CORONER'S COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	**Inquest into the death of Felipe Esteban Alvarez (No 1)**
Citation:	**[2025] ACTCD 11**
Decision Date:	7 July 2025
Before:	Coroner Archer
Findings :	[26]-[48]
Catchwords:	**CORONIAL LAW** – MANNER AND CAUSE OF DEATH – practice and procedure of ACT Coroners Court – Section 51A of the *Coroners Act 1997* – Section 34A of the *Coroners Act 1997* – when a hearing is required – will hearing advance the Coroners investigation into manner and cause of death – is it in public interest to conduct investigations in public
Legislation Cited:	*Coroners Act 1997* (ACT) ss 3BA, 13, 34, 34A, 51A, 52, 55, 58 *Coroners Act 1956* (ACT) s 12
Cases Cited:	*Maksimovich v Walsh* [1995] 4 NSWLR 318 *Tkalac v Cooper* [2023] TASSC 7
Texts Cited:	Explanatory Memorandum, *Coroners Act Bill 1997* (ACT) *Coronial Law and Practice in NSW* (4th edition), K.M Waller
Representation:	**Counsel Assisting the Coroner** K Lee (instructed by S Richards, S Beckedahl) **Counsel for Canberra Alliance for Harm Minimisation (CAHMA)** T Maling **Counsel for Ms Emma Snazelle** K Musgrove (instructed by G Borzuola) **Counsel for Ms Gabriela Alvarez** S Lynch (on 13 December 2025; 28 April 2025) D Rutherford (on 26 March 2025) **Solicitor for Ms KT, Ms NB, Ms DK, Mr XD** (on 28 April 2025 on a duty basis) E Wallis **Solicitor for Mr PK** (on 26 March 2025; 28 April 2025) G Briggs
File Number:	CD 094 / 2021

CORONER ARCHER

Introduction

1. A hearing in the inquest into the death of Felipe Esteban Alvarez ('Mr Alvarez') has been listed for 4 to 7 August 2025.

2. After that hearing and having regard to all of the evidence (including the oral evidence given at the hearing), I am required to make manner and cause findings (section 52(1) of the *Coroners Act 1997* (ACT) ('the Act') and (if relevant) public safety findings (section 52(4) of the Act).

3. For ease of reference those provisions are reproduced:

> **52 Coroner's findings**
>
> (1) A coroner holding an inquest must find, if possible—
>
> (a) the identity of the deceased; and
>
> (b) when and where the death happened; and
>
> (c) the manner and cause of death; and
>
> (d) in the case of the suspected death of a person—that the person has died.
>
> (2) A coroner holding an inquiry must find, if possible—
>
> (a) the cause and origin of the fire or disaster; and
>
> (b) the circumstances in which the fire or disaster happened.
>
> (3) At the conclusion of an inquest or inquiry, the coroner must record the coroner's findings in writing.
>
> (4) The coroner, in the coroner's findings—
>
> (a) must—
>
> (i) state whether a matter of public safety is found to arise in connection with the inquest or inquiry; and
>
> (ii) if a matter of public safety is found to arise—comment on the matter; and
>
> (b) may comment on any matter about the administration of justice connected with the inquest or inquiry.

4. I am of the view that there are public safety issues arising from my inquest into Mr Alvarez's death and that a hearing is necessary to address those issues. Those issues concern the role played by Canberra Alliance for Harm Minimisation and Advocacy (CAHMA) in performing a harm minimisation role amongst Canberra's drug taking community. I intend to cause a single witness to be called to address those issues, Mr Chris Gough, the Executive Director of CAHMA.

The Preliminary Issues

5. Two related preliminary issues have arisen as to how I should proceed in establishing the factual basis of the findings required by section 52 of the Act.

6. The first issue is whether I should give certain persons who were present at or around the time Mr Alverez died ('the affected parties') the opportunity to give evidence in respect of the circumstances surrounding his death. The second issue is whether, in the face of those people choosing not to give evidence, I should nonetheless compel those witnesses to give evidence in respect of the circumstances surrounding his death.

7. I have indicated in correspondence to the parties, and at a number of Directions hearings in the inquest, that I have reached a preliminary view that adverse findings are likely to be made as to the conduct of the affected people in failing to take sufficient action to assist Mr Alvarez after he collapsed after taking illicit drugs on the day he died. In light of that preliminary view, I drew the attention of the affected people to the potential for those findings to be made and invited their submissions as to whether they wanted to appear as witnesses and/ or be represented at the hearing. The preliminary view I also conveyed to the affected people and Mr Alvarez's family, was that I had sufficient information in the brief of evidence I had received from coronial investigators to make the manner and cause findings required by section 52(1) of the Act without the affected parties giving oral evidence at the hearing.

8. The family have submitted that the persons present when Mr Alvarez died should be compelled to give evidence. I address that contention below.

Section 58

9. The circumstances of Mr Alvarez's death have previously been referred to the Director of Public Prosecutions (DPP) pursuant to section 58 of the Act. The DPP has advised that no charges will be preferred in respect of Mr Alvarez's death.

Factual Context

Jurisdiction

10. Mr Alvarez died on 30 March 2021. On that day, at about 1257 hours, the Australian Federal Police (AFP) were called to an address in Taylor in response to a duress call from ACT Ambulance Service (ACTAS). On their arrival, they found ACT Fire Brigade (ACTFR) and ACTAS members administering medical treatment to an unconscious male, now known to be Mr Alvarez, who appeared to be suffering a drug overdose. Despite their efforts Mr Alvarez was not able to be revived.

11. Mr Alvarez's death was referred to the Coroner pursuant to section 13(1)(a) of the Act as he died in unknown circumstances.

Social context of Mr Alvarez

12. Mr Alvarez had three full siblings; Emma Snazelle (Ms Snazelle), Gabriela Alvarez (Ms Alvarez) and Jamie Alvarez, and a half-brother, Cameron Fitzpatrick.

13. Mr Alvarez had moved to the ACT, with the help of his sister, Ms Alvarez, at the start of 2020 to have a fresh start. He had been released from a gaol in NSW several months earlier, after having spent approximately 22 years in custody for a range of offences. He was a known drug user.

Circumstances Surrounding Death

14. In very broad terms, the coronial investigation suggested that a number of people (including the affected people) were present in the unit before Mr Alvarez's death:

    a) Ms NB;

    b) Mr XD;

    c) Mr PK;

    d) Ms DK;

    e) Mr NE[1]; and

    f) Ms KT.

15. All of them were known to Mr Alvarez to a greater or lesser extent.

16. I draw upon and summarise the submission made by Counsel Assisting in setting out the following factual outline:

    a) Two days before his death, Mr Alvarez went to Sydney with Ms NB, Mr XD and Mr PK to purchase drugs. Mr Alvarez asked Mr NE, a neighbour, to look after the residence and his dog.

    b) During the morning of 30 March 2021, Mr Alvarez, Mr PK and Ms DK all injected heroin from a bag of heroin Mr Alvarez had obtained in Sydney the day before.

    c) Soon after injecting the heroin, Mr Alvarez got 'jelly legs' and started to fall to the ground. Mr PK and Ms DK recognised that as a sign of an overdose.

[1] Mr NE seems to have played a lesser role in the events of the day of Mr Alvarez's death. He is not part of the group referred to as the 'affected parties'.

d) Ms DK called for Mr PK and he caught the deceased and lowered him to the ground on the floor in, or near, the kitchen.

e) Mr Alvarez was turning purple and not breathing and Ms DK started chest compressions.

f) It is likely that by this stage, Mr Alvarez was overdosing.

g) Mr XD and Ms NB, who had temporarily left the unit before Mr Alvarez injected himself, returned to the residence.

h) As they were walking up the stairs, they heard Ms DK and Mr PK yelling, 'He's overdosed, Phil's overdosed'.

i) They walked into the unit and the deceased was on the ground.

j) Either Mr PK or Ms DK were doing chest compressions.

k) Mr XD may have taken over chest compressions.

l) At the time, the deceased was not his normal colour, and he was either not breathing or not breathing properly.

m) After the CPR, the people present determined that Mr Alvarez was breathing, and they left him on the floor but put him on his side, possibly in the recovery position.

n) He was left in that position for a period of time (possibly some hours).

o) No one called an ambulance.

p) Ms KT came to unit during the morning and probably consumed some heroin. She was aware that Mr Alvarez had overdosed.

q) Later (and perhaps hours later) one or more of those present checked to see if the deceased was breathing. He was not. Mr XD checked for a pulse but could not find one. Ms NB also noticed around this time that the deceased was no longer breathing.

r) Mr PK and Mr XD rolled the deceased over. His face was blue. They started chest compressions and Ms NB called an ambulance. The call was made at 12:33pm.

17. Relevantly, Counsel Assisting's summary was primarily based on police interviews with:

    a) Ms DK;

    b) Mr PK;

    c) Ms NB; and

    d) Ms KT.

18. The factual detail of those submissions was not challenged by other parties although it was suggested (below) that there was more to be potentially discovered by having witnesses called and cross examined.

19. As to the findings that Counsel Assisting suggested he would ultimately invite me to make, he submitted (with references deleted):

> It is open to the Coroner to make criticism of certain individuals, on the basis of their actions or inactions set out above. These actions or inactions may have contributed to Mr Alvarez's death, or reduced his chances of survival.
>
> In summary, the Coroner is invited to find as follows:
>
> <u>Mr PK</u>
>
> 1. Mr PK's actions were inconsistent with his CAHMA training.
> 2. Mr PK observed Mr Alvarez displaying various signs of drug overdose, but did not call triple zero immediately or at all.
> 3. Mr PK allowed Mr Alvarez to "sleep it off".
> 4. Mr PK did not have naloxone with him, even though he attended the residence with the intention of using heroin and had been supplied with "2 naloxone packs [four doses] on request two weeks beforehand on 16th March [2021]".
> 5. During the time Mr Alvarez displayed symptoms of overdose whilst Mr PK was present at the residence, Mr PK did not remain with him to monitor him and ensure he was in the recovery position.
>
> <u>Ms DK</u>
>
> 6. Ms DK observed Mr Alvarez displaying various signs of drug overdose, but did not call triple zero immediately or at all.
> 7. Ms DK's actions were inconsistent with her CAHMA and other relevant training.
> 8. During the time Mr Alvarez displayed symptoms of overdose whilst Ms DK was present at the residence, Ms DK did not remain with him to monitor him and ensure he was in the recovery position.
>
> <u>Mr XD</u>
>
> 9. Mr XD observed Mr Alvarez displaying various signs of drug overdose, and was told he was overdosing, but did not call triple zero immediately or at all.
> 10. During the time Mr Alvarez displayed symptoms of overdose whilst Mr XD was present at the residence, Mr XD did not remain with him to monitor him and ensure he was in the recovery position.

Ms NB

11. Ms NB observed Mr Alvarez displaying various signs of drug overdose, and was told he was overdosing, but did not call triple zero immediately.
12. Ms NB did not provide the triple zero operator with a full and honest account of what had happened to Mr Alvarez, namely that he had taken heroin earlier in the day and was likely overdosing.
13. During the time Mr Alvarez displayed symptoms of overdose whilst Ms NB was present at the residence, Ms NB did not remain with him to monitor him and ensure he was in the recovery position.

Ms KT

14. Ms KT's actions were inconsistent with her CAHMA training.
15. Ms KT observed Mr Alvarez displaying various signs of drug overdose,but did not call triple zero immediately or at all.
16. Ms KT allowed Mr Alvarez to "sleep it off".
17. Ms KT either did not have naloxone with her, or if she did, she did not administer it.
18. During the time Mr Alvarez displayed symptoms of overdose whilst Ms KT was present at the residence, Ms KT did not remain with him to monitor him and ensure he was in the recovery position. Ms KT left the residence whilst Mr Alvarez was displaying symptoms of overdose, without seeking any assistance for him.

20. At this stage in the proceedings, I do not express a concluded view as to whether I will make the factual findings and adverse comments suggested by Counsel Assisting. However, I have indicated to the parties that those findings [19] are certainly open to me and that adverse comments may be made.

The Proceedings

21. From 28 November 2024 to June 2025 efforts have been made by the Court to have the affected parties:

    a) come to court at time set for directions hearing;

    b) seek out legal representation; and

    c) indicate whether it was their wish to give evidence in the proceedings.

22. Ultimately, the Court was told that Ms DK, Ms KT and Mr PK did not want to give evidence or make submissions. Mr XD and Ms NB indicated it was their wish to be called. However, when they were made aware that they would be required to

provide a statement outlining what they might say if called, they ultimately refused to participate in that process.

The Submissions from the Family

23. I have given leave to the sisters of Mr Alvarez to appear at the inquest and to be represented by a lawyer. They made separate submissions on the issue of compelling the affected parties to give evidence. The more detailed submissions were developed by Counsel who appeared on behalf of Ms Emma Snazelle. However, there was a commonality of submissions made on their behalf.

24. It was put by Counsel for Ms Snazelle:

    a) That as a matter of principle a Coroner was under a duty to sufficiently investigate the manner and cause of death:

        > A proper and thorough investigation of the evidence in this matter requires a hearing. There are too many unanswered questions regarding the circumstances of Mr Alvarez's death and the conduct of those with him in the crucial four hours between overdose and 000 call. Further, the evidence of most witnesses present at the crucial time is conflicting, less than the fulsome and forthright and warrants exposure to cross-examination. Ensuring the sufficiency of inquiry requires nothing less than a full hearing into the manner and cause of death.

    b) In applying section 34A of the Act, the Coroner should have regard to the purposes of the Act set out in section 3BA of the Act which enjoins a Coroner 'as far as practicable' when conducting an inquest to carry it out in a manner that recognises the family's interest in 'having all reasonable questions about the circumstances of the person's death answered'.

    c) It was conceded that section 3BA was 'constrained' 'by the limitations provided for by section 52 requirements', 'particularly the findings of manner and cause of death'.

    d) The section 55 process contemplates that affected persons should be given the opportunity to meaningfully respond to any proposed adverse comment. This imports a requirement for the Coroner to ensure to adopt a process 'to enable properly informed findings and comments to be made'.

    e) Relevant to the manner of Mr Alvarez's death is why the affected persons:

        i. acted as they did; (for example, in not calling an ambulance or by removing or concealing some of the drugs obtained in Sydney); and

ii. why Ms DK and Mr PK ignored their CAHMA training to respond appropriately when someone has apparently overdosed (by using naloxone and calling an ambulance).

25. On behalf of Gabriela Alvarez, the above submissions were adopted. It was further submitted that certain other people (in addition to the affected people) should be called:

a) a person who allegedly played a role in providing transport to Ms KT on the day who was 'affiliated with CAHMA'.

b) Mr Dave Baxter, the Naloxone Co-ordinator for CAHMA;

c) a person responsible for staff recruitment and training at CAHMA; and

d) The ambulance officer who attended to Mr Alvarez and said that Mr Alvarez could have survived if medical assistance had been sought earlier.

DECISION

26. I have indicated that a hearing in the inquest will be conducted. A hearing date has been set.

27. As to how any hearing is to be conducted, section 51A of the Act provides:

> **51A Practice and procedure for inquests and inquiries**
>
> (1) An inquest or inquiry must be conducted in accordance with any practice or procedure for taking a step in the inquest or inquiry that is prescribed under this Act or another territory law under which the step is to be taken.
>
> (2) However, if a practice or procedure for taking a step in an inquest or inquiry is not prescribed under this Act or another territory law—
>
> a) the Chief Coroner may give directions for the practice or procedure (a coronial practice direction) to be followed for the step; or
>
> b) if the Chief Coroner has not given a coronial practice direction for the step—the coroner holding the inquest or inquiry may give directions about the practice or procedure to be followed in the inquest or inquiry.
>
> (3) The rules may prescribe matters in relation to the practice and procedure for a hearing.
>
> In this section: 'rules' means 'rules under the Court Procedures Act 2004 applying in relation to the Coroner's Court.

28. Relevantly, there are no practices or procedures established by the Coroner's Court for the purposes of coronial hearings.,

29. I am given a wide discretion as to how these proceedings are to be conducted[2], subject to the terms of the Act;

    a) ensuring that the inquest as a whole (not just the hearing) establishes a sufficient evidential basis for section 52 findings to be made; and

    b) ensuring that parties are accorded procedural fairness.

The Terms of the Act

Section 34A

30. Given a hearing is to be held, section 34A does not have direct application. However, the section may provide guidance as to considerations relevant to the scope of a hearing that is to be conducted.

31. The *Coroners Act 1997* changed the law (*Coroners Act 1956 as amended)* applicable to the coronial function in the ACT. It is clear from the explanatory material to the *Coroners Act Bill 1997* that one purpose of the amending legislation was to give greater clarity around the use of the expression 'inquest' in the *Coroners Act 1956* (the governing statute as it then stood). Prior to the enactment of the *Coroners Act 1997* it was open to the Court to make findings absent holding an 'inquest': section 12 of the *Coroners Act 1956*. However, some uncertainty surrounded how procedurally an 'inquest' could be dispensed with when the concept of an 'inquest' only expressly included the coronial investigation.

32. The Explanatory Memorandum to the Bill suggested that the relevant amendments to *Coroners Act 1997* (the present-day equivalent provisions to sections 34 and 34A of the Act) intended to make clear that an inquest could be constituted by a process of investigation and also a hearing associated with that inquest. The Explanatory Memorandum to the Bill expressed that intent:

> A "hearing" is to mean the hearing provided for in Division 1 of Part V. Clause 34 provides that a Coroner may conduct a hearing for the purposes of an inquest or inquiry. In referring to an 'inquest' or 'inquiry' the Former Act refers to the process of the investigation into a death or a fire occurring within the jurisdiction, from the notification of the event to the formal hearing of evidence and the making of findings. The inclusion of the hearing in the meaning of 'inquest' or 'inquiry' results in the provisions of the legislation which apply to the conduct of the hearing being ambiguous or impossible of compliance.
>
> ……
>
> Clause 14 provides for the circumstances in which a Coroner may decide not to conduct a hearing into a death and replaces section 13 of the Former Act which provides for a Coroner to dispense with the holding of an inquest. An inquest commences on the death of a person

[2] See generally Maksimovich v Walsh [1995] 4 NSWLR 318.

> in violent, sudden, or unexplained circumstances and is required to be held to establish the cause and circumstances of the death. However, the Coroner need not conduct a Court hearing of evidence relating to the death where, for instance, the cause of death is able to be disclosed without such a hearing. Subclause 14(1) provides that a Coroner may decide not to conduct a hearing if satisfied that cause of death is sufficiently disclosed and that a hearing is unnecessary.

33. The clear legislative intention was to enable Coroners responsible for an inquest to dispense with a *hearing* when the information made available to the Coroner made it possible to make the findings required by section 52 of the Act (and of the *Coroners Act 1997* as passed) without a hearing. Expressed in another way, section 34A(1)(b) gives a Coroner the procedural option of dispensing with a hearing after a determination is made that the information at hand from a coronial investigation is sufficient to make the findings required by section 52 of the Act.

34. The determination of whether a hearing is necessary will be substantially informed by its potential to advance the coronial investigation[3] and whether it is in the public interest to have the hearing aspect of the investigation conducted in public. Deciding which witnesses ought to be called would be informed by similar considerations. In that context, a Coroner would consider whether the power to compel witnesses to give evidence, and for them to be cross examined, will make it more likely that he/she will be able to make the findings required by section 52.

35. I accept that the 'manner of death' can have a variable content depending on the circumstances of a particular case. I accept that the concept of 'manner of death' should not be construed too narrowly[4]: However, in this case, the information at hand already tells me:

    a) what drugs Mr Alvarez had taken before his death and how they, in aggregate and separately, may have caused his death

    b) how the drugs that may have been implicated in Mr Alvarez's death were obtained and where they most probably were at the time of Mr Alvarez's death;

        (i) who was present at the time he took them;

        (ii) that he collapsed after he took the drugs;

        (iii) what was done after he collapsed;

            (iv) what training those present had in administering care to those suffering an 'overdose';

[3] See generally Tkalac v Cooper [2023] TASSC 7 (4 May 2023) and the authorities set out therein.
[4] Waller Coronial Practice in NSW 4th edition at pg. 26 and the authorities set out therein.

(v) when the ambulance was called and what Mr Alvarez's condition was at the time;

(vi) that some of the drugs obtained in Sydney were not found at the unit by the police; and

(vii) what health vulnerabilities might have increased the risks of taking illicit drugs.

36. I have evidence in the inquest as a whole that indicates what training the CAHMA workers underwent , and what best practice would otherwise be when someone shows signs of an illicit drug overdose. I can, subject to submission from the affected parties, draw some inferences as to why an ambulance was not called earlier than it was and why trained users may have departed from the procedures suggested by their training. However, it is my view that making appropriate manner of death findings in this case does not require me to make definitive findings as to the motives of the affected parties in doing what they did or failed to do.

37. I find that the calling of the affected parties is unlikely to advance the coronial investigation because:

a) the events are now 4 years ago;

b) the affected parties were, perhaps at different times, all affected by the drugs they had taken (and perhaps significantly affected);

c) some were criminally implicated in obtaining the drugs and possibly the removal or concealment of the drugs at the unit;

d) all would, I anticipate, be reluctant to give evidence that would implicate them in criminal or other possible offending (even if a certificate was provided); and

e) given what is already known by me from the brief of evidence and what was seen at the Directions hearings, some of the affected parties have continuing mental health and drug usage challenges.

38. I cannot discount the interest the Court has in ensuring its limited resources are used efficiently. It was conceded in oral submission by Counsel for Ms Snazelle that if one of the affected parties was called, all would have to be called and the testing of their evidence might take weeks given the number of people who may be legally represented. There is, in my view, no public interest considerations that would persuade me to take a different view.

Section 3BA(2)(a) of the Act

39. The provision provides:

> (2) As far as practicable, the objects of this Act must be carried out in a way that—
>
> (a) for an inquest into a person's death—recognises the following:
>
> (i) the family and friends of the deceased person have an interest in having all reasonable questions about the circumstances of the person's death answered;

40. The operation of the provision is subject to limitations. It is not a provision that elaborates the jurisdiction of the Court. Other than for deaths in care or custody, a Coroner is only empowered to make the findings required by section 52 of the Act. The questions that I seek to answer can only be considered in the context of the scope of my inquest conducted for the purpose of making section 52 findings. In my view, I cannot seek to answer those questions outside that statutory context.

41. Section 3BA is a provision that recognises that the family 'for an inquest into a person's death' have an *interest* in having all reasonable questions about the circumstances of the death answered. I am not obligated to answer all reasonable questions the family may have, and the section does not enhance my powers in conducting an inquest other than to make the findings required by section 52. The provision is also subject to the express limitation of practicability. I am of the view the provision does not require me to call the affected parties, to determine their motives for doing what they did or what they failed to do, when such an exercise would require perhaps weeks of Court time.

Submissions as to Section 58

42. As the submission was understood by me, it was put that the grounds for referral under section 58 (reasonable grounds for believing that a person mentioned in the inquest had committed an indictable offence) could only be addressed properly if the affected parties were called. It was submitted that 'Ms Alvarez wants this matter referred again to the DPP for further investigation and consideration into potential criminal liability'.

43. It is not the role of a Coroner to investigate matters with a view to referring matters to the Director of Public Prosecutions (DPP) or to make findings as to possible criminal culpability. As noted, the matter has already been referred to the DPP, and no charges have been preferred. If the section is potentially re-enlivened by the limited evidence called at the hearing, then a referral can be reconsidered.

A Sufficient Evidential Basis for Section 52 Findings

44. Clearly the information at hand allows me to determine the cause of death and put that death in an appropriate context. Whilst there is an evidential basis to draw inferences as to why the affected parties acted in the way they did, such findings are

not necessary to discharge my responsibilities under section 52 of the Act.

Procedural Fairness

45. The submissions on this point proceeded on the basis that the procedural fairness protections provided for in section 55 of the Act required me to ensure that the affected parties were given an opportunity to put a position as to the events surrounding Mr Alvarez's death from the witness box. I am required to act fairly and to afford a person who may be subject to an adverse comment made in my findings the protections offered by section 55 of the Act. Ms DK, Ms KT and Mr PK have indicated they do not want to give evidence. Mr XD and Ms NB have been offered the opportunity to provide a statement as to their version of events but have not accepted the offer. All the affected people will be afforded the protections offered by section 55 if and when the section applies.

46. For the reasons given in my ultimate decision, a non-publication order has been made with regard to those present at the unit on the day Mr Alvarez died.

Witnesses to be Called

47. Mr Chris Gough from CAHMA is to be called. It is my view that he is well placed to answer any questions relevant to the issues raised in respect of how CAHMA operated at the time.

48. There is evidence available in the brief to be tendered as to the treatment of Mr Alvarez on the day. Further evidence will be adduced from ACTAS as to how overdose cases are treated by attending paramedics.

49. At this stage, I am not minded to call further witnesses other than Mr Gough.

I certify that the preceding forty-nine[49] numbered paragraphs are a true copy of the Decision of his Honour Coroner Archer.

Associate:

Date: 7 July 2026