



MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Robert Webster, Coroner, having investigated the death of Timmothy Matthew Gardiner,

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

- a) The identity of the deceased is Timmothy Matthew Gardiner (Mr Gardiner);
- b) Mr Gardiner died in the circumstances set out further in this finding;
- c) Mr Gardiner's cause of death was a gunshot wound to the chest; and
- d) Mr Gardiner died on 18 May 2019 at Launceston, Tasmania.

Introduction

In making the above findings, I have had regard to the evidence gained in the comprehensive investigation into Mr Gardiner's death. That evidence includes:

- Police Report of Death for the Coroner;
- Affidavits establishing identity and life extinct;
- Affidavit of Dr Donald Ritchey, Forensic Pathologist;
- Ambulance Tasmania electronic patient care record;
- Forensic Science Service Tasmania – toxicological and analytical report;
- Forensic Science Service Tasmania – laboratory report dated 15 July 2019;
- Affidavit of Tania Louise Phelps, mother of Mr Gardiner;

- Electronically recorded video interview with Aydain House together with a transcript of that interview;
- Electronically recorded video interview with Jake Clarke, also known as Wells, together with a transcript of that interview;
- Electronically recorded interview with Joshua McDonald together with a transcript of that interview;
- Affidavit of Constable Calvin Heppell;
- Affidavit of Constable Richard Groves;
- Affidavit of Detective Sergeant Peter Roberts;
- Affidavit of Detective Sergeant Matthew Stewart;
- Affidavit of Detective Senior Constable David Gammon;
- Affidavit of Senior Constable Glenn Hindle;
- Affidavit of Detective Senior Constable Troy Smith;
- Affidavit of Amanda Munro (rank not stated), Tasmania police;
- Affidavit of Samuel Lloyd (rank not stated), Tasmania police;
- Affidavit of Detective Senior Constable Dean Logan;
- Affidavit of Senior Constable Skye Carey;
- Affidavit of Detective Senior Constable Jason Savage;
- Affidavit of Senior Constable Maree Fish together with photographs she took of 16/1 and 12/1 Blyth Street, Ravenswood;
- Affidavit of Constable Hayley Bowen;
- Affidavit of Constable Thomas Kenny;
- Affidavit of Constable Rohan Johnson;
- Affidavit of Senior Constable Simon Taylor, Ballistics Section of Tasmania police;
and
- Forensic evidence.

Background

Mr Gardiner was born in Launceston on 7 December 1989. He was aged 29 years, he was single, he had had one child, and he was in receipt of Newstart allowance at the time of his death. Mr Gardiner's mother, Ms Phelps, says he lost his Housing Tasmania unit approximately 6 months prior to his death. During that period he was couch surfing. Ms Phelps would usually see Mr Gardiner daily but he would not regularly sleep at her unit. She says her son used drugs and probably had drug debts.

The Circumstances of Mr Gardiner's Death

At approximately 7.45am on Saturday, 18 May 2019, Mr Gardiner was at Joshua McDonald's unit at 12/1 Blyth Street, Ravenswood. In addition to Mr Gardiner and Mr McDonald, Jake Wells and Aydain House were also present at the unit. Mr Gardiner was in the process of gathering his belongings with a view to departing the unit on his BMX bicycle. As he was bending over to collect some of his belongings, a firearm he had in his possession discharged which resulted in Mr Gardiner being shot in the chest by a .22 calibre projectile.

Mr Gardiner left that unit and proceeded to knock on the door of his mother's residence at unit 16/1 Blyth Street, Ravenswood. Ms Phelps answered the door and used a mobile telephone she was handed to call 000. There is a further call made by Ms Phelps to 000 and during that call the arrival of police can be heard. Thereafter members of Ambulance Tasmania entered Ms Phelps's unit and located Mr Gardiner on the lounge room floor. CPR was commenced. However, Mr Gardiner could not be saved. He was pronounced deceased at the scene. His body was left *'in situ'* while a police investigation commenced to determine how Mr Gardiner had been shot.

Initially the investigation was overseen by members of the Northern Criminal Investigation Branch of Tasmania police. At the outset it was not known how the fatal shot occurred and therefore Mr Gardiner's death was categorised and treated as suspicious until the contrary was established. To assist the investigation, Inspector Orr declared the unit at 16/1 Blyth Street, Ravenswood a crime scene at 11.03am on 18 May 2019. Those premises were forensically examined and searched by police and the declaration made by Inspector Orr was revoked by Detective Inspector Steven at 5.30pm on 18 May 2019.

On 18 May at 3.50pm, Detective Inspector Steven declared the unit at 12/1 Blyth Street, Ravenswood a crime scene. Those premises were forensically examined and searched by police and Detective Inspector Steven therefore revoked his declaration at 6.30pm on 18 May 2019. The declarations made by Inspector Orr and Detective Inspector Steven were made pursuant to s63(1) of the *Police Offences Act 1935*. Those declarations indicate Mr Gardiner's death was being investigated as a murder and at the time the declarations were made the person responsible for shooting Mr Gardiner, and any possible motive, was not known.

Investigation

The first 000 call was received at 7.47am and 47 seconds. During that call, Ms Phelps advised her son had been shot, that she did not know who the offender was or whether the offender was still present. An ambulance was dispatched at 7.49am. Ambulance Tasmania records disclose the following: *"Staged (sic) short distance from scene awaiting arrival of police. Single police officer attended approx 1 min after amb arrival. Single police officer entered some minutes after back-up police arrived. Amb crew called in at 08:02 hours after scene declared clear."* Treatment, including CPR, was continued until 8.20am at which point Mr Gardiner's electrical activity continued to decrease in regularity. Airway clearance was attempted when his airway filled with blood. Intravenous access was attempted without success whereas intra-osseous access was attempted and achieved on the second attempt. Resuscitation ceased after unsuccessful attempts were made to revive Mr Gardiner.

At 7.55am on 18 May 2019, Constable Groves responded to back-up a uniform unit that had been dispatched by radio dispatch services to attend a report of a male having been shot in the chest at 16/1 Blyth Street, Ravenswood. At that time, no further information was provided as to whether the offender was there or not. Constable Groves arrived at the address just before 8.00am and went to the front door of the unit which was closed. He called out that he was police and from inside he heard a reply from a female yell out that the front door was open. At that time Constable Johnson arrived and they entered the premises and cleared those premises. They secured the scene. They observed Ms Phelps sitting on the floor near a bed with a person slumped across her legs who was identified as Mr Gardiner. Ambulance personnel were called in to attend to Mr Gardiner. I find it was clearly appropriate for the premises to be cleared before ambulance personnel entered the unit given the report that a male had been shot in the chest and it was not known whether the offender was present or not.

Constable Johnson was notified of the shooting by radio dispatch services and he was advised Constables Kenny and Bowen were attending as was Constable Groves. He asked whether there was any information about the person responsible and he was advised there was no further information available. He says due to the risk to officers he instructed them to put in ballistic plates and wait a short distance from the address and to move in with numbers. He picked up Constable Lee and drove to Blyth Street. He observed ambulance personnel parked nearby, he was advised Constable Groves was in the unit complex and he ran into the complex and located Constable Groves and assisted him to secure the unit. He asked Ms Phelps where the person responsible was and she said she did not know. He immediately arranged for ambulance personnel to enter the unit and treat Mr Gardiner. He arranged for the area to be declared a crime scene and he managed it until mid-afternoon. Constable Kenny was tasked with providing scene security. Constable Heppell walked back to the Ravenswood police station, located crime scene tape and then returned to the scene and taped off the entrances and exits to the unit block.

Constables Groves, Heppell, Bowen, Logan and Detective Castles conducted door knocking of a number of units in Blyth Street and residences in Warring Street, including the units at 33 Warring Street. They spoke to a number of people. Nobody heard or saw anything which would assist in determining the circumstances leading up to the shooting. Some of the residents of the units at 33 Warring Street knew Mr Gardiner but said he had not lived there for a number of months. Constable Carey telephoned Zar-Lea Marshall who confirmed she was the subscriber for the phone number which had first called 000 but that Mr Wells used that telephone.

Detective Sergeant Roberts was recalled to duty by Detective Senior Constable Savage at 8:00am on 18 May 2019. On his way to work, he informed Detective Inspector Steven of the incident. He also recalled to duty a number of detectives. On arrival he received a briefing from Detective Senior Constable Savage by which time Mr Gardiner had passed away. He recalled more detectives to duty and had staff recalled to the crime management unit so they could manage the intelligence side of the investigation. At 9.30am, he allocated key roles and one of those was to put Detective Sergeant Stewart in charge of the scene. At 10.45am, he briefed Detective Inspector Steven and they both travelled to the scene and received a briefing. As a result of information received, they then focused on locating Mr House, Mr McDonald and Mr Wells. Mr House was located in the transit centre, in the Launceston CBD, opposite the police station in Cimitero Street. At 4.05pm, he and Detective Munro commenced an electronically recorded interview with Mr House. After the interview, Mr House left the police station. At approximately 5.12pm, he was advised Mr

Wells and Mr McDonald had presented themselves to the police station. At 5.22pm, Detective Sergeant Stewart and Detective Senior Constable Savage commenced an electronically recorded interview with Mr McDonald. At the end of the interview, Mr McDonald left the police station. At 6.40pm Detective Sergeant Roberts and Detective Sergeant Stewart commenced an electronically recorded interview with Mr Wells. At the conclusion of the interview, Mr Wells left the police station. Detective Sergeant Roberts believes, based upon all of the available information obtained during the investigation, there were no suspicious circumstances in relation to Mr Gardiner's death.

A short time after 9.30am on 18 May 2019, Detective Sergeant Stewart spoke to Mr Wells and Mr McDonald at 12/1 Blyth Street, Ravenswood and arranged to obtain statements from them. Detective Sergeant Stewart left the unit and on his return, Mr Wells had left but he did obtain a statement from Mr McDonald in which he said Mr Gardiner had visited with another male, they had both stayed a short while and had left. At no stage did he say there was any incident involving a firearm or that Mr Gardiner had been shot in his unit.

Senior Constable Fish attended 16/1 Blyth Street Ravenswood at approximately 9.45am on 18 May 2019. She processed the scene with and under the direction of Sergeant Maher. She makes observations of Mr Gardiner lying on the floor in the unit, she conducted a walk-through and she took a series of photographs. At 3.45pm that day she attended 12/1 Blyth Street, she describes what she observed at the unit and that during a search a backpack identified as belonging to Mr Gardiner was located. It was searched and a pen gun believed to be the firearm involved in this incident was located. Again she took a series of photographs. She believes there were no suspicious circumstances surrounding Mr Gardiner's death and that all the evidence obtained and her observations were consistent with Mr Gardiner's injury being a self-inflicted gunshot. I accept her opinion.

I have watched the electronically recorded interviews and read the transcripts of those interviews of Mr House, Mr McDonald and Mr Wells. The versions of events given by them are generally consistent with one another. In essence they say Mr Gardiner visited 12/1 Blyth Street with Mr House early in the morning on 18 May 2019. The tenant of that address was Mr McDonald and he was present with Mr Wells. Mr Gardiner was in possession of a home-made .22 firearm that he had constructed himself and which he had been in possession of for a number of days. As Mr Gardiner was handling that firearm, he fumbled it causing it to fall to the floor. Upon hitting the floor, the firearm has discharged into his chest. Mr Gardiner has then said he has shot himself and he immediately left the unit and went to his mother's unit at 16/1 Blyth Street where he told her that he had been shot. It was Mr Wells who

dialled 000 and handed the phone he used to Ms Phelps to telephone emergency services. It also appears Mr Gardiner had, prior to the discharge of the firearm, offered to sell some speakers and a bike to Mr Wells. Mr Gardiner had also visited Mr McDonald's unit earlier that morning at which time he and Mr McDonald smoked cannabis. Mr McDonald says he had not told the truth in his previous police statement because he panicked and did not want to be blamed for Mr Gardiner's death.

Senior Constable Taylor has been attached to the ballistics section, forensics services of Tasmania police for over 20 years. He has extensive experience in attending and examining firearm related crime scenes and conducting laboratory examinations on firearm exhibits. He has also attended many autopsies with persons who have died as result of a firearm. He has completed a number of relevant courses and he regularly undertakes independent proficiency testing of his skills. He is a qualified armourer and a member of the Association of Firearm and Toolmark Examiners. On 18 May 2019 at 11.40am, Senior Constable Taylor attended 16/1 Blyth Street, Ravenswood. He examined the scene. He examined the wound sustained by Mr Gardiner. Senior Constable Taylor examined and took possession of a grey puffer vest, black puma jacket and a multi-coloured jacket which all had a small hole to the front right side in a similar location to the wound found on Mr Gardiner. He left the scene at approximately 2.40pm, but returned at 4.20pm where he examined the scene at 12/1 Blyth Street. During a search of that property, a black coloured Nike backpack was located. Senior Constable Taylor searched that backpack and located a small torch wrapped in black tape which on closer inspection was determined to be a home-made single shot firearm which had been converted from a torch. He removed the head of the device and observed a .22 calibre fired cartridge case. He removed the cartridge case and retained that and the firearm for later examination.

On 20 May 2019, he attended the autopsy conducted by Dr Ritchey. At that time, he examined the wound and determined it was consistent with having been caused by the impact of a small calibre bullet. The non-circular shape of the wound together with the path of the bullet through the body indicated to him the bullet was unstable/yawing at the time of impact. There was no obvious gunshot residue located in or around the entry wound and the spent bullet was removed by Dr Ritchey. Examination of the firearm determined it was in working order and capable of propelling a projectile by means of an explosive which could inflict a lethal wound upon a human being. It is operated by unscrewing the front section, exposing the barrel/chamber. A cartridge is inserted into the chamber and the barrel reattached. The torch body is held with one hand, with the other hand pulling the striker handle at the rear of the torch body to the rear under spring compression. When released

the striker tip impacts the rear of the chamber cartridge causing a discharge. The cartridges are not well supported and are loose in the chamber and the firearm has no separate trigger mechanism and requires 2 hands to discharge it. He notes attempts to test fire the firearm were not always successful and he lists a number of reasons related to its construction and design for that. The firearm was also tested by dropping it on the end of the striker onto surfaces of different hardness. The construction and design was such that if the striker was struck with a jarring blow from the rear it would cause a discharge as the firing pin rests directly on the rim of the chambered cartridge. He conducted tests by dropping the firearm onto its striker on 3 different surfaces which revealed that when dropped onto a lino covered concrete floor, the device would discharge from approximately 30cm or higher; when dropped onto a rubber test surface, it would discharge from approximately 50cm or higher; and when dropped onto a carpeted floor, it would discharge from approximately 70cm or higher. He also examined the fired cartridge case, the spent bullet, the 9 x .22 calibre cartridges which were found in a small white container in Mr Gardiner's front right jeans pocket, 2 T-shirts and the 3 jackets.

On 11 September 2019, he attended a shooting range and conducted a series of tests using the home-made firearm and similar ammunition and determined bullets fired from this weapon were unstable and would begin to yaw after leaving the barrel. These tests confirmed the wound sustained by Mr Gardiner was consistent with a wound that one would expect this weapon to cause. This firearm produced a low muzzle velocity but it was more than sufficient to cause a fatal wound in a human being. As a result of the investigation carried out by Senior Constable Taylor, he could not exclude the possibility Mr Gardiner had dropped the loaded home-made firearm onto its striker while he was partially bent over which resulted in its discharge. I accept Senior Constable Taylor's opinion.

Post Mortem Examination

The forensic pathologist, Dr Donald Ritchey, performed a post-mortem examination on Mr Gardiner on 20 May 2019. He also considered histological evidence and the results of a CT of the head, neck, thorax and abdomen along with toxicological results. As a result of his investigations, Dr Ritchey determined Mr Gardiner's cause of death was a gunshot wound of the chest. He says in his report: "*[t]he autopsy revealed a normally developed and nourished adult Caucasoid man with a gunshot wound of the right upper chest. The haemorrhagic wound track perforated the interior chest wall, the right lung and penetrated into the posterior chest wall where a remarkably deformed small calibre projectile was recovered. Associated injuries included collapse of the right lung with haemopneumothorax (approximately 1 litre partially clotted blood in the right*

pleural space). Toxicology testing of samples obtained at autopsy revealed a markedly elevated concentration of methylamphetamine that may correlate with recent intravenous injection of the same. It is unlikely that methylamphetamine directly contributed to death despite its high post mortem concentration.” Dr Ritchey goes on to say that the mechanism of death was hypovolemic shock. That is, severe blood loss which results in the heart being unable to pump enough blood around the body which can cause damage to organs and lead to multiple organ failure. I accept Dr Ritchey’s opinion.

Conclusion

After reviewing and considering all of the evidence on file, I am satisfied Mr Gardiner’s death occurred when he was bending over to pick up some of his belongings at which time he dropped a home-made firearm he had in his possession. That firearm then accidentally discharged and this resulted in Mr Gardiner sustaining a fatal chest wound. There is no evidence to suggest his death was caused by any other means or involved any other people.

Comments and Recommendations

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

I convey my sincere condolences to the family and loved ones of Mr Gardiner.

Dated: 18 February 2022 at Hobart Coroners Court in the State of Tasmania.

Robert Webster
Coroner