CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Michael Leslie BURRELL**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	2016/3877
DELIVERED ON:	20 June 2019
DELIVERED AT:	Brisbane
HEARING DATE(s):	20 June 2019
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, death in custody, natural causes.

REPRESENTATION:

Counsel Assisting:	Ms Sarah Lane
Queensland Corrective Services:	Ms Vanessa Price
Registered Nurse Roser Alexis:	Ms Melissa Carius (Barry Nilsson)
Metro South Hospital & Health Service:	Ms Danielle Blonde

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Introduction

1. Michael Leslie Burrell was 58 years of age when he died in palliative care in the Princess Alexandra Hospital Secure Unit (PAHSU) on the morning of 18 September 2016. Mr Burrell had been transferred to the PAHSU the previous evening from the Wolston Correctional Centre (WCC) where he was serving a term of imprisonment for manslaughter. Mr Burrell died of natural causes from terminal liver cancer, which developed as a result of cirrhosis of the liver and Hepatitis C infection.

The Investigation

2. Senior Constable Marcelle Sannazzaro from the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU) oversaw the investigation into the circumstances leading to Mr Burrell's death. Having regard to the circumstances of the death I am satisfied that the investigation was satisfactory.

3. After being notified of Mr Burrell's death, CSIU officers attended the PAH on 18 September 2016. Mr Burrell's correctional records and his medical files from WCC and the PAH were obtained. QPS Photographic officers attended and took photographs of Mr Burrell. No forensic examinations were considered necessary as it was ascertained that Mr Burrell had been under guard since his admission. The scene had been appropriately preserved.

4. The CSIU investigation was supplemented by statements from relevant nursing staff and medical officers at the PAH. These statements were tendered at the inquest.

5. On the basis of the evidence obtained Detective Senior Constable Sannazzaro provided a report containing the following conclusions:

    1. *The deceased had previously been diagnosed with Hepatocellular Carcinoma.*
    2. *The deceased had been receiving medical treatment at the [PAH] for his ailments up to the time of his death.*
    3. *The deceased was always afforded medical care for his illness during his time as an inmate at the WCC.*
    4. *QCS staff correctly followed death in custody protocols.*
    5. *QPS staff correctly followed death in custody protocols and conducted a thorough investigation.*
    6. *An autopsy was performed on the deceased which confirmed the cause of death was his illness.*
    7. *No other circumstances contributed to the deceased's death.*
    8. *No suspicious circumstances exist in relation to his death.*[1]

[1] Exhibit A4, p 8.

Social and medical history

6. Mr Burrell was born on 31 July 1958 in Mildura, Victoria.[2] Mr Burrell had been serving his prison sentence since 2009, and had no next of kin or other emergency contacts listed in his medical records at his most recent admissions.[3]

7. Mr Burrell had a significant medical history which included the contraction of hepatitis C sometime after 1979. It is likely that Mr Burrell acquired this infection from intravenous drug use or in the course of getting one of his many tattoos.[4]

8. Mr Burrell also had a lengthy criminal history. In 1976, when he was aged 18 years, he was convicted of possessing a prohibited plant. Mr Burrell's convictions show that, from then on, his offending was reasonably regular, and escalated in seriousness until, in 1992, he received his first sentence of imprisonment for an assault occasioning bodily harm, and served six months. In 1995 Mr Burrell was imprisoned for 18 months for an offence of unlawful wounding.[5]

9. In 1997, Mr Burrell was involved in a serious car accident. As a result of his injuries, he had his spleen removed, and his right leg was amputated below the knee.[6] In 1998, he was sentenced to two years imprisonment for dangerous driving while affected by an intoxicating substance.[7]

10. In 2001, after his release from prison, Mr Burrell was admitted to the PAH to be fitted with a prosthetic leg.[8] The delay in fitting his leg had been caused, in part, by recurring chronic infections in his stump, which made it impossible for him to wear any prosthetic. It was during this admission that investigations revealed that Mr Burrell had hepatitis C, and he was reviewed to determine his suitability for antiviral therapy to treat that infection. Given that he reported a history of depression, his treating team decided that he was not a good candidate for this therapy because of the risk of neuropsychiatric side-effects. Mr Burrell was advised to avoid alcohol. [9] Mr Burrell continued to suffer from intermittent infections in his stump, and from time to time was confined to a wheelchair because he could not wear his prosthetic.[10]

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[2] Exhibit A1.
[3] Exhibit B6.1, p 223, 260.
[4] Exhibit B6, para 11.
[5] Criminal history.
[6] Exhibit B6, para 12.
[7] Criminal history.
[8] Exhibit B6.1, p 408.
[9] Exhibit B6, para 13.
[10] Exhibit B6.1

11. In 2003, Mr Burrell attended the PAH as an outpatient for ongoing management of his hepatitis C. He reported to the specialist that he made his own home-brew and was quite a heavy drinker. He also reported that he was a smoker and a regular user of marijuana, and was currently taking an antidepressant. The specialist considered that Mr Burrell was still a poor candidate for treatment for hepatitis C, given his depression, recurrent leg infections and the fact that Mr Burrell advised he was not prepared to reduce his alcohol consumption. Mr Burrell was diagnosed with significant liver disease, likely due to his hepatitis C and heavy alcohol consumption.[11]

12. Mr Burrell suffered a significant ongoing infection in his stump in 2005 and he was referred to the Infectious Diseases Clinic at the PAH. It was recommended that he have debridement surgery to remove infected tissue and bone, followed by a long course of antibiotics.[12] Mr Burrell had this surgery at the PAH in March 2006, but required a second surgery in October 2006. Following the second surgery he developed an abscess under his stump post-surgery, despite being on intravenous antibiotics.[13]

13. In March 2009 Mr Burrell was sentenced to 10 years imprisonment for manslaughter. He was an inmate at the Maryborough Correctional Centre (MCC). Mr Burrell was frequently transferred to the Brisbane Correctional Centre (BCC) in order to attend medical appointments at the PAH for his liver disease, his stump and prosthesis, ongoing shoulder pain and urological problems. There were sometimes difficulties with accommodating him because of his restricted mobility. On two occasions (2010 and 2012) Mr Burrell refused to attend an appointment at the Urology Clinic at the PAH due to problems with wheelchair access at BCC.[14] In 2013 Mr Burrell was transferred to the WCC.[15]

14. By early 2015, Mr Burrell's liver disease had progressed to incurable liver cancer (multifocal hepatocellular carcinoma), and he was considered a candidate for transcatheter arterial chemoembolization (TACE) therapy, which is a form of chemotherapy which can prolong life. Mr Burrell received his first course of this treatment on 29 July 2015. At this time Mr Burrell had been suffering from urinary tract infections for around a year and was kept in hospital for around two weeks following the TACE procedure for investigation and treatment of this problem.[16]

[11] Exhibit B6.1, pp 197 – 198.
[12] Exhibit B6.1, p 194.
[13] Exhibit B6.1, pp 298 - 401.
[14] Exhibit B6.1, pp 147 and 149.
[15] Movement Records (3), p 2.
[16] Exhibit B6.2, p 7 and Exhibit B6.1, pp 792 - 932.

15. Mr Burrell was readmitted within a few days after discharge, as he had begun to suffer confusion due to his liver disease (hepatic encephalopathy). From this point on, Mr Burrell was frequently admitted to the PAH for ongoing treatment of his liver disease, investigation and treatment of his urological difficulties, and episodes of chronic shoulder and neck pain and encephalopathy. He received a second round of TACE therapy on 21 January 2016. [17]

16. On 22 March 2016, Mr Burrell's gastroenterologist at the PAH, Dr Graeme Macdonald, provided a letter for the Parole Board in which he advised that:

> *[Mr Burrell] has advanced liver disease complicated by unresectable hepatocellular carcinoma. We have been palliating growth of his liver cancer with episodes of TACE therapy. At best, this will hold the growth for a while but I suspect we will run into problems with liver failure in the next year or so and he is unlikely to be able to survive much beyond that.*[18]

Circumstances of the death

17. On 17 September 2016, at 9:30am Mr Burrell attended the WCC medical centre complaining of nausea and vomiting. He was given anti-nausea medication and kept in the medical centre under observation. Mr Burrell's nausea settled but at around 1:45pm he began complaining of abdominal pain. An ambulance was called, and at 2:15pm Mr Burrell was transported to the PAH Emergency Department (ED).[19]

18. Mr Burrell was admitted to the ED at 3:08pm following triage. He was subsequently reviewed by the ED Registrar, Dr Cameron Stirling, who ordered various tests, including an abdominal and a chest x-ray, and performed an abdominal ultrasound on Mr Burrell during his review. The ultrasound was done to identify whether there was any fluid in the abdominal cavity that required draining. It was determined that drainage would not be required, and that Mr Burrell should be treated with IV antibiotics.[20] The report of the abdominal x-ray noted that "[t]he appearances are consistent with partial small bowel obstruction".[21]

19. At 8:58pm Medical Registrar, Dr Adrian Peters, reviewed Mr Burrell and the pathology and chest x-ray results, and noted that Mr Burrell was confused, and had a raised heart-rate but no fever. Dr Peters did not mention the abdominal x-ray in his notes, but did review it, and interpreted the image as showing 'faecal loading' (constipation).[22] Dr Peters noted that the cause of Mr Burrell's condition was likely to be encephalopathy brought on by an infection. He determined that Mr Burrell should be admitted under the care of Dr MacDonald.[23]

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[17] Exhibit B6.1, pp 497 - 792.
[18] Exhibit B6.1, pp 494 - 495.
[19] Exhibit B3.
[20] Exhibit E3, p 3.
[21] Exhibit B6.1, p 242.
[22] Exhibit E3, p 3.
[23] Exhibit B6.1, pp 230 – 232.

20. Mr Burrell was transferred to the Secure Unit just after 11:00pm on 17 September 2016. Registered Nurse (RN) Cissamma James was assigned to care for Mr Burrell, and noted that he was still confused, his heart rate remained high, and that he was “rousable but can’t stay awake”.[24]

21. The nurse in charge of the night shift, RN Chisholm, conducted the handover with the ED nurse while RN James settled Mr Burrell into his bed. When she looked at his records from the ED, RN Chisholm was concerned that Mr Burrell’s heart rate had been high (between 110 and 130bpm) since he had been admitted to the ED, and remained high. According to PAH procedure, a code blue – medical emergency should be called if the patient’s heart rate reached 140bpm. RN Chisholm had Dr Peters paged and asked him if Mr Burrell should have a ‘modified call criteria’ given his consistently high heart rate. Dr Peters advised that the call criteria for Mr Burrell should stay as per usual procedure, and advised that he would order an IV fluid bolus if RN Chisholm was concerned. RN Chisolm said that Mr Burrell was still being settled in and assessed, so did not ask for that order during the conversation.[25]

22. Mr Burrell’s Glasgow Coma Scale (GCS) score had fallen from 14/15 (on admission to the ED) to 11/15 (on admission to the SU). Although a drop in GCS score of 2 or more points is also a PAH criteria for calling a code blue, nursing staff did not call a code blue in respect of the GCS score.

23. RN Chisholm advised RN James to page Dr Peters and request a fluid bolus if Mr Burrell’s heart rate rose above 140bpm. RN James monitored Mr Burrell closely overnight, and his heart rate remained below that level for the remainder of her shift. [26]

24. At 6:00am on 18 September 2016, Nurses Chisholm and James handed over to the nurses on the morning shift, the nurse in charge RN Roser Alexis and RN Natalie Ryan. RN Alexis was familiar with Mr Burrell from previous admissions, and knew that his treatment had been palliative for some time. Nurses Chisholm and James advised that they were very concerned about Mr Burrell’s condition and that he had deteriorated since around 2:00am that morning.[27]

25. During handover, RN Ryan expressed concerns that, despite the fact that Mr Burrell had been in palliative care for some time, there was no Acute Resuscitation Plan (ARP) in place which would provide a clear end-of-life directive for staff if Mr Burrell suffered an acute deterioration. RN Ryan advised that she would take the matter up with Mr Burrell’s Medical Treating Team later that day.[28]

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[24] Exhibit B6.1, pp 233 – 235 and Exhibit B4, paras 2 - 3.
[25] Exhibit B2, paras 8 – 15 and Exhibit B6.1, p 230
[26] Exhibit B4, paras 4 - 7.
[27] Exhibit B1, paras 7 – 11 and Exhibit B7, paras 2 – 3.
[28] Exhibit B7, paras 4 – 5.

26. After the verbal handover at the nurses' station, the nurses on morning shift went with RN James to carry out a head-to-toe check on Mr Burrell. They entered his cell at around 6:20 to 6:30am and observed that he was he was lying on his back. They noted that he had blue, mottled skin on his limbs, and appeared to be in pain and having difficulty breathing. RN Ryan commented that "it appeared that his peripherals were shutting down". RN Ryan noted that Mr Burrell's skin was cold to the touch and that his abdomen was grossly distended, tight and shiny. The RNs turned Mr Burrell onto his side to make him more comfortable and adjusted the angle of his head to enable him to breathe more easily.[29]

27. Mr Burrell began thrashing around in the bed and attempting to speak. RN Ryan asked if he would like some pain relief. Mr Burrell was not fully conscious and could not answer verbally, but RN Alexis saw him nod when asked if he was in pain. RN James left as she had finished her shift, and both RN Alexis and RN Ryan returned to the nurses' office to page a doctor.[30]

28. RN Ryan paged the doctor on call, Dr Wang, who said she was unable to attend to review Mr Burrell at that time. RN Ryan requested that Dr Wang authorise morphine for Mr Burrell to keep him comfortable until she could attend, and Dr Wang authorised the morphine. RNs Ryan and Alexis dispensed the morphine into a needle, and returned to Mr Burrell's cell. They re-entered the cell at around 6:40am.[31]

29. Upon entering, RN Alexis noticed a very strong smell of faeces. Mr Burrell appeared to be unconscious and did not respond to the nurses. When they rolled him over to check his vital signs they saw that his body was covered with black faecal vomit and faecal matter which had been expelled from his abdomen through his mouth. The nurses found no pulse or signs of breathing, and noted that his pupils were fixed and dilated. RN Alexis considered that Mr Burrell was deceased.[32]

30. RN Ryan called out "Code Blue" to the Correctional Officers standing near the cell. She then went to the nurses' station to make a call to the Rapid Response Team (RRT), and returned to the cell with the emergency trolley.[33]

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[29] Exhibit B7, para 7 and Exhibit B4, para 7.
[30] Exhibit B1, paras 12 – 15 and Exhibit B7, paras 7 – 8.
[31] Exhibit B1, paras 15 – 16 and Exhibit B7, paras 8 – 10.
[32] Exhibit B1, paras 16 – 20 and Exhibit B7, paras 10 – 11.
[33] Exhibit B1, paras 20 – 26; Exhibit B1.1, paras 11 and 12; Exhibit B7, paras 12 – 16.

31. There was some discussion between RN Alexis and RN Ryan about whether to commence CPR on Mr Burrell while they were waiting for the RRT in accordance with the PAH's code blue procedure. It was determined that they would not do CPR as Mr Burrell was assessed as not showing any signs of life and CPR would be futile. CPR was also not considered feasible due to the presence of faecal matter on Mr Burrell, and the risk of hepatitis C infection to the nurses if they performed CPR was too great.[34]

32. CCO Petra Lewis was on duty in the Secure Ward with two other CCOs. She said that she was present when RN Ryan examined Mr Burrell, and again when RNs Ryan and Alexis returned to give Mr Burrell the morphine. She said there was only around 5 minutes between these events. CCO Lewis said that RN Ryan immediately notified her that Mr Burrell was deceased, and that she contacted her Corrective Supervisor Richard Woods who called a code blue, and that the RRT arrived at approximately 7:00am.[35]

33. Medical Registrar Dr Robert Harvey recorded that he and the RRT arrived at the door of the Secure Unit at 6:48am, but that they did not enter until 6:54am as they had to wait for security and sign in. Dr Harvey examined Mr Burrell and attached a heart monitor, and determined that he had no life signs. Dr Harvey considered that Mr Burrell appeared to have had "a massive aspiration event as [he] suffered a respiratory and cardiac arrest, and that any further attempts to resuscitate would not be successful. Dr Harvey pronounced time of death at 7:21 am.[36]

Autopsy

34. On 20 September 2016, Specialist Pathologist, Dr Andrzej Kedziora conducted an autopsy consisting of an external examination of the body. The cause of death was given as "a) Multifocal hepatocellular carcinoma, *due to, or as a consequence of* b) Cirrhosis of the liver, *due to, or as a consequence of* c) Hepatitis C infection".[37]

35. The toxicology results were negative for alcohol and illicit drugs, and showed only quantities of the medications Mr Burrell had been prescribed and/or treated with in palliative care.[38] Dr Andrzej noted that the levels of tramadol (used to treat pain) and Mr Burrell's anti-depressant, Dothiepin, were detected at potentially toxic levels, but that this was not a factor which contributed to Mr Burrell's death, as "[c]oncentrations of drugs normally metabolised by liver tend to be elevated in liver failure".[39]

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[34] Exhibit B1 para 25 and Exhibit B7, paras 11 – 12.
[35] Exhibit B5, paras 12 – 15.
[36] Exhibit B6.1, pp 225 – 226.
[37] Exhibit A2, p 8.
[38] Exhibit A3
[39] Exhibit A2, p 7.

PAH Clinical Review

36. Following Mr Burrell's death the PAH conducted an internal clinical review of the circumstances of the death. In a report dated 26 January 2017, the reviewer, Bronwyn Coote, identified the following "contributing factors":

    1. *The abdominal x-ray taken when the patient was in the Emergency Department indicated a partial bowel obstruction. This was not identified at the time of admission.*

    2. *Nursing staff in the Security Unit did not adhere to hospital procedure and initiate a* code blue – medical emergency *when it was identified the patient's Glasgow Coma Scale had decreased greater than 2 points on admission.*

    3. *Nursing staff in the Security Unit did not adhere to hospital procedure and commence Cardio Pulmonary Resuscitation when they identified the patient as not breathing. Nursing staff called a code Blue for a Medical Officer to pronounce the patient deceased.*[40]

37. In respect of the first contributing factor, it was found that the Medical Registrar reviewed only one of the three x-ray images taken of Mr Burrell's abdomen, and assumed that this was the only image available. The hospital identified this as human error only (there was no problem with the images or the way in which they had been loaded on to the hospital computer system), and the Registrar was given retraining on how to access all images uploaded.[41]

38. With respect of the second and third contributing factors, human error was also found to have caused the failures to adhere to hospital procedures by the relevant nursing staff. The reviewer identified a number of factors in relation to why CPR was not commenced by nursing staff:

    - Confusion regarding what emergency treatment was required as Mr Burrell was identified as a "palliative patient" with a terminal illness. Some staff considered this meant he was not for active treatment while others thought there were some treatment options available but no curative treatment could be offered.
    - Concerns that the death was a death in custody.
    - Concerns about personal safety by being exposed to contaminated bodily fluids.

39. The report also noted the following "issue":

    There was a delay in the RRT entering the SU. This was the result of poor communication between the nursing staff and Corrective Officers when the RN made the code blue call.

[40] Exhibit E3, p 2.
[41] Exhibit E3, pp 4 - 5.

PAH Response to the Clinical Review

40. On 12 February 2019 Dr Stephen Ayre, the Health Service Chief Executive, wrote to advise of the measures that the PAH have put in place in response to the review of Mr Burrell's death. These include:

    a. a dedicated Code Blue phone line has been installed in the Command Room of the SU to ensure that security staff are aware that a RRT has been called and the RRT is not delayed in entering the SU;

    b. education has been given to all permanent SU staff and staff employed since the incident in:

        i. Basic life support;
        ii. Recognition and response to clinical deterioration
        iii. Managing deterioration – Digital hospital Power Chart (Between the Flags)
        iv. Processes for deceased prisoners.

    c. development of a Patient Safety Round to occur at the beginning of each shift in the SU, to ensure that staff on duty have a clear understanding of each patient's management plan.[42]

CFMU Review

41. At the request of the Coroners Court, Dr Ian Home, Senior Forensic Physician, Clinical Forensic Medicine Unit (CFMU) examined the autopsy report, Mr Burrell's medical records as well as the internal review and response by the PAH. In his report dated 30 April 2019, Dr Home concluded:

    As there were no reversible causes identified at autopsy, it is difficult to suggest Mr Burrell's deterioration on 18/09/2016 could have been in any way prevented. Nevertheless, reading the information provided, it is clear that Mr Burrell should have been medically and possibly surgically reviewed soon after his admission to the Secure Unit. Decompression of the stomach via insertion of a nasogastric tube may have provided some relief from abdominal discomfort and prevented further vomiting. Repeat blood tests may have revealed electrolyte disturbances caused by fluid shifts that may have increased susceptibility to a life-threatening cardiac arrhythmia and /or neurological dysfunction. At the very least, the cause of Mr Burrell's deterioration and his management plan should have been reassessed and if appropriate, the reasoning for any limitations of treatment clearly documented.[43]

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[42] Exhibit E4.
[43] Exhibit F1, p 5.

42. In respect of the PAH internal review, Dr Home noted that the review "correctly identified a number of system errors related to Mr Burrell's final admission".[44] Dr Home had no criticisms to offer of the PAH review or of the steps taken by the PAH to prevent similar errors from occurring in the future.

Inquest

43. As Mr Burrell's death occurred while he was in custody, an inquest was required by s27(1)(a)(i) of the *Coroners Act 2003*. The inquest was held on 20 June 2019. All of the statements, medical records and material gathered during the investigation into Mr Burrell's death were tendered to the court. Counsel Assisting proceeded immediately to submissions in lieu of an oral testimony being heard.

44. In considering this matter, I also had the benefit of written submissions from QCS, who advised that they were in agreement with the findings of Detective Senior Constable Sannazzaro and the opinion of Dr Home.

Conclusions

45. Mr Burrell's death was the subject of a police investigation. That investigation has been considered by me and I accept that the death was from natural causes with no suspicious circumstances associated with it.

46. Mr Burrell's death was also the subject of an internal review by the hospital and an independent review by Dr Home. Some shortcomings were acknowledged in the identification of Mr Burrell's abdominal pain on admission, and in adherence by hospital staff to hospital procedures. However, I find that none of these systemic shortcomings caused or contributed to Mr Burrell's death. I am also satisfied that the response by the PAH to the shortcomings identified was appropriate and sufficient.

47. I also acknowledge that where the PAH's clinical review identified human errors as contributory factors, the identification of those factors should not be equated with a finding of fault on the part of the relevant clinical staff. It was necessary to assess the actions of those staff in the context of the circumstances at the time.

48. Subject to the systemic shortcomings identified by the PAH and by Dr Home, I am satisfied that Mr Burrell was given appropriate medical care by staff at WCC and at the PAH while he was admitted there. His death could not reasonably been prevented.

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[44] Exhibit F1, p 3.

49. It is a recognised principle that the health care provided to prisoners should not be off a lesser standard than that provided to other members of the community. The evidence tendered at the inquest established the adequacy of the medical care provided to Mr Burrell when measured against this benchmark.

Findings

50. I am required to find, as far as is possible, the medical cause of death, who the deceased person was and when, where and how he came by his death. After considering all of the evidence, including the material contained in the exhibits, I am able to make the following findings:

Identity of the deceased -	Michael Leslie Burrell
How he died -	On 17 September 2016, Mr Burrell was transferred from the Wolston Correctional Centre to the Princess Alexandra Hospital Emergency Department with general decline, nausea and increasing abdominal pain. He was admitted to the hospital's Secure Unit at 11:30pm. He had a lengthy history of hepatitis C and hepatocellular cancer and had been treated on multiple occasions at the Princess Alexandra Hospital. Mr Burrell had no contact with his family and there was no acute resuscitation plan in place. On the morning of 18 September 2016, Mr Burrell was found to be unresponsive by nursing staff at around 6:40am after he was reported on handover to have progressively declined overnight. Resuscitation efforts were not commenced and he was declared deceased at 7:21am.
Place of death -	Princess Alexandra Hospital, 199 Ipswich Road, Woolloongabba in the State of Queensland.
Date of death -	18 September 2016.
Cause of death -	Mr Burrell died as a result of multifocal hepatocellular carcinoma, due to, or as a consequence of cirrhosis of the liver, due to, or as a consequence of hepatitis C infection.

Comments and recommendations

51. The *Coroners Act 2003* enables a corner to comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.
52. In the circumstances, I accept that there are no comments or recommendations to be made that would assist in preventing similar deaths in future, or that otherwise relate to public health or safety or the administration of justice.

53. I close the inquest.

Terry Ryan
State Coroner
20 June 2019