IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2021 1686

FINDING INTO DEATH WITH INQUEST

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

Deceased:	David Julien Laurie Shan Gardner
Delivered on:	12 January 2023
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing dates:	Inquest: 28 November 2022
Findings of:	Coroner Paresa Antoniadis Spanos
Counsel assisting the coroner:	Leading Senior Constable Fiona Nation from the Police Coronial Support Unit
Representation:	No appearances
Catchwords:	Homicide, theft of motor vehicle, self-help, altercation initiated by deceased, aggression on part of deceased, self-defence, fall down steps, head injury

INTRODUCTION[1]

1. David Julien Laurie Shan Gardner was a 76-year-old married man who resided in Craigieburn with his wife of 30 years, Irene Blanche Gardner (Mrs Gardner). Apart from his wife, Mr Gardner is survived by two adult children Matthew and Samantha, both of whom reside in Western Australia. Mr Gardner was a retired auctioneer with a wide circle of acquaintances who knew him as Shan and, in accordance with the family's wishes, will be referred to as Shan throughout the rest of this finding.

2. In 2003, Shan suffered a mini stroke which led to his decision to quit smoking. After the stroke, he was prescribed medication to deal with his high blood pressure and other medical issues.

3. On the evening of Tuesday 9 March 2021, Shan had been out in his vehicle, a gold-coloured 1998 VT Holden Commodore sedan. When he returned home, he parked the vehicle under the carport as usual and went inside. He was unsure if he had taken the keys with him or locked the vehicle. Later that night, between about 2200 and 2230 hours, Mrs Gardner was watching television when she heard the noise of vehicles driving over the speed humps in their street but gave it no further thought.

4. At about 0610 hours on the morning of Wednesday 10 March 2021, when Shan went outside to get the newspapers, he realised his vehicle had been stolen, and reported the matter to the Victoria Police (**police**). Shan had one set of keys and went to the shed looking for the second set which he kept there but they were missing. When Shan's next-door neighbour returned from his morning walk, he reported seeing a vehicle like his in nearby La Trobe Court which runs off Northern Crescent.

5. Shan went to La Trobe Court and saw his vehicle parked on the street outside. He reported the matter to the police and was advised to leave the vehicle where it was and that they would attend and recover it. Later that day at 1515 hours, police attended Shan's home and advised him that when they went to the La Trobe Court address, the vehicle was not there and had been allegedly 'stolen again'.

6. Shan was angry over this development, started stewing over the loss of his vehicle and became increasingly agitated about it over the next couple of days.

[1] This section is a summary of background and personal circumstances and uncontentious circumstances that provide a context for those circumstances in which the death occurred.

CIRCUMSTANCES PROXIMATE TO DEATH

7. On Friday 12 March 2021, Shan had been working in the garden most of the day. He had also drunk a quantity of alcohol and was again becoming wound up about the loss of his vehicle which had still not been recovered. At about 1630 hours, believing he knew who was responsible for the theft, he decided to take matters into his own hands. Shan went to his shed, took an axe and headed off on foot to 18 Northern Crescent, Craigieburn (**Northern Crescent**).

8. What took place once he arrived at Northern Crescent at about 1700 hours was the focus of the coronial investigation and will be discussed in some detail below. Suffice for present purposes to say that Shan caused property damage at the address and an altercation ensued with one of several people at the premises during which Shan fell backwards down two front steps and sustained a laceration to the back of the head.

9. Emergency services were called and responding police administered first aid including applying pressure to the head wound while waiting for Ambulance Victoria (**AV**) paramedics. The paramedics stabilised Shan who was in a critical condition before taking him to the Royal Melbourne Hospital (**RMH**) where he was diagnosed with a subdural haematoma, fractures of the left temporal bone extending to the orbital apex and fractures of the sphenoid and zygomatic arch.

10. Shan had a complicated clinical course and suffered several complications including pneumonia. Following discussions between the treating clinicians and the family about his poor prognosis, Shan was treated palliatively from 1 April 2021 and kept comfortable until he passed away on 2 April 2021.

INVESTIGATION AND SOURCES OF EVIDENCE

11. This finding is based on the totality of the material the product of the coronial investigation of Shan's death. That is, the brief of evidence compiled by Detective Senior Constable Dean Solomon (**DSC Solomon**) of the Moreland Crime Investigation Unit containing, amongst other things, statements from eyewitnesses, evidence of scene examination, findings on examination of real exhibits and the interview of Andrew John Stanford who was the other party involved in the altercation, as well as an investigation overview provided by DSC Solomon at inquest.

12. All of this material, together with the inquest transcript, will remain on the coronial file.[2] In writing this finding, I do not purport to summarise all the material and evidence. Rather, I will refer to the evidence only in such detail as is warranted by its forensic significance and the interests of narrative clarity.

PURPOSE OF A CORONIAL INVESTIGATION

13. The purpose of a coronial investigation of a *reportable death*[3] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[4] Generally, reportable deaths are deaths that appear to be unexpected, unnatural or violent or appear to have resulted directly or indirectly from an accident or injury.[5]

14. The term 'cause of death' refers to the *medical* cause of death, incorporating where possible the mode or mechanism of death. For coronial purposes, the term 'circumstances in which the death occurred' refers to the context or background and surrounding circumstances but is confined to those circumstances that are sufficiently proximate and causally relevant to the death, and not all circumstances which might form part of a narrative culminating in death.[6]

15. The broader purpose of any coronial investigations is to contribute, where possible, to a reduction in the number of preventable deaths, through the findings of the investigation and the making of recommendations by coroners, generally referred to as the 'prevention role.'[7]

16. Coroners are empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health and safety or the administration of justice.[8] These are effectively the vehicles by which the Coroner's prevention role can be advanced.[9]

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[2] From the commencement of the *Coroners Act* 2008 (the Act), that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act.

[3] The term is exhaustively defined in section 4 of the Act. Apart from a jurisdictional nexus with the State of Victoria (s 4(1)), reportable death includes "a death that appears to have been unexpected, unnatural of violent or to have resulted, directly or indirectly, from an accident or injury" (section 4(2)(a)).

[4] Section 67(1) of the Act.

[5] See section 4 for the definition of "reportable death", especially section 4(2)(a).

[6] This is the effect of the authorities – see for example Harmsworth v The State Coroner [1989] VR 989; Clancy v West (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).

[7] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, compared with the *Coroners Act* 1985 where this role was generally accepted as 'implicit'.

[8] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations respectively.

[9] See also sections 73(1) and 72(5) of the Act which require publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial

17. It is important to stress that coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.[10]

IDENTITY

18. On 2 April 2021, Mrs Gardner signed a Statement of Identification formally identifying the deceased as her husband David Julien Laurie Shan Gardner born 20 March 1945.

19. Identity was not in issue and required no further investigation.

MEDICAL CAUSE OF DEATH

20. Forensic Pathologist Dr Melanie Archer, from the Victorian Institute of Forensic Medicine (**VIFM**), reviewed the circumstances of Shan's death as reported by police to the coroner, post-mortem CT scanning of the whole body performed at VIFM, the medical deposition from RMH and other documents available to her, performed an autopsy of Shan's body in the mortuary and provided a written report.

21. Dr Archer noted head injuries in the form of fractures, evidence of a right craniectomy, contusions of the brain, patchy subarachnoid haemorrhage and changes of global cerebral ischaemic injury; aged bruising and healing abrasions involving the upper and lower limbs externally as well as the subcutaneous tissues of the chest and abdomen; callus (at least subacute over the anterolateral 6th left rib); bronchopneumonia; and natural disease in the form of cardiomegaly, likely due to hypertension.

22. Dr Archer noted that Shan had been operated on by neurosurgeons soon after the head injuries were sustained but nevertheless went on to develop complications caused by brain swelling and the pressure exerted by the subdural haematoma (blood clot) at the injury site. Dr Archer attributed Shan's initial collapse to an acute subdural bleed, an accumulation of blood under the dura (fibrous outer membrane surrounding the brain). When the volume of subdural blood is sufficient, it can apply pressure to the brain and lead to neurological symptoms such as loss of coordination, central nervous system depression and death.

23. Dr Archer identified a subgaleal haematoma (scalp bruise) on the left side of the head toward the back of the skull with an overlying abrasion. She favoured this to be the point at

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recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

which Shan struck his head and was consistent with the reported circumstance of hitting the left side of his head following a fall backwards off the porch steps.

24. Also confirmed at autopsy was the development of bronchopneumonia due to being on a ventilator. Dr Archer described this as a common complication following head injuries with a survival period.

25. While antemortem blood samples were not available for routine toxicological screening for alcohol and other commonly encountered drugs or poison, testing undertaken at RMH detected a blood alcohol concentration of 0.16g/100mL at 2020 hours.[11]

26. Dr Archer concluded by attributing Shan's cause of death to *1(a) Complications following head injuries (operated).*

27. I accept Dr Archer's advice and opinion as to the cause of Shan's death.

FOCUS OF THE CORONIAL INVESTIGATION

28. The main focus of the coronial investigation and inquest into Shan's death was on the circumstances in which he sustained the head injuries to which he ultimately succumbed, specifically the sequence of events and extent and nature of any force exerted by Shan or Mr Stanford which may have led to the fall and head injuries.

29. Shan arrived at Northern Crescent at about 1700 hours. There were two vehicles parked in the driveway. The vehicle nearest the road was a black 2004 Ford XR6 sedan registered to Andrew Stanford (**the black Ford**) who had arrived about 30 minutes earlier to visit his girlfriend Jessica Bux who resided there. The other vehicle parked in the driveway, closer to the house, was a white 2008 Holden Commodore sedan (**the white Holden**) registered to Daniel Garrett who had been at Northern Crescent when Mr Stanford arrived.

30. Shan first approached the black Ford and hit the front and rear passenger side doors near the window with the axe causing minor damage. He then moved forward to the white Holden and hit the rear windscreen with the axe causing it to shatter before moving to the front of the vehicle and hitting the front passenger side of the windscreen with the axe causing it to shatter.

31. Mr Stanford and Ms Bux were laying on her bed when they heard three or four loud bangs and a male screaming before realising that the sounds were coming from the front of the premises. Mr Stanford went to the front door to see what was happening and opened the front door leaving the metal security door locked in time to see Shan smash the front

[11] DSC Solomon's evidence at inquest was that given expected metabolism rates, Shan's blood alcohol concentration at around 1700 hours when the altercation took place was likely to be significantly higher.

passenger side of the windscreen of the white Holden with the axe. Mr Stanford yelled *"Hey, what do you think you are doing?"* and Shan replied, *"You stole my car, you stole my car"* as he approached the front door of the house brandishing the axe.

32. Shan continued to approach and walked up the two steps to the front door. He swung the axe striking the front security door. He then lifted the axe above shoulder height and hit the window panel next to the front door breaking the glass. Shan lifted the axe above his head and struck the front security door a second time. As Shan pulled the axe back above his head again, Mr Stanford opened the security door and grabbed hold of the axe handle. A struggle then ensued between the two men while both had a grip of the axe handle and they pushed and pulled to gain control of the axe.

33. During this struggle, Shan lost his grip on the axe handle and lost his balance falling backwards, down the two steps and striking the rear left side of his head on the concrete footpath below. Mr Stanford put the axe down immediately, went to Shan's aid and found him unresponsive.

34. Jacinta Hocking, another resident of Northern Crescent, came out to see Shan bleeding from the nose, mouth and rear of his head and lying on his back with laboured breathing. Ms Hocking placed Shan in the recovery position to assist his breathing.

35. A short time later, Victoria Police members who were already in the area for other reasons, were flagged down by occupants of 18 Northern Crescent and came to render assistance and called for AV attendance.

36. Mr Stanford gave an account to police at the scene shortly after the incident. He was subsequently arrested and taken to Fawkner Police Station where he participated in an audio/video recorded interview in which he answered all questions put to him, gave an account consistent with the above and provided his clothing and other samples for testing and/or DNA analysis.

37. The scene was examined by members of the Major Crime Scene Unit. Observations of the scene included damage to property (the house and vehicles in the driveway), glass fragments from various sources recovered for examination, seizure of the wooden-handled axe, and blood swabs taken from the concrete path/driveway. Examination revealed no evidence that contradicted Mr Stanford's account of the incident.

38. Coronial Investigator DSC Solomon provided a comprehensive coronial brief and concluded that criminal charges should not be pursued against Mr Stanford on the basis that

Shan was the aggressor, Mr Sanford acted in self-defence and any prosecution was unlikely to succeed.

39. DSC Solomon advised that Shan's vehicle was located by police on 17 March 2021 outside 7 Yarra Street, Craigieburn, some 400 metres from Northern Crescent. The vehicle was towed to a secure facility and forensically examined the following day.

40. A latent fingerprint located on the internal rear vision mirror led to the arrest, on 22 March 2021, of a 17-year-old male who later appeared before the Broadmeadows Children's Court where charges including theft of a motor vehicle were dealt with by way of diversion. The young male was known both to Shan and the occupants of Northern Crescent.

FINDINGS/CONCLUSIONS

41. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[12]

42. <u>Having applied the applicable standard of proof to the available evidence, I find that:</u>

    (a) The deceased is David Julien Laurie Shan Gardner, born on 20 March 1945, known as Shan.

    (b) Shan died on 2 April 2021 at the Royal Melbourne Hospital, Grattan Street, Parkville.

    (c) The cause of Shan's death is the complications following head injuries (operated).

    (d) Shan was understandably angry about the theft of his vehicle and likely intoxicated and disinhibited to an extent by alcohol when he sought to take matters into his own hands. However, he was the initiator and aggressor of the altercation in which he lost his balance and fell backwards sustaining the head injuries to which he ultimately succumbed.

    (e) For completeness, I note that there is no suggestion in the material before me that there was any want of clinical management or care on the part of the staff of The Royal Melbourne Hospital that caused or contributed to Shan's death.

43. I wish to convey my sincere condolences to Shan's family and friends for their loss.

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[12] *Briginshaw v Briginshaw* (1938) 60 C.L.R. 336, especially at 362-363. "*The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…*"

PUBLICATION OF FINDING

44. Pursuant to section 73(1) of the Act, unless otherwise ordered by a coroner, the findings, comments and recommendations made following an inquest must be published on the Internet in accordance with the rules. I make no such order in respect of this finding.

DISTRIBUTION OF FINDING

45. I direct that a copy of this finding be provided to:

Mrs Irene Blanche Gardner

The Royal Melbourne Hospital c/o Melbourne Health

Detective Senior Constable Dean Solomon (#30598) c/o O.I.C. Moreland C.I.U.

Signature:

Paresa Antoniadis Spanos

Coroner

Date: 11 January 2023