INQUEST INTO THE DEATH OF MR. MELVYN GEORGE TURNER

CORONER'S FINDINGS

SUMMARY OF EVIDENCE

Mr. Raynor Halliday, a close friend of Mr. Turner, described how they had spent the early part of the evening of 29th April together at Mr. Halliday's home, as was their regular practice; they had both consumed some alcohol, and Mr. Turner appeared to be his usual bright, cheery self and did not seem down or depressed. He last saw Mr. Turner alive when he left to drive home at about 7.00pm

Mrs. Celia Stewart was the sister of Mr. Turner; she saw him every day when he collected cooking from her to deliver to the West Store; the last time she saw him alive was at 4.00pm on 29th April. On 30th April she became concerned when he did not arrive as usual, so after trying unsuccessfully to contact him by phone, she went to his address about 9.00am. The house appeared not to have been opened up since the previous night. The light was on in the back kitchen when she went in. The door of the cupboard under the stairs was open and she saw him lying inside; there was a gun near him and a mark on his arm; he did not respond when she called his name, so she telephoned PC McDade and waited for him to arrive.
She said Mr. Turner was not a worrier; he was going to the UK for an operation and was making his travel arrangements and looking forward to going. He was very vocal about gun safety.

PC McDade responded to the call from Mrs. Stewart, and he and PC Bryson attended Mr. Turner's house very shortly afterwards; he checked him for signs of life. They waited for the arrival of the ambulance, and subsequently Dr. Edwards, and he left at 9.30am.

Dr. Rebecca Edwards attended the house of Mr. Turner and examined his body; she pronounced him dead at 9.15am on 30th April.

DS David Street, Coroner's Officer, attended the scene at 9.05am with PS Roberts and was briefed by PC Bryson. Mr. Turner was lying on the floor in the cupboard under the stairs; there was a gun next to him; there was a mark on his left arm and that hand was in his trouser pocket.
Mr. Turner was formally identified by PS Roberts.
The scene was recorded by DC Webb, SOCO, and the body was removed to KEMH Mortuary. The gun, a single-barrelled shotgun, was also seized together with ammunition.
DS Street prepared a report to the Coroner on 1st May.

Insp. Len McGill reviewed the investigation on 15th May; he tasked the SOCO to re-visit the scene, where he found splashes of human blood on a vertical post on the west wall of the cupboard; he believed that these marks were caused by the forced expulsion of blood from the body as a result of it being in contact with, or very close to the gun when discharged.
In his opinion as an experienced crime scene investigator, the location of the body, the size of the cupboard and the lack of evidence of significant disturbance or of any

indication of the presence of another person would lead to the conclusion that the injury was self-inflicted.

Mr. Michael Vaughan examined the shotgun and ammunition seized from the property. The shotgun was working normally; the marks on the cartridge case found in the cupboard were consistent with its having been fired by that gun; the gun was not unduly prone to accidental discharge; it would normally require a force of at least 4.5 pounds to make it discharge; it is normal for a gun to discharge without pulling the trigger, if it is subjected to rapid deceleration.

Dr. John Clark carried out the post mortem examination on 4th May. He concluded that the cause of death was Shotgun Injury of Chest.
He also undertook further investigations to establish the circumstances in which death occurred. He concluded that the end of the barrel had been almost against the body when the gun discharged; the other injuries observed, large areas of grazing on the inner half of the left elbow and on the left half of the chest alongside, were suggestive of something rough scraping over the skin, possibly the shotgun itself.

FINDINGS

I am satisfied on the evidence that the cause of death of Mr. Turner was as stated by the Pathologist, namely Shotgun injury of chest.

I am also satisfied that there is no evidence which suggests that the injury was inflicted by another person or persons, nor is there any evidence to suggest that Mr. Turner was the subject of any such malicious intent.

Neither is there any evidence to suggest that he was contemplating self-harm, since the evidence of his demeanour and circumstances at the time of his death speaks of a man in reasonable health with no worries, and who did not habitually show signs of anxiety.

I am satisfied by the evidence that the shotgun was discharged accidentally in the course of being handled by Mr. Turner, and accordingly the cause of his death was Accident. My inquisition will so record.

I extend my condolences to the family and friends of Mr. Turner.

I would like to add a comment of general application regarding the handling and storage of firearms. I understand that this is not the first time that a death has occurred in these islands due to the accidental discharge of a firearm when being improperly handled whilst loaded. This case is another tragic reminder that firearms must be handled with care and respect; they must never be stored when loaded, and they must be kept secure in proper locked cabinets when not in use. I urge the Police and owners of guns of all sorts to co-operate in ensuring that tragedies such as this do not recur in the future.

This inquest is now closed.

Dated 11th September 2009

Signed

John Trevaskis
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