CITATION: *Inquest into the death of Anthony Graham Greig Faulkner* [2015] NTMC 001

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
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DELIVERED ON:	21 January 2015
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HEARING DATE(s):	8 and 9 December 2014
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	**Death in Care, mental Health patient, sudden & unexpected death, heart attack.**

REPRESENTATION:

Counsel:

Assisting:	Jodi Truman
NT Dept of Health	Kelvin Currie

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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0153/2013

In the matter of an Inquest into the death of
ANTHONY GRAHAM GREIG FAULKNER
ON 23 SEPTEMBER 2013
AT COWDY WARD - ROYAL DARWIN HOSPITAL

FINDINGS

Mr Greg Cavanagh SM

Introduction

1. Anthony Graham Greig Faulkner ("Mr Faulkner") was a Caucasian male born on 24 January 1971 at Darwin, in the Northern Territory of Australia. He had a long history of mental illness, being first diagnosed as suffering from bi-polar disorder in 1988 when he was 17 years of age. Following that diagnosis he was treated, including being admitted into hospital both in Darwin and in South Australia, on a number of occasions.

2. On 8 August 2013 at approximately 3.00am, he was admitted as an involuntary patient to the Cowdy Ward at the Royal Darwin Hospital. This was where he remained until his death on 23 September 2013. On that day, at approximately 6.55am, Mr Faulkner was found by staff in his bed and was non-responsive. The Emergency Trauma Team was called. Attempts were made to resuscitate Mr Faulkner; however he was unable to be revived. He was pronounced deceased at 7.16 am.

3. This death was reportable to me because at the time of his death, Mr Faulkner was a patient at the Cowdy Ward of the Royal Darwin Hospital. As a result he was a "person held in care" pursuant to the definition contained in s12 of the *Coroners Act* ("the Act") which includes:

"A patient who, pursuant to the *Mental Health and Related Services Act* is in custody whether in a hospital or temporarily removed from a hospital"

Therefore, pursuant to s15(1) of the *Act*, this inquest is mandatory.

4. Pursuant to s34 of the *Act*, I am required to make the following findings if possible:

"(1) A Coroner investigating:

a. A death shall, if possible, find:

(i) The identity of the deceased person.

(ii) The time and place of death.

(iii) The cause of death.

(iv) Particulars required to register the death under the *Births Deaths and Marriages Registration Act*.

(v) Any relevant circumstances concerning the death"

5. Section 34(2) of the *Act* operates to extend my function such that I may comment on a matter including public health or safety connected with the death being investigated. Additionally, I may make recommendations pursuant to section 35 as follows:

"(1) A Coroner may report to the Attorney General on a death or disaster investigated by the Coroner.

(2) A Coroner may make recommendations to the Attorney General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the Coroner.

(3) A Coroner shall report to the Commissioner of police and Director of Public Prosecutions appointed under the Director of Public Prosecutions Act if the Coroner believes that a crime may have been committed in connection with a death or disaster investigated by the Coroner"

6. This inquest was held on 8 and 9 December 2014. Ms Jodi Truman appeared as Counsel Assisting and Mr Kelvin Currie appeared for the Northern Territory Department of Health. A total of seven (7) witnesses were called to give evidence at this inquest, namely; Detective Senior Constable Brett Wilson, Registered Nurse Duduzile Mutama, Enrolled Nurse Steven Pocock, Registered Nurse Prunella Parson, Dr Rajiv Weerasundera, Dr Subash Heraganahally and Dr Alan Cala.

7. A brief of evidence containing various statements, together with numerous other reports, police documentation and medical records were tendered at the inquest (exhibit 1). Public confidence in Coronial investigations demands that when police (who act on behalf of the Coroner) investigate deaths that they do so to the highest standard. I thank Detective Senior Constable Brett Wilson for his investigation.

Background

8. Anthony Graham Greig Faulkner was the eldest child of Alison Joy Greig and Peter Thomas Faulkner (since deceased). He had two (2) younger brothers, namely Alisdair and Asher. He was born and raised in Darwin and attended primary school at Holy Spirit Primary School in Casuarina and then attended high school at St Johns College in Darwin. He completed high school in 1989. It was in his final year of high school that Mr Faulkner was first diagnosed as suffering from bi-polar disorder.

9. Mr Faulkner's parents separated in 1984 when he was 13 years of age. Eventually his parents both went on to remarry. As a result, Mr Faulkner had four (4) younger half siblings; namely Allegra and Adeodatus on his mother's side, and Mathew and Joannah on his father's side. He remained close to both his parents and his extended family as a whole.

10. Mr Faulkner had a long history of mental illness. According to his medical records he was initially diagnosed with Bi-Polar Effective Disorder, but over time his diagnosis changed to Schizo Effective Disorder and then

Schizophrenia. Over the years he was admitted a number of times to mental health wards both in the Northern Territory and South Australia, in addition to his final admission. He also had periods where he was managed in the community, most notably between 1997 and 2002, then between 2005 and 2010 and lastly the period from 2012 to just prior to his final admission.

11. Following his discharge from the Royal Darwin Hospital ("RDH") in 2012, and after a period of follow-up at the Tamarind Centre, Mr Faulkner was discharged into the care of his General Practitioner in February 2013. He received ongoing support with independent living in a community housing program offered by Top End Association for Mental Health ("TEAMhealth") at Runge Street in Coconut Grove. This is a medium to long term accommodation option offered to people with mental illness. He was well known to staff there and had been living at the same accommodation since August 2012.

12. On 6 and 7 August 2013 however, Mr Faulkner was noted by TEAMhealth workers to be exhibiting "odd" behaviours. The Crisis and Assessment Team ("CAT") were contacted on both days, but on 7 August 2013 they were requested to conduct an assessment. CAT team members attended and determined that Mr Faulkner needed to be admitted on an involuntary basis to the Cowdy Ward for assessment and treatment. The police were called to assist and he was transferred to the hospital.

13. At the RDH Mr Faulkner was assessed and found to be in a psychotic state characterised by paranoia, suspicion and perplexity. He was noted to be ambivalent and thought disordered. Meaningful conversation was difficult. He was therefore admitted into the Inpatient Unit (aka Cowdy Ward) at RDH as an involuntary patient under Section 39 of the *Mental Health Act* at approximately 3.00am on 8 August 2013.

Admission at the Cowdy Ward

14. On admission, Mr Faulkner's mental state was characterised by being in a state of perplexion, hearing voices and showing an ambitendency towards routine activities, i.e. a tendency to act in an opposite way. It was quickly established that he had not been taking his oral antipsychotic medication for a "few weeks". Dr Weerasundera gave evidence that Mr Faulkner advised him that he had stopped taking his medication as he was unhappy with a particular side effect of the Risperidone. Mr Faulkner was also medically assessed and found to have swelling to his knee and a past history of gout, he was otherwise found to be in good physical health at that time.

15. As a result of the side effect that Mr Faulkner was unhappy with, Dr Weerasundera gave evidence that he discussed this with Mr Faulkner and members of his family and a decision was made to commence him on Paliperidone, which is also an anti-psychotic, but a derivative of Risperidone. Initially it was commenced in tablet form and then as a depot, which is a long acting injection. It appears from the records that the change from tablets to injection changed Mr Faulkner's condition significantly and on 19 August 2013 the treating team changed his status from involuntary to voluntary. Unfortunately on 23 August 2013 he relapsed into a paranoid perplexed state and a decision was made to place him back to an involuntary status.

16. During this admission, Mr Faulkner's mental state was noted to be quite variable, he was lucid at times but perplexed at others. His perplexity in fact increased to such an extent that he was transferred from the Cowdy Ward to the Joan Ridley Unit ("JRU") and then to the Contained Assessment Unit ("CAU"), in the hope that a low stimulus environment would be more beneficial for his mental state.

17. Whilst in the CAU Mr Faulkner's father passed away. Mr Faulkner was deeply distressed and continually sought reassurance he would be allowed to

attend the funeral. The presence of family during the funeral period appeared to reassure Mr Faulkner, although he again became distressed after they had left. During this time however Mr Faulkner's mental health began to improve and he was transferred back into the Cowdy Ward. Discussions were being held in relation to potentially discharging him to "Papaya" which is another supportive community housing program offered by TEAMhealth, which provides 24 hour support to residents.

18. On 14 September 2013 however, Mr Faulkner was noted to have an increase in temperature and to have developed a fever. He was perplexed at that point and blood tests were ordered to find out the cause of the fever. An increase in his sodium levels was also recorded. The medical team were asked to see Mr Faulkner and they did so on 15 September 2013.

19. Dr Heraganahally was part of that team and gave evidence that the clinical team conducted a full range of tests and assessments and the results were "unremarkable". On 16 September 2013 Mr Faulkner was thought to be feeling better and thinking better. Medical investigations continued and he remained in the Cowdy Ward during this time. His fever continued and numerous causes were being considered and investigated by the medical team. It was considered that because he had been admitted to hospital for some time that he may not have had free access to water and this may have been contributing to his condition, particularly the high sodium levels. As a result he was encouraged to have free access to water and to have it available in his room.

20. On 19 September 2013 Mr Faulkner had a low grade fever and sore throat. Numerous possible conditions were being considered. The medical consultant ordered antibiotics and a review for the following week. In that time Mr Faulkner's mental status was also reasonably settled and on 20, 21 and 22 September 2013 he was noted by Cowdy staff to be polite, well groomed and behaving appropriately. Urinary collections were ordered by the medical team to continue to be taken every 24 hours for monitoring. It

appears that the only reason he was kept in hospital at that time was to ensure he was physically well enough to be discharged.

21. I received a number of statements, and heard evidence, from persons who were on duty for the night shift commencing at 9.00pm on Sunday 22 September 2013 and ending at approximately 7.30am on Monday 23 September 2013. During that shift, and in accordance with usual procedure, Mr Faulkner and all the other patients were checked on an hourly basis. Registered Nurse ("RN") Duduzile Mutama gave evidence before me that she conducted a check of Mr Faulkner at approximately 6.05am. At that time she observed him to be sleeping on his back (i.e. supine or face up) with the blankets on his legs. RN Mutama did not shine her torch on his face, as she did not want to wake him, but she formed the opinion that he was sleeping. RN Mutama was in fact adamant in her opinion that Mr Faulkner was asleep when she conducted that bed check.

22. Enrolled Nurse ("EN") Catherine Noonan was also on shift. She had limited involvement with Mr Faulkner during the night as a result I did not receive direct evidence from her. EN Noonan did however undertake the hourly checks at midnight and 5.00am. According to her statement to the police; on both occasions Mr Faulkner appeared to be sleeping and she recalled that he was "snoring and fully dressed lying on top of his bed".

23. RN Duduzile Mazibuko was also on duty during the course of that shift. Unfortunately due to the timing of the inquest, she was unable to appear to give evidence as she was in Zimbabwe. Her detailed audio recorded statement was however part of the evidence tendered before me. RN Mazibuko recalled checking on Mr Faulkner twice during her shift at 11.00pm and then at 3.00am. On both occasions Mr Faulkner appeared to be asleep and she in fact recalled being told that he was already asleep when she started her shift at 9.00pm.

24. During the 11.00pm check she recalled that Mr Faulkner was lying on his left side facing the window and she recalled she did not have to approach him as she could hear him snoring from the door. At 3.00am she recalled he was laying face up on his back with the blankets on him. She did not recall him snoring at that time. RN Mazibuko also recalled seeing Mr Faulkner at about 4.30am "or so" when he got up and went to the water cooler to get a drink of water. She was in the nurses' station at the time.

25. In her statement to police, RN Mazibuko recalled that at about 6.50am she was asked by the group activities nurse to go and wake Mr Faulkner as he had requested to participate in a morning walk before breakfast. RN Mazibuko stated she walked in to Mr Faulkner's room and noted it was still dark. She thought Mr Faulkner was still sleeping. She called out to Mr Faulkner twice "in a loud voice", but received no response, so she turned on the lights. When she turned on the lights she noticed that Mr Faulkner was:

> "…laying on his back, he was supine and he had his right ah leg hanging off the bed. Ah I proceeded to approach him and I shook him um as per protocol just to assess his ah response. I got no response from him and when I did touch him I did feel that he felt ah cold to touch and that's when I raised the alarm at – got the um – somebody else to get the crash team to come over".

26. RN Mazibuko stated that she and another nurse then got the oxygen and defibrillator, connected the electrodes and commenced oxygen therapy. They then commenced cardio pulmonary resuscitation ("CPR"). Shortly thereafter the crash team arrived and took over care. This team included a doctor and nurse from the Intensive Care Unit ("ICU"). Attempts were made to insert a cannula but this was unsuccessful. Resuscitation attempts continued but after the fifth cycle, Dr Patricia Hiuana declared Mr Faulkner deceased. This was at approximately 7.16am on 23 September 2013.

27. In terms of how Mr Faulkner was positioned when she entered his room, RN Mazibuko stated that he was on his back with his hands on his sides. His right leg was hanging off the bed and the left leg was on the bed. She

believed that he was wearing shorts and a t-shirt, although she was not absolutely sure. His legs were exposed and "quite cold". It appeared to RN Mazibuko that the linen on his bed was:

> "Um – it was dishevelled like somebody who had been tossing and turning maybe and he wasn't covered um – just – how do I describe that – they were, he was lying on most of the blanket and there was a little bit over his um mid-section here but generally he was exposed his blankets just looked dishevelled".

28. EN Steven Pocock was also on duty. He recalled undertaking the early rounds at commencement of the night shift. At about 9.30 or 10.30pm he recalled seeing Mr Faulkner lying in bed with his eyes open. He did not have a conversation with him at the time and formed the opinion that Mr Faulkner was simply getting settled for the night. EN Pocock recalled that he was told that Mr Faulkner had been seen out of bed and going to the "ice bubbler" at about 3.00 or 4.00am but otherwise there were no other issues during any of the observations. This appears to be the same occasion referred to by RN Mazibuko.

29. EN Pocock's next involvement with Mr Faulkner was when RN Mazibuko raised the alarm. EN Pocock recalled being in the corridor at that time and immediately going to Mr Faulkner's room. He entered the room and immediately felt for a pulse "in a number of different areas". He stated that Mr Faulkner did not feel cold to him but he was "definitely clammy" and was not responsive. When the crash trolley arrived he assisted in the commencement of CPR.

30. RN Prunella Parsons was the nurse in charge of the shift that night. She recalled that when she commenced her shift, Mr Faulkner was already in bed. She conducted rounds at 1.00am and 2.00am and on both occasions she recorded that Mr Faulkner was asleep. Her recollection was that she heard him snoring. Her next involvement was when the alarm was raised by RN Mazibuko at which time she was in the office preparing for handover to the

morning staff. She immediately ran to Mr Faulkner's room and then went to get the emergency trolley. She otherwise had no other involvement.

Mr Faulkner's state of health prior to his death

31. According to the evidence given before me from Dr Rajiv Weerasundera (one of Mr Faulkner's treating psychiatrists during his admission) Mr Faulkner's mental state had in fact improved to such an extent that they were making arrangements to have him transferred out of Cowdy Ward and into supported accommodation at Papaya. The only reason this did not eventuate is that Mr Faulkner developed a fever and his physical health therefore became a concern.

32. As outlined above, the medical team were called in to assess Mr Faulkner's condition. Dr Subash Heraganahally was one of the Consultant Physicians involved in Mr Faulkner's medical care. He noted that the medical team had been asked to "follow up" Mr Faulkner after the medical registrar had seen him on 15 September 2013. He noted Mr Faulkner had significantly elevated sodium levels and renal impairment. Dr Heraganahally stated that it was believed that perhaps the high sodium level was because of poor oral fluid intake and therefore fluids were increased. A renal ultrasound and blood tests were also conducted.

33. In terms of the clinical concerns at the time, Dr Heraganahally gave evidence that it was mainly that Mr Faulkner was suffering from Hypernatraemia; which is an elevated sodium level in the blood, generally not caused by an excess of sodium but rather by a deficit of free water in the body. Greater access to water was therefore arranged.

34. Dr Heraganahally noted that Mr Faulkner was reviewed on 17 September 2013 where he was looking and feeling well. There was mild dehydration evidence, but his blood pressure was normal. He had previously recorded a fever earlier in the day but at the time of review he was no longer febrile.

Tests and assessments continued however in general terms it was considered that his physical health was improving.

35. Dr Heraganahally reviewed Mr Faulkner again on 19 September 2013 where he was noted to be looking and feeling better. His sodium levels had improved and his fever had subsided. A red throat was considered as a possible focus for his fever. Dr Heraganahally stated that as Mr Faulkner's preliminary liver screen had all been normal, they began looking for other causes of chronic hepatitis.

36. Within his statement to police, Dr Heraganahally noted that Mr Faulkner's electro-cardiogram ("ECG") results showed normal sinus rhythm with no acute changes. His ultra sound and CT scan of his head did not show any major abnormalities. A decision was made to commence him on antibiotics. He was not transferred out of Cowdy Ward into a medical ward as it was Dr Heraganahally's opinion that he was improving and looked and felt well and (as noted in his statement) "nothing catastrophic was anticipated". The plan was to review Mr Faulkner again on Monday 23 September 2013 but he passed away before that review.

Comments and Conclusion

Care provided at the Royal Darwin Hospital

37. Mr Faulkner's death was sudden and unexpected. It was so unexpected that Dr Weerasundera in fact stated that he was "shocked" when he heard that Mr Faulkner had passed away. It was clear also on the evidence of the nurses involved in his care that they did not expect he was going to die. Whilst it is clear that he had some medical issues that were being investigated it does not appear, on the evidence before me, that there was any serious underlying medical issue that was evident and not being addressed.

38. Some concern was raised as to whether Mr Faulkner was in fact still breathing at the time of his bed check at about 6.00am by RN Mutama. This

was because RN Mutama did not give evidence to indicate that she heard or saw anything that she could conclude absolutely that he was breathing at that time. Whilst RN Mutama did not give evidence indicating that she could hear him breathing, or saw his chest rising and falling, I also note that it appears there was some movement by Mr Faulkner in his bed in between that check and his being found unresponsive by RN Mazibuko at about 6.55am. This evidence is from the statements given by both nurses as to how he appeared when they checked on him.

39. Whilst I cannot find beyond all doubt that Mr Faulkner was breathing at the time of his 6.00am check, I do find that it appears upon all of the evidence that even if he was not breathing at that time and that had been discovered, that would not have had any significant impact upon his death. I make this finding on the basis of the evidence of Dr Cala that Mr Faulkner's death from sudden cardiac arrest would have been extremely quick (tp.49.1):

> "It's very sudden, and when I say very sudden it's usually a matter of less than half a minute and it may be even as short as one or two seconds. Invariably when the heart goes into one of these lethal rhythms known as ventricular fibrillation or ventricular tachycardia, etcetera, that's an immediate process. So it starts immediately: blood pressure can't be maintained, blood flow up to the brain cannot be maintained, they lose consciousness almost immediately, they might have a seizure as a result of diminished blood flow up to the brain and unless that situation is reversed and the heart rhythm is brought back to normal then death usually occurs within seconds of that, and around about to half a minute as an approximation, but generally no longer than that."

40. After considering the evidence carefully, I am of the opinion that the care and treatment provided to Mr Faulkner prior to his death was appropriate and to an acceptable standard. I make no criticism of the care given and note that at the conclusion of the evidence, his family commended the care provided by staff. I consider the care provided to Mr Faulkner whilst admitted as a patient at Cowdy Ward to have been appropriate both in terms of his psychiatric care and his medical care and I do not consider anything occurred during his period of admission that contributed to his death.

The introduction of Paliperidone

41. I am aware, as a result of matters raised during the course of the evidence that there were concerns raised by family members about the Paliperidone and whether this had any part to play in Mr Faulkner's death. I find that on all of the evidence, it did not. It is clear that Mr Faulkner was unhappy with a particular side effect of the Risperidone and had ceased its use as a result. That cessation of his anti-psychotic medication had brought about his relapse into a psychotic state. Quite simply he needed to take anti-psychotic medication in order to treat his schizophrenia. Without it he became unwell.

42. I accept the evidence of Dr Weerasundera that careful consideration was given to an alternative anti-psychotic and that this was the basis upon which the Paliperidone was introduced. Dr Weerasundera was clearly aware however of the risks associated with ***all*** anti-psychotic medication and ensured that an ECG was taken at the commencement of the administration of Paliperidone and another after one month of use. This was to ensure that it was not having an impact upon Mr Faulkner's heart and particularly his QT interval.

43. I received evidence that an abnormal QT interval is associated with an increased risk of ventricular arrhythmia and at times sudden cardiac death. Dr Weerasundera gave evidence that Mr Faulkner's ECG results showed his QT interval to be within "normal limits" on both occasions. At the time of the first ECG the QT interval measurement was 437 and one month later it was 415. It was therefore decreasing and as a result Dr Weerasundera gave evidence that he had "no reason to suspect or predict that this would happen" (tp.34.3).

44. On all of the evidence, I find that there is no evidence to suggest that the introduction and administration of Paliperidone had anything whatsoever to do with the cause of Mr Faulkner's death.

Cause of death

45. Given Mr Faulkner's death was clearly sudden and unexpected, it was particularly important that an autopsy be carried out. This was done by Dr Alan Cala on 25 September 2013. Dr Cala also gave evidence before me and noted that upon examination there were no injuries to Mr Faulkner's body and therefore no evidence to indicate foul play or any suspicious circumstances surrounding the death.

46. He noted that toxicological analysis showed a high blood level of olanzapine at 0.46mg/L and that at that level drug toxicity was possible, but not provable. Dr Cala noted however that it was also possible that drug redistribution had occurred after death and therefore caution should be taken with the result. He stated that although the level was high, it appeared to be "well below that for deliberate overdose".

47. Dr Cala stated in his autopsy report that Mr Faulkner had a slightly enlarged heart, but noted that:

> "There was no one convincing and unequivocal finding at autopsy to explain the death. A cardiac arrhythmia appears to be the final mechanism of death. Coronary artery disease was insufficiently severe to explain the death. The heart was enlarged with microscopic evidence of cardiac myocyte enlargement."

And further:

> "He was being investigated for a number of rare diseases, but died very suddenly. Sudden cardiac death is known to occur in schizophrenics. This appears to be the most likely cause in this case."

48. I accept the evidence of Dr Cala that the cause of death in this case is sudden cardiac death. I note that in very basic terms Dr Cala agreed that his conclusion that schizophrenia was the morbid condition leading to the cause of death was one reached by "a process of elimination". I accept his process of reasoning however and also the evidence that persons suffering from

schizophrenia appear to be (according to some studies) “three times more likely” to suffer sudden cardiac death than individuals from the general population. I therefore consider that it is more likely than not that Mr Faulkner’s schizophrenia was the morbid condition leading to his sudden cardiac death.

49. After decades as the Coroner of the Northern Territory I have had many unexpected deaths reported to me each year, with a significant proportion being from, what is colloquially known as an unexpected heart attack. Of those deaths a significant number have had no pre-existing symptomology and have died extremely suddenly and without any warning. I raised this very issue with Dr Cala during the course of his evidence (tp.47.9):

> “THE CORONER: Doctor, I think you'd agree then - because it's my experience that a lot of these unexpected deaths by heart attack are with people who have presented with no symptoms whatsoever but just fall over?---That's correct, your Honour. I've been a doctor over 30 years and even back in the '70s and '80s when I trained - and I don't think it's changed a great deal - that about a third of people with heart disease present as sudden death. Most of them as I said have coronary artery disease but that's a large proportion still of people presenting for the very first time not with chest pain or shortness of breath but who die and who therefore come my way because their initial presentation is one of just simply dropping dead.”

50. This appears to be precisely the case in relation to the passing of Mr Faulkner. I do not consider anything could have been done to avoid his death.

Formal Findings

51. On the basis of the tendered material and oral evidence given at this inquest, I am able to make the following formal findings:

i. The identity of the deceased person was Anthony Graham Greig Faulkner who was born on 24 January 1971 in Darwin, in the Northern Territory of Australia.

ii. The time and place of his death was approximately 7.16am on 23 September 2013 at the Cowdy Ward - Royal Darwin Hospital.

iii. The cause of death was sudden cardiac death in the context of schizophrenia.

iv. Particulars required to register the death:

a. The deceased's name was Anthony Graham Greig Faulkner.

b. The deceased was not of Australian Aboriginal or Torres Strait Islander descent.

c. The death was reported to the Coroner.

d. The cause of death was confirmed by post mortem examination carried out by Dr Alan Cala on 25 September 2013.

e. The deceased's mother is Alison Joy Greig and his father was Peter Thomas Faulkner (deceased).

f. The deceased was unemployed at the time of his death.

Recommendations

52. I have no recommendations arising from this inquest.

Dated this 21st day of January 2015

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GREG CAVANAGH
TERRITORY CORONER