MAGISTRATES COURT of TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995

Coroners Rules 2006

Rule 11

I, Simon Cooper, Coroner, having investigated the death of Michael David Williams

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that

a) The identity of the deceased is Michael David Williams;
b) Mr Williams died as a result of injuries sustained in an unlawful assault;
c) The cause of Mr Williams' death was head injury following an assault; and
d) Mr Williams died on 18 February 2011 at the Royal Hobart Hospital, Hobart in Tasmania.

The Role of the Coroner

1. A coroner in Tasmania has jurisdiction to investigate a death if she or he suspects homicide. In this case there is no doubt that Mr Williams died as a result of homicide and therefore his death had to be investigated in the coronial jurisdiction, irrespective of what other investigations had taken place and no matter what other legal proceedings had arisen from it.

2. When investigating any death, whether or not an inquest is held, a coroner performs a role very different to other judicial officers. The coroner's role is inquisitorial. She or he is required to thoroughly investigate a death and to make findings with respect to that death. This process requires the making of various findings, but without apportioning legal or moral blame for the death.[1] A coroner is required to make findings of fact from which conclusions may be drawn by others.[2]

[1] see *R v Tennent; ex parte Jaeger* [2000] TASSC 64, per Cox CJ at paragraph 7.
[2] see *Keown v Khan* [1998] VSC 297; [1999] 1 VR 69, Calloway JA at 75 – 76.

3. A coroner neither punishes nor awards compensation – that is for other proceedings in other courts, if appropriate. Nor does a coroner charge people with crimes or offences arising out of a death the subject of investigation. In fact a coroner in Tasmania may not even say that he or she thinks someone is guilty of a crime or offence.[3]

4. One matter that a finding must be made about is how death occurred.[4] It is well-settled that this phrase involves the application of the ordinary concepts of legal causation.[5] Any coronial inquiry necessarily involves a consideration of the particular circumstances surrounding the particular death so as to discharge the obligation imposed by section 28(1)(b) upon the coroner.

5. It is also important to recognise that where someone is charged with a crime in relation to a particular death, no finding by a coroner about the same death may 'contain a finding which is inconsistent' with the result of the proceedings relating to that charge.[6]

Mr Williams' background

6. Mr Williams lived with his mother and brother in Kingston, and had done so for the 6-7 years before his death.

7. He had struggled with alcohol and marijuana abuse since he was 12 years old. In addition, he had cognitive impairment issue and suffered from epilepsy. Mr Williams was something of a loner, tending to keep to himself. However, he was particularly close to his uncle Shayne Anthony Waller. The men spent a lot of time together.

8. Three or four weeks before Mr Williams' death, Mr Waller moved into a unit at Stainforth Court. Mr Williams visited him there several times before 17 February 2011.

Circumstances of death

9. After spending the afternoon and evening of Thursday 17 February and the early

[3] section 28(4) of the *Coroners Act* 1995.
[4] section 28(1) (b) of the Act.
[5] see *March v E. & M.H. Stramare Pty. Limited and Another* [1990 – 1991] 171 CLR 506.
[6] section 25(4) of the Act.

hours of Friday 18 February 2011 drinking, Jamie Peter Smart, Rhys Louis Gardner and Andrew Woodhouse caught a taxi to Stainforth Court Unit Complex near Cornelian Bay Cemetery.

10. They arrived shortly after 3.00am. Once at Stainforth Court, Smart, Gardner and Woodhouse went to a unit in Block C and tried to wake the occupants. This involved Gardner kicking the front door a number of times in an attempt to wake the occupants. The occupant of the unit woke and told the men to go away as he had a baby in the unit.

11. As a result of the noise caused by the three men in Block C, police were called to Stainforth Court.

12. At 3.46am uniform police arrived. As they did they saw Gardner in the phone box in front of the units and Woodhouse and Smart standing nearby. Police observed that Smart was drinking from a Jim Beam can. He was spoken to and issued with a Liquor Infringement Notice and a Littering Notice at 3.50am. Police were then called to another incident and left the area.

13. Smart, Gardner and Woodhouse then milled around the area in front of blocks B and C of the units. They saw Mr Waller, Mr William's uncle, walk through the carpark of the Unit Complex. Mr Waller was apparently returning from a trip to a shop.

14. The men spoke with Mr Waller for a short time, and Smart invited himself and the other two men into Mr Waller's unit for a drink. After some initial reluctance, Mr Waller acquiesced and agreed to allow the men into his unit to drink.

15. Mr Waller took Woodhouse, Smart and Gardner to his unit where Mr Williams was asleep on the couch in the lounge room. After a short time drinking in the unit, Smart and Mr Waller began arguing. Smart and Gardner both attacked Mr Waller knocking him to the floor before kicking and stomping on his head and body until he was rendered unconscious.

16. So concerned was Woodhouse about the viciousness of Smart and Gardner's attack upon Mr Waller that he fled the unit, fearing he would be next.

17. Smart and Gardner then turned their attention to Mr Williams. He was still asleep and unable to defend himself. Gardner at least then dragged him off the couch

and proceeded to stomp on his head and body until he has also lost consciousness.

18. Both Smart and Gardner left Mr Waller and Mr Williams unconscious on the floor of the unit and went to another unit nearby where they continued to drink with acquaintances. Shortly after moving to the second unit, Gardner noticed he had a large amount of blood on his white 'hoodie'. He left the unit briefly and walked across the road to some rubbish bins near Rugby Park. Gardner put his blood-stained 'hoodie' in a wheelie bin and set the jumper alight in a bid to destroy it. He then returned to the unit and kept drinking.

19. Eventually Gardner left Stainforth Court, walked to a nearby bus stop and caught a bus home to his unit in Bellerive. Once home he washed his remaining clothing in a washing machine (overlooking the shoes he was wearing which he left in the unit's lounge area) before going to bed.

20. In the meantime, Smart remained at Stainforth Court during part of Friday 18 February sleeping there.

21. At around 11.30am Mr Williams' mother arrived at Mr Waller's unit to pick up her son. She found Mr Waller and Mr Williams terribly injured. Mr Waller was barely conscious and Mr Williams was unconscious. She called for someone to phone an ambulance.

22. Police and ambulance officers were quickly on the scene. Both men were rushed to the Royal Hobart Hospital in critical conditions.

23. Not long after being admitted to hospital, Mr Williams died during emergency surgery. The cause of his death was subsequently determined to be the result of injury to his brain, which caused a subdural haemorrhage and swelling of the brain with duret haemorrhages and cerebral contusions.

24. The autopsy found that Mr Williams had suffered 6 or 7 separate injuries to his head, as well as injuries to his chest, abdomen and neck. The marks on Mr Williams' head were consistent with having been inflicted by Gardner's shoes, which were recovered from his lounge room. The shoes were found upon forensic examination to have Mr Williams' blood on them. Mr Waller also had marks on his head made by shoes of the type worn by Gardner.

25. At about 6.35am on 19 February 2011, Gardner surrendered himself at the Hobart Police Station. He was interviewed and made a number of admissions about attacking Mr Williams. Ultimately, he was charged with, and convicted of, Mr Williams' murder (as well as causing grievous bodily harm to Mr Waller).

26. Smart was convicted of causing grievous bodily harm to Mr Waller. Both he and Gardner received lengthy prison sentences.

Comments and Recommendations

27. The circumstances of Mr Williams' death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995.

28. I convey my sincere condolences to the family and loved ones of Mr Williams on their loss.

Dated: 19 November 2018 at Hobart in Tasmania.

Simon Cooper
Coroner