of those at the scene with regard to the preservation of evidence are either misguided or unrealistic.

There were compelling reasons for the movement of the gun and continuity of that movement was ultimately able to be established. There was also an entirely reasonable basis for extricating Mr Press from the house prior to the declaration of his death. The bagging of the gun and Mr Press' right hand by Ms Matthews showed that she was clearly mindful of evidence being preserved where at all possible.

Findings required by s. 45

I am required to find, as far as is possible, who the deceased person was, how he died, when and where he died and what caused his death. As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses, the material parts of which I have summarised above, I am able to make the following findings.

Identity of the deceased - The deceased person was Connon Kenneth Press.

How he died - He died as a result of shooting himself in the head with a 0.22 inch projectile fired at close range from a sawn off rifle. This was unprovoked and occurred, without warning, in front of his partner.

I am unable to find that Mr Press was capable of forming the intent to end his life.

Place of death - He died at Mount Morgan in Queensland.

Date of death - Mr Press died on 28 April 2012.

Cause of death - Mr Press died from a gunshot wound to the head.

Concerns, comments and recommendations

Section 46, in so far as it is relevant to this matter, provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

I have already made comment in relation to the approach taken in this case to testing for GSR. It may have been prudent to have obtained swabs from Ms Marsh and, to a lesser extent, Ms Hare.

The initial view of the investigating officers, that Mr Press' death was self-inflicted, has ultimately proven correct. It is also true that positive GSR test results from either of the two women in the house would be inconclusive of anything sinister without other evidence implicating them.

The possibility that some other significant evidence, inconsistent with the gunshot being self-inflicted might emerge should nonetheless have been considered at least until all interviews had been completed and probably until after the autopsy examination several days later. The GSR results might then have taken on more significance should such evidence have arisen.

The approach taken by investigating police in relation to such things does not readily lend itself to a 'one size fits all' approach.

Each crime scene requires its own considerations and I do not consider the circumstances in this case point to any systemic failing requiring further comment or recommendation.

I close the inquest.

Terry Ryan
State Coroner
Rockhampton
19 March 2015