CORONERS ACT, 2003

SOUTH  *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 24th day of May 2017, the 2nd and 9th days of June 2017, the 13th, 14th, 15th and 16th days of August 2018 and the 23rd day of October 2019, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Anthony Stephen Gibson.

The said Court finds that Anthony Stephen Gibson aged 53 years, late of Port Augusta Prison, Augusta Highway, Stirling North, South Australia died at The Queen Elizabeth Hospital, 28 Woodville Road, Woodville South, South Australia on the 3rd day of July 2015 as a result of aspiration pneumonia on a background of oesophageal cancer and ischaemic heart disease. The said Court finds that the circumstances of his death were as follows:

1. Introduction and reason for inquest

1.1. Anthony Stephen Gibson was aged 53 years when he died at The Queen Elizabeth Hospital (TQEH) on 3 July 2015.

1.2. At the time of his death Mr Gibson was serving a term of imprisonment. For that reason Mr Gibson's death was a death in custody in respect of which an inquest was mandatory pursuant to the provisions of the Coroners Act 2003.

1.3. These are the findings of that inquest.

2. Cause of death

2.1. Mr Gibson had been in hospital since 6 June 2015. He was in the Port Augusta Hospital from that date until 12 June 2015 on which day he was transferred to the TQEH where he died on 3 July 2015. Mr Gibson's clinical course in both hospitals was clear. The case files from TQEH were examined by medical practitioners at Forensic Science South Australia (FSSA). A pathology review conducted at FSSA recommended that Mr Gibson did not require an autopsy in order to establish his cause of death. Rather, the cause of death was determined from Mr Gibson's TQEH case files. It was considered that his cause of death was aspiration pneumonia on a background of oesophageal cancer in a man with ischaemic heart disease. The pathology review report of Dr Iain McIntyre as discussed with Associate Professor Neil Langlois[1], a forensic pathologist, expresses that cause of death. I find the cause of Mr Gibson's death was aspiration pneumonia on a background of oesophageal cancer and ischaemic heart disease.

3. Issue at inquest

3.1. Mr Gibson's death was from a natural cause. Nevertheless, during the course of the investigation into the circumstances of his death at TQEH it was revealed that due to the fact that Mr Gibson was a prisoner serving a sentence he had been shackled to his bed by either hand or foot or both and that this had been so despite the fact that he was dying, had no means of escape and had been under guard for the entire duration of his admission.

3.2. It is not unusual for a prisoner to be shackled while undergoing treatment in a hospital, but the issues as far as Mr Gibson was concerned was whether the shackling and the extent of it had been necessary in the days prior to his death and whether or not having regard to the nature of his illness the shackling of him to the bed and the resulting position of the bed in terms of its inclination contributed to his death.

3.3. In the days preceding his death at TQEH there had been a number of concerns voiced by clinical staff members about Mr Gibson's shackling. In fact there had been attempts

[1] Exhibit C2a

to relieve the shackling bearing in mind two issues. The first issue was whether having regard to his escape risk status Mr Gibson required both arm and leg shackling or indeed required shackling at all. The second was whether the shackling was inhibiting his treatment. In the event attempts to relieve his shackling were for the most part thwarted by imperfect communication channels between employees of the Department for Correctional Services and employees of the private organisation responsible for security of prisoners in hospital known as G4S.

4. Background

4.1. On 8 May 2015 Mr Gibson was taken into custody at the Port Augusta Prison. This related to a breach of parole. Mr Gibson had been released from prison on 14 November 2014. His previous medical history included Hepatitis C. He was also a regular user of alcohol and had been a heavy smoker. He would not be diagnosed with oesophageal cancer until this most recent and, as it would transpire, final incarceration. Upon his admission to the Port Augusta Prison Mr Gibson indicated that he had lost several kilograms in weight. It was noted that there had been a hospital admission for pneumonia and dysphagia which is difficulty in swallowing. On his readmission to prison on 8 May 2015 he presented as unkempt and was generally looking unwell. He was to be reviewed daily by the South Australian Prison Health Service (SAPHS). On 9 May 2015 the assessment was that he was very unwell, emaciated and was distressed upon movement. In the following days he complained of shoulder pain, lower back pain and numbness. Crepitations in his lungs were detected and a moist cough was also observed.

4.2. On 25 May 2015 Mr Gibson experienced a conscious collapse in the Port Augusta Prison exercise yard. He was taken to the Port Augusta Hospital. Chest X-rays revealed extensive consolidation which was believed to be likely due to an infection. He was placed on antibiotics.

4.3. On 3 June 2015 Mr Gibson was returned to the Port Augusta Prison to continue with oral antibiotics and be subject to medical reviews.

4.4. On 4 June 2015 Mr Gibson was located lying on his cell floor. He was alert and responsive but reported back pain among other things.

4.5. On 6 June 2015 an ambulance conveyed Mr Gibson to the Port Augusta Hospital. He would not return to prison after this time. During the course of this admission Mr Gibson underwent an endoscopy which revealed a malignancy in the lower part of his oesophagus.

4.6. Mr Gibson was admitted to TQEH on 12 June 2015. He was initially under the care of the upper gastrointestinal team. Ultimately Mr Gibson had a percutaneous endoscopic gastrostomy (PEG) inserted. This is a procedure in which a flexible feeding tube is placed through the abdominal wall into the stomach. It allows nutrition, fluids and medications to be placed directly into the stomach, bypassing the mouth and oesophagus.

4.7. Mr Gibson was at a significant risk of aspiration associated with difficulty in swallowing and resultant regurgitation. This was related to the cancer obstructing the passage of food, to how frail he had become and to his posturing in bed. The risk of aspiration was an ongoing one throughout his treatment at TQEH.

4.8. From 23 June 2015 medical staff at TQEH requested that Mr Gibson be unshackled so that they could more appropriately administer care to him. Due to the risk of aspiration they wanted him to be nursed at a 45° angle in bed or even while sitting upright. It was suggested that the manner in which he was shackled interfered with his care because the bed could not be raised to a 45° angle. During the course of the inquest there was some debate about the bed angle that the shackles would allow, a debate that was not really resolved.

4.9. Mr Gibson also developed pressure sores, but these had no bearing on the cause of his death.

4.10. In the event the shackles would not be completely removed until 3 July 2015 at a time very close to the time of his death on that day. As things transpired his death was in fact quite unexpected that day.

5. Whether the shackling contributed to Mr Gibson's death

5.1. Evidence in this regard was given by Dr Sally Williams who is a consultant in palliative care at TQEH. Dr Williams has been involved in palliative care since 2000 both in

South Australia and the Northern Territory. She is a Fellow of the Australasian Chapter of Palliative Medicine, holds a Clinical Diploma in Palliative Medicine and is a Fellow of the Australian College of Rural and Remote Medicine. Dr Williams provided three statements to the inquest and gave oral evidence[2].

5.2. In her statements and in her evidence Dr Williams said that she saw Mr Gibson for the first time on 30 June 2015 which was three days before his death. By that stage Mr Gibson had deteriorated significantly and the focus of his care was palliative. He was no longer suitable for radiotherapy or chemotherapy. It appeared that he was developing a lower respiratory tract infection or pneumonia which they attempted to treat with intravenous antibiotics.

5.3. On 1 July 2015 the upper gastrointestinal team performed a barium swallow test. During that test Mr Gibson aspirated a large amount of barium into his chest. According to the statement of Dr Williams this '*precipitated him entering a more actively dying phase with increased chest secretions and poor oxygen saturations, despite IV antibiotics being continued*'.

5.4. In her statement dated 22 March 2016[3], Dr Williams asserts:

> 'My primary concern relative to our ability to effectively care for Anthony revolved around the fact that he was shackled to his bed at all times. Even during the terminal phase of his illness he was shackled by his arm and leg, with a guard in attendance continuously. He could no longer walk and the shackling in this manner meant that we couldn't posture him upright to reduce the chances of aspiration.
>
> On several occasions I asked the correctional services staff in attendance if the shackles could be reduced or removed, however the shackles were not removed until the day the patient died, despite the patient not being a flight risk, and appearing to be in the terminal phase of his illness. It was not until the General Manager of the prison had been contacted that the authority was given for the shackles to be removed, a process that should have taken a few hours but in fact took several days to arrange.'

5.5. In her evidence before the Court Dr Williams explained that the barium swallow test that was performed on 1 July 2015 was conducted with Mr Gibson's palliation in mind. The test was conducted by the Radiology Department. The test involves the patient swallowing barium. During this process X-rays are taken for the purpose of assessing

[2] Exhibits C20, C20a and C20b
[3] Exhibit C20

whether there is any interruption of the tracking of barium into the stomach. Dr Williams explained the purpose of this in Mr Gibson's case in the following way:

> 'Well, I think, in him, he had an oesophageal cancer and we knew that it was at the lower end of his oesophagus. He had an artificial feeding tube had already been placed in his stomach, so he was receiving feeds, but I think it was a reasonable test to do because to have information that can then guide you as to whether a patient would be able to take any food or fluid orally seems a reasonable thing to do, even from a palliative perspective, because to say to a patient that they can never have anything to eat or drink again is a big loss for someone's quality of life. So the purpose of doing that test was to see whether it was safe for him and whether his pathology was such that he wasn't going to be able to take anything orally and swallow,…' [4]

5.6. Using Mr Gibson's clinical record, in her evidence Dr Williams explained what had taken place during the barium test. He had been in a sitting position and was initially given two small amounts of barium boluses. However, they were too small. At the third attempt he swallowed more barium and aspirated it into his lungs. Mr Gibson desaturated to 90% and so was provided with oxygen. He became tachycardic and the study was therefore abandoned. In Dr Williams' opinion this event changed Mr Gibson's clinical picture in that he became much more sick thereafter.

5.7. When Mr Gibson was subsequently examined his lungs were crackly. He was frail and was unable to lift his arms. He would not allow clinicians to roll him over in order to examine his pressure wounds. The assessment was that he had aspirated the barium and that he had an ongoing high risk of aspiration.

5.8. Dr Williams said that prior to this event there had been a prognosis that Mr Gibson might survive for a couple of months. However, the aspiration event of 1 July 2015 required that prediction to be revised. Dr Williams explained that his risk of aspiration was always high. As a result, prognostication in his case was fraught with difficulty. Dr Williams further explained that if complications did not occur a patient might live longer, but when a complication such as the one that occurred happens at any stage it might tip the patient into an unstable and then a dying phase.

5.9. In the event Dr Williams suggested that Mr Gibson's death was sudden[5]. Asked specifically whether the level of shackling had altered Mr Gibson's prognosis or the

[4] Transcript, pages 35-36
[5] Transcript, page 53

timeline of that prognosis she said that it did not. She said '*I didn't think that the shackling of this patient had an impact on his dying*'[6]. She further explained as follows:

> 'Because we had been given the ability to move him from the bed to a sitting position if he wanted to do that and we were still in the process of, I think, getting our physio to see how much walking and things he could do. We could still sit him up as upright as we needed to. The nurses could care for him properly with just the one shackling. So he was sick from the aspiration and his chest infection.' [7]

Dr Williams went on to state that the contribution of the barium aspiration was that it was probably the main event where his clinical condition changed quickly. He was very sick after that.

5.10. It appears that Mr Gibson's final state of shackling was to one leg only. Dr Williams stated that she did not believe that the shackling to one leg posed any risk as far as aspiration was concerned if he was able to sit upright. In answer to me Dr Williams suggested that she did not think that the shackling of the patient had any impact. Asked as to why she held that view, she said:

> 'Because we had been given the ability to move him from the bed to a sitting position if he wanted to do that and we were still in the process of, I think, getting our physio to see how much walking and things he could do. We could still sit him up as upright as we needed to. The nurses could care for him properly with just the one shackling. So he was sick from the aspiration and his chest infection.' [8]

Dr Williams went on to say that Mr Gibson had been in a poor condition independently of the barium incident in that he had been frail, deconditioned, malnourished and was probably aspirating anyway, the cause of that being his general frailty.

5.11. Dr Williams also made the pertinent observation that if the prognosis of two months life expectancy had come to pass, Mr Gibson's quality of life would have been poor because any person who is not able to eat or drink has a difficult life. In addition he may well have been in bed for the rest of his life if he had lived any longer. That said, she acknowledged that this may have provided him with more time to have connected with his family.

5.12. The notion that the shackling, or the degree of shackling, did not contribute to or hasten Mr Gibson's death was not the subject of any meaningful challenge by counsel at the

[6] Transcript, page 53
[7] Transcript, page 53
[8] Transcript, page 53

inquest. In his final address Mr Bleechmore for Mr Gibson's family fairly acknowledged that there was no evidence that the shackling led to the death or to a worsening of Mr Gibson's situation.

5.13. I have accepted Dr Williams' evidence. In my opinion the evidence demonstrated that Mr Gibson's life expectancy was foreshortened not by the shackling or the degree of it, but by the aspiration of barium. There is no suggestion that the test that involved the swallowing of barium was anything other than a legitimate clinical exploratory measure that was undertaken in the interests of Mr Gibson's comfort and palliation.

5.14. It is my finding that Mr Gibson's shackling did not contribute to his death.

5.15. This is not to say, however, that the shackling was not a relevant circumstance in connection with his death. The Court examined the circumstances surrounding the shackling. It is not necessary for me to examine the evidence that was given about this matter in any great detail except to summarise the pertinent events and to indicate whether or not the shackling was necessary and whether in future cases a more humane and common-sense approach might be taken.

6. Timeline re relevant events

6.1. A compliance checklist conducted in the Port Augusta Hospital on 11 June 2015 reveals that Mr Gibson was on full restraints comprising a leg restraint between the legs with one hand cuffed to the metal frame of the bed. One of the legs was also restrained to the bed. I believe that when on 12 June 2015 Mr Gibson was transferred to TQEH, this level of restraint or similar was also employed.

6.2. A Department for Correctional Services (DCS) document of 16 June 2015 described leg restraint to the bed with one hand cuffed to the bed frame, with flexicuffs to be used when medical procedures were involved. This level of restraint was approved by the General Manager of the Yatala Labour Prison (YLP).

6.3. On 23 June 2015 it was noted that Mr Gibson had pressure areas and that a reduced level of restraint was recommended if possible. It was observed at that point that Mr Gibson had little capacity to get up and walk away. It also needs to be borne in mind that a single security guard employed by G4S was in attendance.

6.4. On 24 June 2015 the level of restraint was recorded to be a leg restraint to the bed with one hand cuffed to the bed frame.

6.5. On 25 June 2015 an email from the Nurse Management Facilitator to the SAPHS sought a review of the restraint regime regarding Mr Gibson's frailty and the need for frequent nursing care interventions. On the same day a further email to the Assistant General Manager of YLP sought a review of the restraint requirements. This was then forwarded to the General Manager who in the afternoon responded by recommending a single restraint of Mr Gibson's leg to bed. However, a compliance checklist later that same day recorded the current level of restraint as being a leg restraint to the bed with one hand cuffed to the bed frame notwithstanding a further notation in other documentation suggesting that there had been a reduced restraint level due to medical complications.

6.6. As the evidence unfolded in this inquest the actual level of restraint as it had been at any one point in time during Mr Gibson's final days of life was not completely clear to me. There were many documents tendered and emails that had been sent backwards and forwards that did not fully elucidate the matter. It appeared that there was almost invariably some measure of shackling or restraint when Mr Gibson was bedbound.

6.7. On 26 June 2015 it was noted in a log that a chain had been changed from the right hand to the left hand due to swelling. The compliance checklist recorded the current level of restraint as being a leg restraint to the bed with a leg restraint to be used when the prisoner is out of bed.

6.8. On 28 June 2015 the compliance checklist noted the current level of restraint at that point as a leg restraint to the bed with one hand cuffed to the bed frame.

6.9. On 29 June 2015 a compliance checklist recorded the current level of restraint as a leg restraint to the bed with one hand cuffed to the bed frame. A notation signed by Mr Pumpfrey of DCS stated that Mr Gibson was very frail and that he would now recommend a reduction of restraint to simply '*arm to bed*'. However, there was a notation signed by the General Manager indicating that the restraint would be reduced to '*leg to bed*' only.

6.10. On 30 June 2015 in the early evening a log entry recorded that the restraint level was altered insofar that the wrist restraint would be removed from the bed and the level of restraint would be reduced to foot to bed only.

6.11. On 1 July 2015 there were numerous developments in relation to the level of restraint. At 2:55pm the Nurse Management Facilitator emailed the SAPHS stating the following:

> '**Please arrange urgent review of current restraint as per previous request** – current chain restraints at 2 points are having a significant negative impact on the ability of Mr Gibson to adequately and safely maintain his airway, also placing him at considerable risk at further adverse clinical events.
>
> - Chain weight pulling prisoner down in bed and frail condition means prisoner can independently return to more upright position – this means prisoner is breathing fluid into his lungs (aspirating) causing pneumonia.
> - Current restraint additionally limiting ability to freely set out or try walking – increasing further deterioration and risk of clotting, deconditioning, compromised breathing, etc.' (the emboldening is in the original text)

6.12. On that same day at 4:33pm Mr Ken Dalton, the Security Manager of the YLP, emailed a Ms Pritchard at G4S, the organisation responsible for providing the security guard for Mr Gibson while in hospital, confirming that restraints for Mr Gibson would consist of leg to bed only. An email from the General Manager of the YLP to the Nurse Management Facilitator indicated that in the previous week upon a medical request restraint levels should have been reduced to a single point, namely leg to bed only. The email expressed an apology in respect of his directions not having been followed. The compliance checklist for that day noted that the current level of restraint was leg to bed only.

6.13. A compliance checklist for 2 July 2015 noted that the current level of restraint was leg to bed.

6.14. The following day, 3 July 2015, was the day of Mr Gibson's death. I have already referred to the evidence of Dr Sally Williams. In her oral evidence Dr Williams told the Court that on 3 July 2015 she phoned the General Manager of YLP, Mr Stephen Mann, and followed through with an email to him. She said that she did this because she was frustrated due to the difficulty in securing changes to Mr Gibson's shackling. She felt that any level of shackling was unnecessary given his frailty. She said in her evidence:

> 'So I thought perhaps the best way to get some action was to go to the top, so that's why I sent that email.' [9]

[9] Transcript, page 51

I set out that email in full. It was sent at 10:18am:

> 'Dear Stephen
>
> Thanks for taking my call this morning. I am the Palliative Care Consultant responsible for the medical care of Mr Anthony Gibson DOB 16.04.62. Anthony has a diagnosis of metastatic Oesophageal Carcinoma and is receiving supportive palliative care for his incurable disease. His prognosis is poor, and most likely to be weeks.
>
> Currently he is bed dependant and unable to swallow food without risk of aspiration. He is receiving treatment with IV antibiotics for an aspiration pneumonia and PEG feeds. He has bed sores on his sacrum, back and both elbows as a consequence of his frailty and long periods spent in bed. He is still shackled on one leg. A physio review conducted on 30/6/15, and confirmed verbally again yesterday afternoon, revealed Mr Gibson would require 2 persons to assist him when walking. He has not been out of bed since 30/6/15.
>
> I request that urgent consideration be given to this man's security needs as the current level of shackling is restricting his posturing in bed and causing significant issues with his ability to be fed safely.
>
> I am happy to be contacted again as needed on my mobile (*number removed*)
>
> Dr Sally Williams' [10]

At 10:35am Mr Mann replied to Dr Williams' email and copied it to a number of persons within DCS. Mr Mann's email simply said:

> 'Thank you for the information on Mr Gibson and I advise that I will approve the removal of all restraints for the better care and treatment of Mr Gibson.' [11]

6.15. All shackles were removed from Mr Gibson shortly thereafter. Unfortunately he died at approximately 11:40am when it was observed that he had ceased breathing. Heart and respiratory sounds were absent. He was pronounced deceased at 11:40am.

6.16. It will be noted in Dr Williams' email to Mr Mann that she said that Mr Gibson's prognosis was poor and was most likely to be weeks. That of course was a prognostication of his life expectancy. Unfortunately this prediction did not come to pass. I have already referred to Dr Williams' evidence about the fact that Mr Gibson's death was in a sense wholly unexpected on the day that it actually occurred. Notwithstanding the fact that it was unexpected, there is no evidence to suggest that his death had any connection either with the degree of restraint that he had been under that morning, or with the removal of that restraint.

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[10] Exhibit C16a
[11] Exhibit C16a

6.17. It was unfortunate that for a significant period of time Mr Gibson had required any level of restraint at all. This of course is especially so given the fact that there was a guard present at the hospital. Dr Williams told the Court that she believed that on the day before Mr Gibson's death she did not think that he needed to be shackled at all. I have accepted that evidence. Dr Williams also told the Court that she had contacted the General Manager partly with respect to Mr Gibson's dignity but also because it did not seem like he was going to run away[12]. Asked as to what the difficulty from her point of view was in respect of the shackling to only one leg she said:

> 'Well he'd been lying in bed, he had bed sores, he was frail, he wasn't a flight risk. It seemed like overkill. ' [13]

6.18. During the course of the evidence adduced in this inquest it became evident that there had been a number of elements involved in the confusion about Mr Gibson's level of restraint. This was in part due to imperfect communication systems, particularly between DCS and G4S personnel. I am not critical of this set of circumstances. It was a factor in this that G4S were not included in a DCS email distribution list that was designed to communicate the necessary requirements for prisoner restraint in hospital.

6.19. Evidence was led during the course of the inquest concerning measures that have been adopted since Mr Gibson's death. The Court received into evidence the affidavits of Mr Michael John Reynolds[14], along with his oral evidence, given in his capacity as the Director of Operations, Statewide Operations, Department for Correctional Services and the affidavit of Angela Yvonne Gransden[15] in her capacity as the Director, Operational Support and Performance, Statewide Operations, DCS.

6.20. Mr Reynolds' affidavits deal with DCS responses to certain recommendations regarding prisoner restraint in hospital made by the Ombudsman in 2012. It is not necessary to have regard to those issues as far as the issues in this inquest are concerned. However, in his first affidavit Mr Reynolds refers to the review of Standard Operating Procedure 13 (SOP13) of the DCS, the review of which was undertaken due to the confusion of the level of restraint required for Mr Gibson prior to his death.

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[12] Transcript, page 61
[13] Transcript, page 79
[14] Exhibits C21 and C21a
[15] Exhibit C21

6.21. The new SOP13 dated 30 January 2017 reflected the policy in force from that date and incorporated a number of changes as a result of the circumstances surrounding Mr Gibson's restraints between 11 June 2015 and 3 July 2015, which was the date of his death. The relevant changes are set out as follows:

> 'a. Any recommendations made by the Compliance Officer about the adjustment of level of restraint of a prisoner must result in a telephone call to the General Manager whilst the Compliance Officer is still present at the Hospital (MJR4 paragraph 3.1. 7);
>
> b. If any change is authorised by the General Manager then the Compliance Officer must record and sign the hospital log book and ensure that the change is implemented by informing the Hospital Watch Officer to adjust the level of restraints unless there is reason for delay e.g. if the prisoner is receiving medical treatment (MJR4 paragraph 3.1.8);
>
> c. Recommendations made by the Compliance Officer regarding the level of restraints must also be recorded on the Compliance Checklist Hospital Watches (Hospital Escorts) and signed by the General Manager. This document must be forwarded via email to the DL:DCS Hospital Watches and Escorts (this was required under the SOP 13 (MJR4)). In addition a copy of the Compliance Checklist for Hospital watches (Hospital Escorts) reflecting the changes made must be given to the Hospital Watch Officer on the next visit by the Compliance Officer (MJR4 paragraph 3.1.9). This latter requirement was added to make sure that any changes in the levels of restraint would be communicated to the Hospital Watch officer on the next shift to make sure that the decreased level of restraint was still being applied to the prisoner.'

6.22. In his affidavit Mr Reynolds foreshadowed a further review of the departmental shackling policy to take place in February 2018. Ms Gransden's affidavit[16] makes it plain that the review of the shackling policy did in fact occur and was approved by the Chief Executive of the DCS on 31 May 2018. The relevant amendment to the 2018 version of SOP13 was that if any change was recommended in respect of the restraint level of a prisoner, compliance officers *must* phone the General Manager while at hospital to seek approval for the change and then action the change if one is to be made. As well, in June 2018 the department initiated a morning and afternoon hospital compliance check to be undertaken, which change would be incorporated in the following review of SOP13.

[16] Exhibit C21b

6.23. It is hoped that the organisation G4S has been included in any measures relating to communication between DCS staff and those whose responsibility it is to act as escorts and security guards in respect of prisoners in hospital.

6.24. There are no recommendations in this matter.

Key Words: Death in Custody; Natural Causes; Prison

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 23rd day of October, 2019.

Deputy State Coroner

Inquest Number 14/2017 (1153/2015)