OFFICE OF THE STATE CORONER
FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Casey Andrew FRIZZEL**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Proserpine
FILE NO(s):	COR 121/07(0)
DELIVERED ON:	19 February, 2010
DELIVERED AT:	Bowen
HEARING DATE(s):	16 – 18th September, 2008, 9th December, 2008 and 19th February, 2010
FINDINGS OF:	Mr Ronald William Muirhead, Coroner
CATCHWORDS:	Coroners: inquest, death in workplace, heat stroke on new housing construction site in tropical conditions in North Queensland, lack of first aid training in workplace, response of Queensland Ambulance Services, failure to properly preserve scene of death.

REPRESENTATION:

Counsel Assisting:	Ms J.M. Sharp
Family:	Mrs W. Armour (Mother) Mr W. Armour (Step Father) Mr D. Frizzel (Brother) Ms J. Frizzel (Sister)
Queensland Ambulance Service:	Mr Kevin Parrott (Crown Law)
Barry Jervis:	Mr D. Lang, Solicitor
Mark Sorensen	Mr D. Lang, Solicitor

These are my findings in relation to the death of Casey Andrew Frizzel (born on 02/02/1976) who died on Wednesday 10th January, 2007 at Lot 40 Galbraith Park Drive, Cannonvale. These findings seek to explain as far as is possible the cause of death of Mr Frizzel and to consider any changes to practices that should be implemented in an attempt to reduce the likelihood of any further deaths occurring in similar circumstances in the future.

Section 45(4) of the Coroner's Act provides that a coroner's written findings must be given to the family of the person who died and to each of the persons or organisations who were granted leave to appear at the inquest. These findings will be distributed in accordance with the requirements of the Act and will be posted on the web site of the Office of State Coroner.

I offer my sincere condolence to the family of Mr Frizzel for the loss of a loved one and also apologise for the delay since the evidence was taken and these findings being delivered. I acknowledge the distress which would have been caused to the family of Mr Frizzel by reason of the delay. However there were a number of reasons for the delay. At the conclusion of the evidence I considered that it was appropriate and necessary that the siblings of Mr Frizzel be medically tested for any possible heart problems. Such tests were obtained and there was no indication of any such problems. Due to the state of the evidence in relation to the cause of death it was then considered appropriate that an assessment by an independent expert on heatstroke be commissioned to evaluate the evidence and provide an opinion as to the cause of death. Such a report was obtained from Associate Professor Lindsay Brown in late October, 2009 and then written submissions were obtained from all interested parties.

It is my view that obtaining the family heart tests and the report by Associate Professor Brown were not only appropriate, but essential factors in assisting in making findings as to the cause of death of Mr Frizzel. It is my opinion the state of the evidence was such that without such tests and report being obtained, it would not have been possible to make findings as to the cause of death with any degree of certainty whatsoever.

I also place on record my appreciation to Ms Julie Sharp (Counsel assisting the coroner) for the assistance provided during the inquest and for her written submissions.

I also acknowledge the assistance provided by Mr Kevin Parrott (appearing on behalf of Queensland Ambulance Service) in relation to his written submissions especially in relation to possible recommendations to be made by the coroner.

I can indicate at the outset that essentially all recommendations as submitted by Ms Sharp and Mr Parrott have been included in my findings as formal recommendations.

Coroner's Jurisdiction

A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death and an inquest can be held if the coroner considers it desirable to

do so. In this case, the family of Mr Frizzel requested that an inquest be held and it was considered desirable that in the circumstances an inquest should be held.

Under the provisions of section 45 of the Act a coroner is required to find (if possible):-

Whether a death in fact happened;
The identity of the deceased;
When, where and how the death occurred; and
What caused the person to die.

It can be indicated at the outset that the only contentious matters to be considered are under paragraphs (c) and (d) above i.e. how the death occurred and what actually caused the death of Mr Frizzel.

It is not a purpose of an inquest to seek to attribute blame or apportion liability to any particular person or entity. Section 46(3) of the Act specifically provides that a coroner must not include in any comments any statements that a person is, or may be:-

guilty of an offence; or
civilly liable for something.

Instead the focus of an inquest is on discovering what happened, informing the family and the public of how the death occurred with a view to attempt to prevent deaths from similar causes happening in the future. In that regard, section 46(1) of the Act provides that a coroner may make comments on matters relating to:-

public health or safety; or
the administration of justice; or
ways to prevent deaths from happening in similar circumstances in the future.

Section 51 of Act is as follows:-

51(1) A coroner must keep a record of the coroner's findings and comments.

(2) The record of the coroner's findings and comments is not evidence in any court or tribunal of any fact asserted in the record.

(3) If a coroner becomes aware of a clerical mistake or omission in the record, the coroner must correct it.

In inquests, the civil standard of proof applies i.e. on the balance of probabilities but the approach referred to as the Briginshaw sliding scale is applicable.[1] This means that the more significant the issue to be determined; or the more serious an allegation; or the more inherently unlikely an occurrence; then in those cases the clearer and more persuasive the evidence should be in order for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[2]

[1] Anderson v Blashki [1993] 2 VR 89 at 96 per Gobbo J
[2] Briginshaw v Briginshaw (1938) 60 CLR336 at 361 per Sir Owen Dixon J

I can indicate that I have considered all of the evidence presented during this inquest and I have given full consideration to all such evidence and to the submissions of the parties who appeared at the inquest.

Evidence at the Inquest

Introduction

The deceased person was Casey Andrew Frizzel (born 2nd February, 1976) who was 30 years of age at the time of his death. He resided with friends at an address in Toowoomba. He had lived in the Toowoomba area for about one year prior to his death. [3]

Prior to living in Toowoomba Mr Frizzel had lived and worked in and around Palm Cove in North Queensland for about 10 years.

Jodie Frizzel (sister of Casey) gave evidence at the inquest and said that her brother was in good health and was a hard worker. His employer at the time of his death [4] and a co-worker [5] also said that Mr Frizzel was a reliable and hard worker.

Mr Frizzel had commenced employment as a bricklayer with Barry Jervis on Monday 8th January, 2007 on a new housing construction site situated at Galbraith Park Estate, Cannonvale. Mr Frizzel had previously worked for Mr Jervis on a casual basis for three days about six months earlier at Tara in south west Queensland. [6]

Mr Jervis operated a brick laying service based in Toowoomba. The principal contractor for the housing construction site in Cannonvale was Mark Sorenson and he had employed Barry Jervis as a subcontractor to do the brick laying work.

On Sunday 7th January, 2007 Mr Jervis had picked up Mr Frizzel from his residence in Toowoomba to travel to Cannonvale to begin work on a new housing construction site.

At the time, another bricklayer namely Justin Radke was also employed by Mr Jervis on the building site. All three men were residing at the residence of the principal contractor Mark Sorensen.

Mr Frizzel worked on the building site on Monday, Tuesday and Wednesday (8th, 9th and 10th January, 2007). The weather was very hot on those three days and the only shelter provided for the men on site was some scaffolding with a plank across it. [7]

---

[3] Evidence of Jodie Frizzel at page 2-53 of transcript
[4] Barry Jervis at page 1-35 of transcript
[5] Justin Radke at page 1-67 of transcript
[6] Evidence of Barry Jervis at pages 1-33 and 1-35 of transcript
[7] Evidence of Gavin Wesche, Principal Inspector, Dept. of Workplace Health & Safety at page 4 - 25 of transcript. During the investigation into Mr Frizzel's death an Improvement Notice was issued by that Department to the principal contractor Mark Sorensen requiring him to take action to ensure that a room or sheltered area to eat meals or take breaks was available to workers on site.

The evidence at the inquest was that Mr Frizzel ate very little food from the time he left Toowoomba up to the time of his death. Food was provided by the principal contractor. Drinking water was provided for Mr Frizzel and there was also access to tap water on the site.

During a lunch break at around 12.30pm on Wednesday, Mr Frizzel told his fellow employee, Justin Radke that "*I feel a bit crook*" and stated "*I've got pains in the chest*".

After the lunch break Mr Frizzel informed Mr Jervis that he had some chaffing and Mr Jervis went to a chemist and obtained some medication for that problem.

Sometime that afternoon between 3.00 and 4.00pm, David Scodellaro [8] observed Mr Frizzel to be mixing concrete on the site. Scodellaro inquired as to how he was going to which Mr Frizzel replied "*It's hot. I feel buggered mate*." The evidence of Mr Scodellaro was that Mr Frizzel didn't look good, was uncoordinated in his movements and even seemed a bit unsure of his footing.[9] He was advised by Mr Scodellaro to sit down and have a drink of water. The evidence of Barry Jervis was that Mr Scodellaro had informed him that Mr Frizzel "*looked a bit delusional"*. In evidence at the inquest Mr Scodellaro said he could not recall using the word "*delusional*" but agreed that he appeared shaky and unsure of his footing.

At around 4.00pm on that day, Mr Frizzel was observed by Jervis to be sitting on block work on the site. Jervis inquired if he was okay to which Mr Frizzel replied "*I will be alright, I am just sitting down for a few minutes*".

At around 5.00pm Radke spoke to Mr Frizzel who was lying down and appeared to be asleep. Radke then inquired as to whether he was alright, to which Mr Frizzel replied "*I will be in a minute*". The evidence of Mr Radke was that he did not sound real confident when he said that.[10]

Radke then reported to Jervis that Mr Frizzel was sleeping.

At around 5.45pm[11] Mr Jervis and Mr Radke went over to the area where Mr Frizzel was seen sleeping at around 5.00pm. They discovered Mr Frizzel lying on the floor of a blocked garden bed with blood coming from his mouth. At that time they also heard a groaning noise from Mr Frizzel. An electrical lead connecting a saw to a portable power box was lying across the chest of Mr Frizzel.

At this stage the power was still turned "on".

Mr Jervis then called his employer Mark Sorensen (the principal contractor for the housing project) and then called triple 0.

Triple 0 recordings indicate that the call was received at 5.59pm.

---

[8] The owner of the site under construction
[9] Page 1 of statement of David Scodellaro
[10] Paragraph 5 of statement of Justin Steven Radke
[11] Statement of Barry Jervis (although Mr Jervis did state in evidence at the inquest that it may have been closer to 5.55pm.)

Two police officers namely Constable Simon Docking and Constable Tasman Place arrived on the scene at around 6.25pm.

The evidence of Constable Place was that he thought he could feel a pulse in Mr Frizzel's right wrist. He described the pulse as feeling strong then weak and very irregular. When the police officer let go of Mr Frizzel's arm it began moving in a twitching motion.[12]

Upon a request by Constable Place, Mr Jervis turned the power off for the whole of the work site.

At this time Mr Frizzel's arm continued to twitch constantly and at one stage his right arm lifted from level with his stomach to his shoulder before dropping back down.

Constable Place was preparing to perform cardio pulmonary resuscitation (CPR) when a Queensland Ambulance vehicle arrived. The ambulance officers in that vehicle were the driver, Intensive Care Paramedic Frederick Rieger and the passenger, Advanced Care Paramedic Michael Manly, both from the Whitsunday Ambulance Service.

The point in time when ambulance officers arrived on the scene was 6.26pm. Ambulance Officer Rieger gave evidence that he observed Mr Frizzel lying flat on his back with a power cord draped over him, positioned between two besser block walls (approx. 80 centimetres apart and approx. 500 centimetres high). Officer Rieger said his initial thought was that Mr Frizzel had been electrocuted. He then confirmed that the power supply had been turned off and then conducted an initial clinical assessment which confirmed that Mr Frizzel's cardiac rhythm was asystole in that he was not breathing and had no palpable pulse. He then connected Mr Frizzel to the cardiac monitor/defibrillator.

Whilst moving Mr Frizzel, he observed what appeared to be an involuntary movement of his right arm. Despite Mr Frizzel appearing to be deceased, the arm movement prompted him to commence cardio pulmonary resuscitation (CPR).

Mr Frizzel was then placed in the rear of the ambulance vehicle and given further resuscitation treatment. Mr Frizzel did not respond and was unresponsive to stimuli, apnoeic and pulseless.

At approximately 6.50pm, it was assessed that further resuscitative efforts would be futile and resuscitation was ceased. During the 20 minute resuscitation, Mr Frizzel's vital signs were regularly assessed and there was no change from that which was noted and recorded at 6.26pm. [13]

At around 8.20pm Mr Frizzel's body was transferred to the Government Undertaker and the body was placed in the Morgue at the Proserpine Hospital at 9.00pm on 10th January, 2007.

[12] Statement of Constable T.G. Place at paragraph 23
[13] Paragraph 59 of Statement of Ambulance Officer Rieger

The evidence of Officer Rieger was he considered that Mr Frizzel had been deceased for about 20 to 30 minutes prior to his arrival.[14] Officer Rieger was unable to offer any explanation for the movement of Mr Frizzel's arm.

During cross examination, Officer Rieger stated that it was possible that Mr Frizzel may have been deceased when the triple 0 call was first made (which was at 5.59pm).

The answers he gave in evidence are as follows:-

Q (Questioned by Mrs Wendy Armour) …Is it possible – you were very surprised when you found Casey and you feel that he could have been dead for anything up to half an hour.

A. Yes

Q. It took the ambulance 20 odd minutes to get there. Could he have been dead when Barry Jervis made the first phone call?

A. I don't know. I would suggest probably only by my observation of how he was when I got there, my initial getting there. It's really hard to say but I would say yes.

Q So, that is, is it possible that when they found him and then made the phone call that he was already deceased.

A. Yes. That would be my guess.

There were a number of matters raised during the inquest which I consider are pertinent to these proceedings, namely:-

Amount of food consumed by Mr Frizzel in the three days immediately preceding his death;
Refusal of Mr Jervis to attempt CPR;
Delay in the Ambulance Officers attending the scene;
Failure to preserve the scene; and
Power failure at the Proserpine Morgue.

Amount of food consumed by Mr Frizzel from when he left Toowoomba
Mr Frizzel was picked up from his place of residence in Toowoomba at about 3.45am on Sunday 7th January, 2007. Also in the car were Barry Jervis (driver of the vehicle) and Justin Radke.

The evidence of Mr Jervis was as follows (in relation to food consumption by Mr Frizzel from that point in time):-

They stopped for fuel at Dalby at about 4.30am. Jervis inquired if anyone wanted anything to drink or eat and no one did. He said they made several stops on the way to Cannonvale and he had asked Mr Frizzel if he wanted anything for morning tea or lunch and the offer was declined each time. On the Sunday night he did not recall Mr

[14] At page 3-13 of transcript

Frizzel eating anything. To the best of his recollection, Mr Frizzel had only consumed a mars bar and a bottle of orange juice all day on Sunday.

Mr Jervis said that accommodation and food for the job in Cannonvale was supplied by the principal contractor, Mark Sorensen. He also said that he had made both of his workers (Mr Radke and Mr Frizzel) fully aware that food was being provided. [15]

He said that on Monday morning Mr Frizzel did not eat breakfast even though he was advised that it was provided for him. He also said that Mr Frizzel declined to eat anything at smoko or lunch time although he was told again that there was food available for him to eat. He was heard to say that he was "feeling the heat". On Monday night he did have a little to eat and then went straight to bed.

On Tuesday, Mr Frizzel again did not eat breakfast. He had a packet of chips at smoko time and nothing to eat at lunch. On Tuesday night he arrived at his residence at 6.00pm, had a shower and went straight to bed. He was awoken by Jervis at about 7.15pm for tea and all he ate was a little bit of pasta. He had one alcoholic drink with his meal and then went to sleep at about 8.30pm.

On Wednesday morning Mr Frizzel again did not eat breakfast but had a packet of chips for smoko. The only food he was observed to eat for lunch on that day was another packet of chips.

That evidence was supported by the evidence of Mr Radke who said that he did not see Mr Frizzel eat much during the relevant period. The three men were in relatively close contact for the three day period as they all worked together on the building site and all three resided in a house owned by Mark Sorensen and that Mr Jervis and Mr Frizzel shared a room in that house.

The evidence is also clear that there was no excessive alcohol or drug use by either Mr Frizzel or his fellow workers. Quite the opposite in fact, as the evidence was that Mr Frizzel had only one alcoholic drink over the three day period. As well, toxicology tests revealed there was no alcohol or drugs detected in the blood of Mr Frizzel at the time of his death.

However, the evidence is clear that Mr Frizzel had consumed very little food for the period from 7th January to his death on 10th January, 2010.

Failure of Mr Jervis to attempt CPR (Cardio Pulmonary Resuscitation)

The evidence was that Mr Jervis called triple 0 and that the operator at the call centre requested him to perform CPR. Mr Jervis refused to do so as he said that he was in shock and there was what appeared to be blood and vomit around the mouth area of Mr Frizzel. Further he stated that he didn't have any first aid training. [16]The operator requested Mr Jervis to move Mr Frizzel onto his side to free his airway but Mr Jervis was unable to do so due to the size and weight of Mr Frizzel.

[15] Evidence of Mr Jervis at page 1-36 of transcript
[16] Evidence of Mr Jervis at page 1-63 and in his statement

I have made recommendations to address the issues of lack of first aid training and education on heatstroke on work sites.[17]

Delay in Ambulance Officers attending the scene

The evidence of the Ambulance Officers Rieger and Manly was that at approximately 6.03pm on 10 January, 2007, they were advised by QAS Central Region Communications Centre (CAPCOM) to attend a male person located at Henderson Street, Airlie Beach. [18] The information provided was that the person was experiencing difficulty breathing and that the case had been categorised as a code 1 which required an immediate response. The two officers then immediately proceeded to their ambulance vehicle and departed from the station with the vehicle's warning devices activated.

Their evidence was that they departed the Whitsunday Ambulance Station at approximately 6.04pm and travelled in the direction of Airlie Beach. The ambulance vehicle was being driven by Officer Rieger whilst Officer Manly consulted the street directory in a tourist map which was in the vehicle but he could not locate a Henderson Street in Airlie Beach.

The officers then contacted CAPCOM via the ambulance radio to ask for directions to Henderson Street. Difficulties were experienced with the radio communication and they were requested to contact CAPCOM by their mobile phone.

Contact was made by mobile phone and they were advised by the Emergency Medical Dispatcher (EMD) that the caller had provided directions to take the Shute Harbour Road and turn right at the traffic lights immediately after the Woolworths Shopping Centre. They were advised that Henderson Street was a new estate and they were actually being directed to a construction site in that new estate.

They were also advised to keep a look out for a maroon coloured four wheel drive vehicle (which was being driven by Mr Jervis) who would direct them to the exact location. The Ambulance Officers continued along Shute Harbour Road in a south west direction towards Cannonvale. They came to traffic lights adjacent to the Cannonvale Shopping Centre [19] and discovered they could not turn right. They then decided to turn left as they were not sure of the direction from which the caller had been approaching the traffic lights. Accordingly they turned off Shute Harbour Road into Island Drive.

During this time they had received a report advising that the patient had suffered a cardiac arrest and that a back up ambulance had been dispatched from Proserpine.

The Ambulance Officers travelled to the end of Island Drive but could not locate Henderson Street or see a maroon coloured four wheel drive vehicle. The Ambulance vehicle was stopped and contact was made with CAPCOM seeking further directions. They were advised that the caller was not from the area and had

---

[17] Recommendation numbers two, four and five

[18] The correct address location was Henderson Street, Cannonvale (not Airlie Beach)

[19] The instructions were to turn right at the Woolworths Store which is located in the Centro Shopping Centre. The Cannonvale Shopping Centre (also referred to in evidence as the Whitsunday Shopping Centre) has a Coles Supermarket but not a Woolworths Supermarket

not been able to provide any cross streets or any details other then Henderson Street. EMD were then requested to contact the Queensland Police Service (QPS) to request assistance in locating Henderson Street or the maroon coloured vehicle. EMD responded that the caller was on another line but that additional directions were being sought.

The Ambulance officers remained in that location for several minutes. They were reluctant to move in case they went further from the intended location. Their reasoning was that they were close to a shopping Centre (the Cannonvale Shopping Centre) and considered they were likely to be close to the intended location.

They were then directed by ECM to proceed to Galbraith Park Drive, which was located in Cannonvale not Airlie Beach.

The Ambulance officers then travelled to Galbraith Park Drive and were able to locate Henderson Street and the construction site. Henderson Street actually runs into Galbraith Park Drive. [20] The correct address was Lot 40 Galbraith Park Drive, Cannonvale which was a new housing estate under construction.

It is clear that the initial confusion related to the caller (Mr Jervis) informing CAPCOM that the address was Henderson Street, Airlie Beach, Mr Jervis was not from the Whitsunday area and had only arrived there from Toowoomba three days earlier. As well, the two Ambulance Officers were also relatively new to the area with Officer Rieger only having been there for approximately six months and Officer Manly for approximately three months.[21]

The evidence of Ambulance Officer Rieger was that there were only three reference factors available to him in regards to locating addresses, namely:-

Whitsunday Tourist Map (of a type as in Exhibit number N1)
Officer Rieger gave evidence that his research had revealed that this Map contained a number of errors. However it must be remembered that this was a tourist map only and was not prepared on the basis of it being intended for use as a directory for government emergency services.

Information provided from CAPCOMS
Detailed evidence was provided by Ian Conaghan [22] and Lloyd Axelsson [23] in relation to map address information utilised by Queensland Ambulance Services. The process of preparing geo-spatial information for use by the State Government is coordinated through the Queensland Spatial Information Council (QSIC). That council accesses information from a number of Government Departments including Main Roads Department, Treasury Department, Queensland Rail, Queensland Police Service, Department of Emergency Services and Department of Natural Resources. The evidence was that the collection and compilation of such data does take time as it is constantly changing and appropriate tests and checks are required to achieve accuracy.

[20] Evidence of principal contractor Mark Sorensen at page 2-23 of transcript
[21] Evidence of Officer Rieger at page 3-23
[22] Data Manager, Department of Emergency Services
[23] System Data Administrator, Department of Emergency Services

A GPS (Global Positioning Device) device in the ambulance vehicle
The evidence of Mr Rieger was GPS devices were not supplied by the Ambulance Service and that he had in fact purchased one himself at a cost of approximately $1,000.00 to assist in his duties. However the reality was that Henderson Street was situated in a new building estate which had not been put on the GPS software and to that extent was of no assistance whatsoever in the circumstances. [24]

In submissions Mr Parrott advised that Queensland Ambulance Service is currently installing GPS devices in all vehicles. However, as Mr Parrott pointed out, any GPS device can only be as accurate as the information contained within that device.

I have made a recommendation at the end of these findings (as submitted by Mr Parrott) in an attempt to improve the information capabilities of QSIC.[25]

Failure to preserve the scene
The issue of site security in the event of an incident such as the one the subject of this inquest was raised during the inquest.

In this case the police at Whitsunday had run out of crime scene tape to properly secure the scene and no-one was enlisted to guard the scene overnight. An officer from Workplace Health and Safety, Mr Gavin Wesche [26] and an officer from the Electrical Safety Office Mr Joseph Smith [27] arrived at the site from Mackay at about 7.05am on Thursday 11th January, 2007.

Mr Wesche gave evidence that he considered it appropriate that he not travel to the site from Mackay until early the following morning as he believed that the scene would be secured by Whitsunday Police. However Whitsunday Police had only a very limited amount of crime scene tape available and were only able to secure a small area namely the immediate area surrounding the besser blocked garden bed area in which Mr Frizzel was found. The electrical switchboard and surrounding area was not secured.

Upon arrival at the site, Mr Wesche and Mr Smith discovered that an electrician Peter Andrew was actually performing work on the switchboard. The evidence was that the electrician had made prior arrangements with the principal contractor Mark Sorensen to carry out work on the switchboard that day.

As well there were other bricklayers working in the general area (although not within the secured area). I have also noted the evidence that Mr Radke had cleaned up the area (as instructed by Mr Jervis) prior to police arriving on the scene.

Fortunately the work done by Mr Andrews on the switchboard was able to be reversed by him and tests were able to be conducted as it had been on the previous day.

---

[24] Evidence of Officer Rieger at pages 3-19 and 3-20 of transcript
[25] Recommendation numbers one, two and five
[26] Principal Inspector of Investigations for Workplace Health and Safety Queensland, Department of Employment and Industrial Relations, Mackay
[27] Regional Manager, Electrical Safety Office, Central Queensland and Wide Bay

The end result is that the lack of site security in this particular case did not in my view, compromise the findings to be made. However, clearly there is potential for such a lack of security to frustrate or even render it impossible for a coroner to make findings in certain cases. It is not difficult to envisage situations where a scene has been disturbed or interfered with, thereby making it impossible for a coroner to form any conclusions with any degree of certainty.

In an attempt to enhance and preserve site security in future coronial matters, I have made a recommendation which is included at the end of these findings.[28] Counsel Assisting the coroner advised in submissions that she was aware that the Coronial Support Unit is currently in the process of working on a Memorandum of Understanding with the Department of Workplace & Safety. I have made recommendations that such Memorandum of Understanding contain provisions regarding responsibilities for effective scene preservation.

Power failure at Proserpine Hospital Morgue

Mr Frizzel's body was delivered to the Proserpine Morgue at 9.00pm on 10th January, 2007 (the Morgue refrigerator was turned on once the hospital was notified that the body was coming in). The body was transferred to Mackay for an autopsy in Mackay on 15th January, 2007 and returned to Proserpine that same day.

The temperature log for the Proserpine Hospital Morgue indicates the following dates, temperatures and reading times:- [29]

- 10 January 2007 - off at 07:00 hrs. (time temperature read)
- 11 January 2007 – 35 degrees Celsius at 06:45 hrs
- 12 January 2007 – 5 degrees Celsius at 06:00 hrs
- 13 January 2007 – 4 degrees Celsius at 07:00hrs
- 14 January 2007 – 4 degrees Celsius at 07:00hrs
- 15 January 2007 – 3 degrees Celsius at 06:35 hrs

The evidence was that on 11th January, 2007 an alarm was raised by the hospital wardsman in relation to the refrigeration temperature in the Morgue. An Electrical contractor was contacted and he attended immediately and established the problem was with electrical wiring which had burnt out. The wiring problem was repaired and temperatures returned to an acceptable level by 8.30am on 11th January, 2007.

It is unknown what time the wiring burnout occurred but it can be concluded that it must have been between 9.00pm on 10th January and 6:45am on 11th January, 2007.

The power failure causing the loss of refrigeration resulted in a degree of decomposition of Mr Frizzel's body. This obviously caused undue distress to Mr Frizzel's family and also affected the capacity of the pathologist, Dr Fitzpatrick to establish the cause of death at the autopsy.

Obviously the failure to maintain an appropriate level of temperature at the Morgue is completely unsatisfactory and is a matter of great concern. I have also noted the

[28] Recommendation number six
[29] Paragraphs 3, 4 and 5 of Statement of Lisa Milne

evidence of Dr Fitzpatrick who performed the autopsy that problems had been encountered at the Proserpine Morgue once or twice in the past.

However the problem has since been rectified by the Proserpine Hospital by installing an alarm system which is activated when the temperature rises to 10 degrees Celsius or drops to 0 degrees Celsius. Additionally the Morgue refrigerators are now left "on" constantly and not turned "on" and "off".[30]

In my view the remedial and preventative steps as outlined above which have now been implemented at the Proserpine Hospital obviate the need for any recommendations to be made in that regard.

WHEN, WHERE AND HOW DID MR FRIZZEL DIE

The evidence is conclusive that Mr Frizzel died on 10th January, 2007 at Lot 40 Galbraith Park Drive, Cannonvale (which was a new housing estate under construction at that time).

The exact time of death is uncertain.

Mr Frizzel was last seen conscious at about 5.00pm by Justin Radke.
At around 5.45pm Jervis and Radke found Mr Frizzel in the foot of the besser block garden bed. They both heard groaning noises coming from Mr Frizzel. Dr Fitzpatrick gave evidence that those sounds were probably consistent with end of life.

Ambulance Officers Rieger and Manly arrived at the scene at about 6.26pm. At that time his opinion was that Mr Frizzel had been deceased for somewhere between twenty minutes and one half of an hour.[31] Triple 0 recordings indicate that Mr Jervis informed the operator that he could not find a pulse during the call commencing at 6.09pm.

The two police officers (Const. Docking and Const Place) arrived on the scene at approximately 6.25pm. Both officers' initial impression upon observing Mr Frizzel was that he was deceased. However Const. Place grabbed his right wrist and said that he thought he could feel a pulse.[32]

I have noted the evidence of Const. Place that he "thought" he could feel a pulse. He did not indicate he could actually feel a pulse. There appears to be some doubt as to whether or not he could feel a pulse.

That evidence is at odds with the evidence of the very experienced Ambulance Officer Rieger [33] who arrived approximately one minute after the police officer.

Upon a consideration of all of the evidence presented at the inquest I consider that on the balance of probabilities,[34] Mr Frizzel died at some point in time between 5.45pm and 6.09pm on 10th January, 2007.

---

[30] Paragraph 8 of Statement of Lisa Milne
[31] Although he did qualify that by stating that the time may have been shorter in light of the hot weather
[32] Page 3 of Statement of Const. Garrick Tasman
[33] An Intensive Care Paramedic who has had extensive experience in the ambulance field since 1979 having worked in New York, New Zealand and in Queensland.

Although it is obviously pure speculation, I consider that on the evidence before the inquest it is likely Mr Frizzel would have died even if there had not been any delay in the Queensland Ambulance Service attending at the site. The evidence of Ambulance Officer Rieger was that when a person goes into cardiac arrest, then breathing assistance is required in a worst case scenario within four to six minutes to save the brain.[35] In the event of heatstroke, immediate immersion in cold water and emergency hospitalisation is necessary to reverse the symptoms.[36]

Based on those criteria, I consider it unlikely that the Ambulance Officers could have saved Mr Frizzel's life even if they had attended at the site without any delay (and it must be remembered that there was a possibility that Mr Frizzel was already deceased when the emergency call was received by the Ambulance Officers).

There is no way of knowing if Mr Frizzel may have survived even if he was given appropriate first aid treatment when he was discovered by Mr Jervis and Mr Radke, lying in the garden bed at around 5.00pm. However, it is not unreasonable to speculate that his prospects of survival may have been increased if he was given appropriate first aid treatment at 5.00pm or even earlier when he complained of suffering from chest pains.

In an attempt to address the issue of first aid training I have made a recommendation at the end of these findings.[37]

How did the Death Occur

There were a number of possibilities raised at the inquest as to how Mr Frizzel may have died, namely:-

Electrocution;
As a result of having received a head injury;
Heart condition; or
Heatstroke

Electrocution

Initially it was thought that Mr Frizzel may have died as a result of being electrocuted. The only basis for that theory was that when he was found lying in the block wall, there was an electrical cable lying across his chest.

Mr Jon Smith, Regional Manager of the Electrical Safety Office for Central Queensland and Wide Bay conducted an investigation into this fatality. He gave the following evidence at the inquest (in relation to the possibility of electrocution):-

"What I can say is I found no fault in the equipment and the tests confirmed the RCDs [38] work, and there was no fault in the equipment that would indicate any electrocution or any possibility of an electrocution". [39]

---

[34] The required standard of proof in coronial matters
[35] Page 3-9 of transcript
[36] Pages 8 and 10 of Report of Associate Professor Brown
[37] Recommendation numbers two and five
[38] The reference to RCD is a reference to Residual Current Device

He was then asked:-

Q. Would you expect to see, had there been an electrocution, evidence of that.

A. Yes, I would have expected to see that.

The evidence was that an electrician (Peter Andrews) had reconfigured the switchboard at the site before Mr Smith arrived on 11th January, 2007. Mr Andrews was directed by Mr Smith to restore the switchboard to the configuration in which he found it and there was no reason to doubt that that was done competently. [40] As well, the Residual Current Devices were not tampered with by Mr Andrews and were functioning properly.[41]

Later Mr Smith gave the following evidence in relation to a question by Counsel assisting the coroner:-

Q. Is it a fair summary of evidence that according to the test you conducted, and assuming Mr Andrews reconstructed the switchboard accurately that there's no evidence to suggest an electrocution.

A. That's correct.

Additionally the Autopsy Report contains the following statement (on page 2 under the heading "Signs of Recent Injury"):-

"No burns consistent with electrocution or other significant injury can be found".

Further the pathologist who performed the autopsy gave evidence at the inquest that he was confident there were no burns consistent with electrocution. [42]

Professor Ansford gave evidence on the material provided to him that electrocution could be effectively ruled out. [43]

There was no evidence produced at the inquest to indicate that Mr Frizzel died as a result of being electrocuted and in my view that possibility can be discounted completely.

As a Result of a Head Injury

The family of Mr Frizzel were initially informed by police that he had an injury to the back of his head which might have had something to do with his death.

The only basis for any speculation as to a head injury would appear to be the fact that there was blood on the head of Mr Frizzel when he was first located by police.

---

[39] Evidence of Mr Smith at pages 1-93
[40] Evidence of Mr Smith at page 1-94
[41] Evidence of Mr Smith at page 1-93
[42] Evidence of Dr Fitzpatrick at page 4-38 of transcript
[43] Evidence of Professor Ansford at page 4-51 of transcript

However there was no evidence whatsoever found of any head injury at the autopsy.

I again refer to the notation on the Autopsy Report under the heading "Signs of Recent Injury":-

"No burns consistent with electrocution or other significant injury can be found".

There was no evidence produced at the inquest as to Mr Frizzel having sustained any head injury and the possibility that he died as a result of a head injury can also be discounted completely.

Heart Condition

Dr Fitzpatrick [44] performed the autopsy and was unable to determine the cause of death. His evidence was that the body was in the early stage of decomposition upon arrival in Mackay for the autopsy and that did have some affect on his capacity to establish the cause of death.

His evidence was as follows:-

A. …there was sort of some autolysis or degenerative change in the organs such as the heart, the liver, the spleen, so sort of - it - it was probably a bit more severe than sort of mildness.[45]

He said that the liver and spleen being softer tissue were severely autolysed but that didn't have any affect on his capacity to establish the cause of death as those organs are not associated with sudden death.

However he indicated there was some autolysis or degenerative change in the heart and that did affect his capacity to examine and attempt to establish myocarditis or some other condition affecting the heart muscle.

Dr Fitzpatrick explained that myocarditis is an inflammation of the heart and there were a number of different types of myocarditis. The most common type being lymphocytic myocarditis.

However Dr Fitzpatrick did indicate that despite the presence of autolysis as a result of decomposition, the cause of death in his opinion was not lymphocytic myocarditis and further that myocarditis was not the cause of death.

He gave evidence that the cause of death may have been a form of cardiac arrhythmia. He said there were several types of arrhythmia, two of which were the long QT syndrome and short QT syndrome.

The QT syndromes can be detected in life through an ECG test but cannot be detected at an autopsy.

---

[44] His evidence was that he was a Specialist Pathologist having two special degrees in Pathology as well as a Medical degree (see page 4-35 of transcript) and that he had been performing autopsies at Mackay for about 28 years.

[45] Page 4-36 of transcript

However Dr Fitzpatrick's opinion was that he considered QT syndrome to be unlikely to have been the cause of death.

Dr Fitzpatrick also indicated that he did not detect any signs of cardiomyopathy. He gave the following evidence in relation to the detection of signs of cardiomyopathy (during questioning by Counsel assisting the coroner):-

Q. But none of those signs.

A. Didn't see them.

Q. No. And that's not because the samples were decomposed, it's because they weren't there.

A. No, no, no it was just the - they just weren't there.

After hearing of the behaviour exhibited by Mr Frizzel on the day of his death, Dr Fitzpatrick said he suspected that could fit in with the cause of death as being heatstroke. However he said he was not familiar with heatstroke and was unsure if any sign of heat stroke could even be detected at an autopsy.

In relation to the possibility of heatstroke his evidence was as follows (during questioning by Counsel assisting the Coroner):-

Q……..,but given the history that you've heard about Mr Frizzel's state of well being or lack thereof, really on the day in question, that you couldn't exclude heat stroke as a cause of death.

A. No, you couldn't.

Q. And I think I've already asked this but I just want to clarify because it's one of the questions his Honour will have to answer if he can, is whether you can say that it's more likely that the death was caused by heat stroke than some cardiac condition.

A. Yeah, because especially since – since he's been in the sun and he's been working in – in the heat.

Q. So you would support a finding that the likely cause of death was heat stroke.

A. Yes I – I don't know a lot about heat stroke but it's - sort of from what you've told me and – I'd say its certainly could be the cause.

Q. Alright. And otherwise, the cause is likely to have been an unknown cardiac condition.

A. Most – most likely, yes, yes..

Dr Fitzpatrick also indicated there are a number of sudden deaths due to heart conditions for which autopsies do not reveal any cause of death.

Evidence was also given by Professor Anthony Ansford [46] who is employed as the Consultant Senior Specialist Forensic Pathologist at the Queensland Health Scientific Services. The Professor was not present when the autopsy was performed but was provided with a copy of the transcript and all documentary evidence presented at the inquest (including the Autopsy Report completed by Dr Fitzpatrick).

The evidence of Professor Ansford was that heat stroke was less likely to be the cause of death of Mr Frizzel as he would have expected him to exhibit some of the usual signs of heat stroke such as nausea, cramping and abdominal pain, vomiting and diarrhoea.[47]

Professor Ansford's opinion was that a cardiac condition being either myocarditis (essentially an inflammation of the heart) or cardiomyopathy (meaning heart muscle disease) was the most likely cause of death.

The evidence of Dr Fitzpatrick was that despite the presence autolysis (as a result of decomposition) in the heart muscles, he was able to conclude that the cause of death was not lymphocytic myocarditis. He said that although some lymphocytes were present, it was not to any extent and the heart muscle fibres appeared to be intact.[48]

Professor Ansford referred to the presence of lymphocytes which were noted on the Autopsy Report by Dr Fitzpatrick (which he said were part of the body's immune system which produced antibodies to act as a defence to viruses and infections) in the heart which he considered abnormal. His view was that small numbers of such cells may be extremely difficult to diagnose in the presence of decomposition. [49] He said that when lymphocytes were found in the heart it was associated with chronic infections or the presence of a virus. He further indicated that such a viral infection may have been in existence at the time of death or may have occurred months or even years previously, and could have caused damage to the heart muscles.

He gave the following evidence in relation to questioning by Counsel assisting the coroner:- [50]

Q. So he might have had this flu-like illness years prior.

A. That's right.

Q. And that causes damage to the heart muscle.

A. That's correct.

Q. And that - that situation continues and, presumably, exacerbates over time to the point where the heart fails.

---

[46] A legally qualified medical practitioner registered in Queensland as a specialist Pathologist also holding degrees of Bachelor of Medicine and Bachelor of Surgery and a Diploma of Clinical Pathology
[47] At page 4 - 54 of transcript
[48] At page 4 – 37 of transcript
[49] At page 4 – 44 of transcript
[50] At page 4 – 57 of transcript

A. Well, the heart may not necessarily fail. These abnormalities within the muscle of the heart serve as a - a possible trigger to interfere with the normal electrical impulses that keep the heart beating, and can set up a - a rhythm disturbance where the heart's not beating properly, and you may die during that event.

Q. Is that cardiac arrhythmia.

A. Yes, a heart - yes, a cardiac arrhythmia.

Q. All right. And just so we all properly understand, the - the virus, or the scenario involving Mr Frizzel having had a virus at some stage is linked to the possible cause of death, which is myocarditis.

A. Well, it could be myocarditis, or it could be cardiomyopathy.

He later gave the following evidence:- [51]

A…… ..,. but the chest pain, given the fact that he's got some lymphocytes in his heart, given the sudden nature of his death, to me indicates that it's a - likely to be due to cardiac causes, and therefore - I - I believe, upon the evidence available to me, on the balance of probabilities, certainly not beyond reasonable doubt that a cardiac cause of death is most likely.

The evidence of Professor Ansford was that cardiomyopathy is a very common cause of death in young otherwise healthy persons. He further indicated that frequently such heart conditions are "familial or genetic in origin and frequently or sometimes there's a family history of other persons dying suddenly, particularly young people dying suddenly during exercise". [52]

The professor also stated that it would be advisable for the siblings of Mr Frizzel to be checked by a cardiologist to ascertain if any heart muscle problems could be detected. Tests were undertaken by Danny and Jodie Frizzel and fortunately no signs of heart problems were detected in either person.

Dr Fitzpatrick indicated there were no further tests that could have been carried out on the body of Mr Frizzel to attempt to establish the cause of death.

The evidence of Professor Ansford was that the only further tests that could have been carried out on the tissue samples were genetic testing (provided that the samples were in an appropriate condition having regard to the presence of autolysis to enable the testing to be carried out). He further indicated that such testing has only become available recently and would not have been on the pathologist's mind at the time of the autopsy. He also said that such tests were "complicated and not readily available and rather expensive". [53]

[51] At page 4 - 58 of transcript
[52] Page 4 - 55 of transcript
[53] Page 4-60 of transcript

To assist in similar occurrences in the future I have made a recommendation that genetic tests be considered by a coroner in appropriate cases.[54]

Heatstroke

Upon considering the evidence of Dr Fitzpatrick and Professor Ansford, I considered it necessary to have an expert in heat stroke evaluate the evidence and provide an opinion as to the possible cause of death.

A report dated 22nd October, 2009 was provided by Associate Professor Lindsay Brown [55] who had been provided with all of the evidence before the inquest.

Associate Professor Brown said that heat stroke could be divided into two types namely classic and exertional. Classic heatstroke is usually seen in older individuals in heat wave conditions whilst exertional heatstroke occurs in the setting of strenuous exercise in hot conditions e.g. athletes, soldiers and labourers.

The Professor indicated that there were nine major risk factors for exertional heat illness namely:- [56]

- dehydration defined by urine specific gravity, urine colour or body mass;
- obese or unfit (BMI = body weight in kilograms divided by height^2 in metres) greater than 22 kilograms/metre^2 or insufficient level of aerobic activity in a hot, humid environment within past three months;
- recent illness or digestive problem such as diarrhoea or vomiting;
- recent evidence of exertional heat illness such as heat cramps or heat exhaustion;
- poor nutrition or hydration status;
- environmental conditions;
- intensity and duration of exercise;
- inappropriate work: rest ratios;
- inadequate accessibility to fluid and shade.

Based on the evidence provided to him the Professor stated that Mr Frizzel had the following risk factors for exertional heat stress around the time of his death:- [57]

- dehydration;
- BMI greater than 22 kilograms/metre and likely to be unacclimatized to working in the probably hotter and more humid climate of Cannonvale;
- poor nutrition or hydration status;
- environmental conditions; and
- intensity and duration of exercise.

The professor stated that it was not known if any of the remaining four risk factors applied to this case (he did also indicate that there was no information to exclude either of those factors).

[54] Recommendation number eight
[55] The academic qualifications of Associate Professor Brown are listed at the beginning of his Report.
[56] Page Six of Report
[57] Page 7 of Report

At page 9 of his report, Associate Professor Brown stated:-

"Your letter of 5 August, 2009 asks me to provide an opinion as to whether the evidence supports a finding that the cause of death was by heat stroke or from a cardiac condition as suggested by Professor Ansford.

Heat stroke is known to cause tachycardia (increased heart rate) together with an increased risk of blood clotting and cardiac rhythm disturbances. These cardiovascular signs offer a plausible explanation to the symptoms reported by Mr Frizzel during the afternoon before his death and are sufficient to cause death".

In the conclusions to his report Associate Professor Brown stated:- [58]

"Based on the information provided by you, Mr Frizzel was likely to have been positive around the time of his death for five major risk factors for exertional heat stroke, namely dehydration, BMI greater than 22 together with poor acclimatization, poor nutrition or hydration status, environmental conditions and intensity and duration of exercise. While there is no information to support the involvement of a further four risk factors (recent illness or digestive problem such as diarrhoea or vomiting, recent evidence of exertional heat illness such as heat cramps or heat exhaustion, inappropriate work: rest ratio and inadequate accessibility to fluid and shade),[59] there is also no information to exclude these factors. The comments provided by his colleagues strongly suggest that Mr Frizzel was suffering from heat stress and possibly heat stroke during the afternoon preceding his death.

On the other hand, there appears to be little information implicating pre-existing heart disease in Mr Frizzel. The autopsy findings do not convincingly support the presence of myocarditis or cardiompathy that could have caused sudden death by rhythm disturbances. However, this evidence is not essential as life-threatening cardia rhythm disturbances can appear in otherwise healthy individuals.

Since heat stroke is known to cause tachycardia (increased heart rate) together with an increased risk of blood clotting and cardiac rhythm disturbances. These cardiovascular signs offer a plausible explanation to the symptoms reported by Mr Frizzel during the afternoon before his death. Further, damage to the heart and changes in the blood during heat stroke are sufficient to cause sudden death".

I have given much consideration to the evidence of Dr Fitzpatrick, Professor Ansford and Associate Professor Brown. Each is eminently qualified and their opinions obviously should be treated with great respect.

However it must be remembered that Professor Ansford, whilst eminently qualified and experienced in the field of pathology was not present at the autopsy. His evidence was given solely on reliance of documentation provided to him (the document most relied upon being the Autopsy Report by Dr Fitzpatrick). As well, he did not have the benefit of hearing the evidence given by Dr Fitzpatrick as he gave

[58] Page 10 of Report

[59] It must be noted that the evidence was that there was inadequate accessibility to shade (as indicated on page 4 of these findings. However there was ready access to water

his evidence immediately after the conclusion of Dr Fitzpatrick's evidence. [60] Accordingly his evidence is qualified to that extent.

I consider that the opinion of Professor Ansford should be treated with utmost respect but in this particular case his evidence must be considered in light of the circumstances under which his evidence was given. In that regard I refer to the extent of the autolysis present in the heart. Obviously Dr Fitzpatrick who performed the autopsy had first hand knowledge of the extent of that autolysis. My impression of the evidence of Dr Fitzpatrick was that although autolysis was present, it did not affect his capacity to examine the heart to any great extent.

On the evidence before the inquest, it is not possible to exclude either a cardiac condition (either cardiomyopathy or myocarditis) or heat stroke as the cause of death of Mr Frizzel.

However after considering all of the evidence at the inquest, I am satisfied on the balance of probabilities [61] that on the 10th January, 2007 Mr Frizzel suffered heatstroke which caused damage to his heart resulting in his sudden and tragic death.

FINDINGS REQUIRED BY SECTION 45 (2) OF THE ACT

Upon consideration of all of the evidence at the inquest I make the following findings:-

Identity of the deceased person

The deceased person was Casey Andrew FRIZZEL.

When the deceased person died

Mr Frizzel died sometime between 5.45pm and 6.09pm on Wednesday 10th January, 2007

Where the deceased person died

Mr Frizzel died at a new housing construction site situated at Lot 40, Galbraith Park Drive, Cannonvale (being a new housing construction site in the Galbraith Park Estate in Cannonvale, Queensland).

How the deceased person died

Mr Frizzel was working as a bricklayer on a very hot day on a new housing estate under construction at Galbraith Park Estate, Cannonvale. He died as a result of suffering from heatstroke which caused damage to his heart.

What caused the death of the deceased person

I am satisfied on the balance of probabilities that the cause of death of Mr Frizzel was heatstroke.

[60] Both gave evidence by telephone
[61] The required standard of proof as explained on page 1 of these findings

Recommendations

In an attempt to avoid death occurring in similar circumstances in the future I make the following recommendations:

That Local Government Authorities provide as soon as possible details of all development applications which have been approved by the Authority to Queensland Spatial Information Council (QSIC). Further, that Local Government Authorities be required to provide details of new roads as they are completed to QSIC.

That all building sites (whether residential or industrial) be required to post an "Emergency Information Sheet" (in a conspicuous format such as a poster) at a designated position on site, such as electrical junction box as well as such other places that make it readily visible and available, containing:-

- Emergency telephone numbers;
- Exact site location details including street cross references and directions as well as longitudinal coordinates; and
- Basic first aid instructions (such as those required to be placed at public swimming pools).

The requirement for an "Emergency Information Sheet" be regulated and monitored by the Department of Workplace Health and Safety.

That all building sites be required to display posters at designated positions (as outlined in paragraph 2 above) warning employees of the signs and symptoms of heatstroke and include guidelines as to the prevention, treatment and management of heatstroke.

That the Department of Workplace Health and Safety give consideration to implementing and monitoring a requirement that all building sites have at least one person who has obtained a prescribed level of first aid training. Such first aid training to include education about the signs and symptoms of heatstroke (as well as prevention and treatment of heat related illnesses) and resuscitation and/or cardio pulmonary resuscitation (CPR).

As well, all employees should receive basic first aid training as part of their induction process to be assessed and monitored by the Department of Workplace Health and Safety.

In relation to a Memorandum of Understanding that is currently being negotiated between the Coronial Support Unit (of Queensland Police Service) and the Department of Workplace Health and Safety, I recommend as follows:-

(a) That such Memorandum of Understanding contain provisions regarding effective scene preservation in the case of a death in a workplace and;

(b) That the Department of Workplace Health and Safety develop information resources for employers and contractors regarding the importance of scene

preservation to prevent scenes being disturbed by workers prior to the completion of an investigation.

That Queensland Ambulance Service give consideration to implementing an orientation policy for officers new to a particular area whereby such officers are required to familiarise themselves with their district (including but not limited to local landmarks and local reference points) at the commencement of their employment. This may also include the preparation and update of a local directory showing relevant local landmarks and reference points which is kept on site.

That in cases where the cause of death cannot be established at an autopsy, then the coroner should consult with the pathologist performing the autopsy to ascertain if it may be of assistance to obtain a family medical history.

The Inquest is now closed.

R.W. Muirhead
CORONER
19th February, 2009