IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 007035

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the ***Coroners Act 2008***

Findings of:	Coroner Ingrid Giles
Deceased:	Paul Francis McHugh
Date of birth:	8 December 1975
Date of death:	8 December 2022
Cause of death:	1(a) Acute hepatic failure due to chronic paracetamol ingestion 2 Chronic pain, acquired brain injury, Hepatitis C
Place of death:	Austin Hospital 145 Studley Road, Heidelberg, Victoria, 3084
Keywords:	Prescribing, dispensing, over-the-counter medications, webster packs, paracetamol toxicity.

INTRODUCTION

1. On 8 December 2022, Paul Francis McHugh[1] was 47 years old when he died in hospital following acute liver failure due to long-term paracetamol consumption. At the time of his death, Paul resided in Frankston South with his mother Rosalba McHugh (**Rosalba**).

Background

2. Paul was raised by parents, John and Rosalba, with his three siblings. Rosalba fondly recalls how her children *'enjoyed a normal and loving family environment'*.

3. At 11 years of age, Paul performed small tasks at a local business in exchange for *'pocket money'*. According to Rosalba, while performing these duties, Paul was sexually abused by an employee of the business. The abuse reportedly continued for approximately 10 years.

4. After Year 11, Paul began to *'drink alcohol heavily'*. His mother believed *'his drinking was a way that he was dealing with the sexual abuse'*.

5. In November 2002, Paul reported the abuse to Victoria Police and in 2004, charges were laid against the employee. However, these were later dismissed. Paul was greatly distressed by the dismissal of the charges. Rosalba recalls:

> *'I believe that the sexual abuse over the 10-year period caused Paul serious psychological problems for which he relied on alcohol and drugs to help with'*.

6. Around 24 years of age, Paul commenced using illicit drugs, including opiates and heroin.

Medical History

7. Paul attended General Practitioners (**GP**), Dr Andrew Taylor (**Dr Taylor**) and Dr John Dickman (**Dr Dickman**). According to Dr Taylor, Paul experienced *'multiple extremely significant illnesses',* including *'near unmanageable anxiety'* and *'untreatable pain'*. He also stated that *'Paul found his pain extremely distressing and was not able to benefit from psycho-education nor other modes of allied health therapy'*.

8. In June 2011, Paul was involved in a motor vehicle collision, causing an Acquired Brain Injury (**ABI**) and damage to the spine that required a cervical decompression and a fusion operation. Paul also experienced a workplace injury to his knee which required multiple operations. He

[1] Referred to throughout this finding as 'Paul', unless more formality is required.

experienced chronic back and knee pain until his death, and had additional diagnoses including Type 2 Diabetes Mellitus, acute myocardial infarction, Hepatitis C and obesity.

9. Paul was a participant in the National Disability Insurance Scheme (**NDIS**), and his mother was his carer. Each week, Paul's medication was administered in two webster packs – large blister packs in which pharmacists had organised his daily medication. Rosalba supervised Paul's medication, and ensured that there was no medication in the house which Paul could otherwise access.

10. Paul had an extensive history of mental ill health. He informed Dr Taylor that he experienced suicidal ideation and frequently felt *'hopeless'.* He had a history of suicide attempts including by an attempted overdose around 2017.

11. Between 2008 and 2022, Paul was admitted as a psychiatric inpatient on 12 occasions – the majority of these occurred at Frankston Hospital, which is operated by Peninsula Health. During these admissions, Paul received multiple psychiatric diagnoses including borderline personality disorder, substance use disorder, and schizophrenia.

Admission from 5 June to 25 July 2022

12. Paul's most recent hospital admission occurred between 5 June 2022 and 25 July 2022. He was admitted as an involuntary patient under the *Mental Health Act 2014* (**MHA**) – as then applied – due to *'deterioration of [his] mental state with psychotic symptoms'*. Upon discharge, Paul was released to the care of the Mornington Adult Community Mental Health Team and was subject to a Community Treatment Order under the MHA.

13. At this time, Paul was prescribed numerous medications, including the anti-psychotic medication, paliperidone, the opioid replacement therapy, buprenorphine, and paracetamol at a dose of four grams per day.

14. On 8 August 2022, Paul returned to live with Rosalba where she resumed her role as carer. He was referred to the Frankston Adult Community Mental Health Team and was allocated a case manager who periodically attended his residence and monitored his health concerns. During attendances on 10 August and 29 August 2022, Paul complained to his case manager of constipation, inappetence, abdominal pain and an inability to pass urine.

15. Rosalba continued to collect Paul's prescribed medications, including paracetamol, in webster packs, and recalls he was *'consistent with taking his medication'.* She further notes that *'Paul*

said to [her] many times in the last 12 months before his death "why don't the doctors believe me when I tell them I am in excruciating pain"'.

16. On 6 October 2022, Paul wrote a note that read, *'something is happening to me and I don't know is very very bad* [sic]*'*. This note was not discovered until after Paul's death.

THE CORONIAL INVESTIGATION

17. Paul's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

18. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

19. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

20. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Paul's death. The Coroner's Investigator conducted inquiries on the Court's behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

21. Coroner Sarah Gebert initially had carriage of the investigation, until it came under my purview in July 2023 for the purpose of finalising the investigation and handing down findings.

22. This finding draws on the totality of the coronial investigation into the death of Paul Francis McHugh including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for

narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

23. On 24 November 2022, Rosalba recalls that *'Paul was very sick'* – he had become immobile, was hallucinating and in extreme pain. At this time, Paul had been taking four grams of paracetamol a day for approximately 16 weeks.

24. Rosalba contacted emergency services and the following morning, 25 November 2022, Paul was transported to Frankston Hospital. Upon arrival at the Emergency Department, Paul was assessed to be tachycardic with abdominal tenderness. At 2:00pm, further examinations revealed a marked elevation in Paul's paracetamol concentration – at 1,501 micromol/L of blood.[3] The impression of the gastroenterology registrar was that he had *'liver derangement in the setting of possible sepsis complicated by medications',* though the source of the possible sepsis could not be identified.

25. At 4:54pm, an Intensive Care Unit (**ICU**) registrar assessed Paul and determined that he *'was suffering from a life threatening staggered paracetamol overdose with progressive liver injury',* and recommended that he be transferred to the ICU. During the ensuing hours, Paul's condition deteriorated, and he was intubated.

26. On 26 November 2022, Paul was transferred to the Austin Hospital where he was admitted to the Liver Unit. However, was transferred to the ICU that evening.

27. On 5 December 2022, Paul was found to have evidence of pneumonia, and his condition deteriorated even further. The opinion of the multidisciplinary team was that the deterioration was likely due to ischaemic colitis in the setting of acute liver injury, with no options for surgical intervention or transplantation. Medical practitioners spoke with the McHugh family and informed them of his poor prognosis. It was decided to transition Paul to an end-of-life pathway.

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[2] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[3] According to the Royal College of Pathologists of Australasia, the toxic range of paracetamol in blood starts at 195mg/L (which equates to approximately 1289.9 micromol/L) four hours after ingesting paracetamol.

28. On 7 December 2022, Paul was extubated. On 8 December 2022, at 6:45 am, Paul passed away.

Identity of the deceased

29. On 8 December 2022, Paul Francis McHugh, born 8 December 1975, was visually identified by his mother, Rosalba McHugh, who completed a Statement of Identification to this effect.

30. Identity is not in dispute and requires no further investigation.

Medical cause of death

31. Forensic Pathologist Dr Yeliena Baber (**Dr Baber**) from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 9 December 2022 and provided a written report of her findings dated 12 December 2022.

32. The post-mortem examination revealed abrasions and bruises about the body including to the right arm, left hip and chest. There was deep jaundice identified and signs of medical intervention in keeping with medical history.

33. A post-mortem computed tomography (**CT**) scan demonstrated a slightly oedematous brain, anasarca, ascites, fatty liver, bilateral pleural effusions and patchy pulmonary oedema.

34. Dr Baber provided an opinion that the medical cause of death was *acute hepatic failure due to chronic paracetamol ingestion* with contributing factors of *chronic pain, acquired brain injury, Hepatitis C.*

35. I accept Dr Baber's opinion.

FAMILY CONCERNS

36. During the course of my investigation, Rosalba expressed concerns regarding the treatment provided to Paul following his June 2022 admission at Frankston Hospital. Rosalba questioned how and why Paul was provided with a high dose of paracetamol for a long period of time. Rosalba also questioned, amongst a number of other concerns, why the reason for Paul's deterioration was not picked up by his clinicians, including his GP, before it was too late.

37. Concerns of Rosalba that are within the scope of my investigation have been explored in this finding.

THE LONG-TERM DISPENSING OF PARACETAMOL

38. In light of Rosalba's concerns, and in the interests of a comprehensive investigation, I sought the assistance of the Coroners Prevention Unit (**CPU**)[4] to better understand the prescribing and dispensing practices of paracetamol in the lead-up to Paul's death.

Paracetamol

39. The CPU provided me with background information on the use and frequency of paracetamol. Paracetamol is a Schedule 2 drug under the *Drugs, Poisons and Controlled Substances Act 1981* (Vic), meaning it is available to consumers without a prescription.

40. Like all medications, paracetamol can have adverse and undesirable effects, most notably liver toxicity. There is a high risk of severe liver injury with large doses of paracetamol taken in a short period of time but there is also some risk of liver injury when paracetamol is taken at or below the maximum recommended dose over a prolonged period of time.

41. The maximum daily dose for adults in four grams per day – generally eight 500mg tablets. This information is written on the medication's packaging. Though the dosage prescribed to Paul did not exceed the maximum, paracetamol is generally indicated for short term use as pain relief. Across named and generic brands, all paracetamol packaging contains words to the effect of *'do not take for more than a few days at a time'*.

42. The CPU advised that the risk of long-term paracetamol use, particularly at high doses, is less well recognised by medical practitioners and the community generally.

Increased consumption of paracetamol from 25 July 2022 onwards

43. Paul was prescribed paracetamol while a psychiatric inpatient at Frankston Hospital, from June to July 2022. All medications provided to inpatients must be prescribed on a drug chart, including those such as paracetamol which are available 'over the counter'. Paracetamol was prescribed *'[as needed] for pain or fever'*.

[4] The Coroners Prevention Unit (**CPU**) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health; as well as staff who support coroners through research, data and policy analysis.

44. At the time of Paul's discharge, the paracetamol prescription was amended from being *'as needed'* to two tablets four times a day.[5] This was not a repeat prescription and therefore, no more than the original 100 tablets were to be dispensed. The CPU advised this provided a degree of safety to Paul in that the prescription only allowed for 12.5 days of paracetamol at that dose.

45. In a statement to the Court provided by a psychiatrist of Peninsula Health involved in Paul's care around this time, the reason for which Paul's paracetamol was increased was not addressed.

46. However, for completeness, I note that there is no evidence that Paul experienced adverse side effects within 12.5 days of commencing the increased dose. Evidence indicates his symptoms commenced on or around 15 August 2022.

<u>Ongoing supply of paracetamol</u>

47. As discussed, the prescription of paracetamol, at a dosage of four grams per day, was not a repeat prescription. Despite that there was no valid prescription, Paul's regular pharmacy (**the Pharmacy**) continued to supply paracetamol to Paul in his webster pack, including as recently as 14 November 2022.

48. Upon Paul's discharge from Frankston Hospital, the Pharmacy was provided with a copy of his discharge summary and discharge prescription. The Pharmacy was alerted to the increased dose of paracetamol *'for pain'*. In its statement to the Court, the Pharmacy stated that Paul's medication was dispensed using a dose administration aid – a weekly webster pack. This is consistent with Rosalba's recollection.

49. On or around 6 August 2022, Paul would have consumed all 100 paracetamol tablets prescribed by Frankston Hospital. However, the Pharmacy continued to dispense paracetamol at a dose of four grams a day. On their continued dispensing, the Pharmacy stated:

> *'Over an approximate sixteen week period, spanning 25 July 2022 to 14 November 2022, the Pharmacy has included paracetamol at a dose of 1g four times a day in [Paul]'s weekly Webster pack.'*

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[5] The medical record of Frankston Hospital read: *'paracetamol (paracetamol 500 mg oral tablet) 2 tab(s), oral, FOUR times a day (not to exceed 4 doses/day), 100 tab(s), Rpt: 0'.*

50. And further,

> *'It does not appear that additional prescriptions from [Paul]'s general practitioner for paracetamol were sought. Rather it appears that paracetamol was issued as an over-the counter medication and packed directly into the weekly Webster packs'.*

51. Given that paracetamol is a Schedule 2 drug and is available over-the-counter, it was not necessary for the Pharmacy to have obtained ongoing prescriptions in order to continue dispensing the medication.[6] It remains however, that Paul was being dispensed paracetamol for a period of time far in excess of the recommended duration.

52. I questioned the Pharmacy as to whether it discussed the dispensing of paracetamol with Paul's GP, Dr Taylor. Evidence indicates that the Pharmacy and Dr Taylor spoke on at least five occasions between 25 July and 16 November 2022 regarding the contents of Paul's webster pack. However, recorded notes of these conversations do not document any consideration of or amendment to Paul's paracetamol dose.[7]

53. When questioned on the reason that paracetamol continued to be provided to Paul, the Pharmacy's representative stated:

> *'I am unable to personally confirm the reason for which paracetamol was included in [Paul]'s webster packs at a standard dosage of 1g [daily] after the expiration of the paracetamol prescription provided at hospital discharge.'*

54. And continued that,

> *'On the basis of the documents provided to the Pharmacy on or around 25 July 2022, I understand that staff members at the Pharmacy have formed a belief that hospital care providers intended at the time of discharge for [Paul] to have regular paracetamol as part of his overall management strategy'.*

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[6] For completeness, I note that the Therapeutic Goods Administration had amended the scheduling of paracetamol, *see in this regard* Final decision on paracetamol access controls in the Poisons Standard – Question and Answers | Therapeutic Goods Administration (TGA). However, I note this change came about, in part, due to acute intentional paracetamol toxicity not due to long term exposure such as in Paul's instance.

[7] Conversely, on 28 June 2021, the pharmacy emailed Dr Taylor regarding ongoing inclusion of topiramate in Paul's webster pack, on the basis that Paul stated he was no longer taking it. Dr Taylor replied that the topiramate should be omitted in the future. While I note that this correspondence occurred prior to Paul being prescribed and continuing to be provided with paracetamol, I consider that it illustrates that pharmacy staff members did turn their minds to consulting with prescribers on the contents of Paul's webster pack, when prompted to do so.

55. If the Pharmacy staff had indeed formed such a belief, the reason for doing so is unclear. The paracetamol prescribed by Frankston Hospital – upon Paul's discharge on 25 July 2022 – did not provide for any repeats. I consider this an indication that clinicians did <u>not</u> intend for Paul to indefinitely consume paracetamol at such a high dose. I am troubled that the pharmacists *'formed a belief'* as to Paul's clinical care rather than consulting with the original prescribing clinicians or Paul's GP.

56. Additionally, I find it concerning that, even with the benefit of hindsight, the Pharmacy did not acknowledge whether its pharmacists ought to have turned their minds to the ongoing dispensing of paracetamol.

<u>Detection of Paul's deterioration by GP</u>

57. Around September or October 2022, Rosalba and Paul visited Dr Taylor, and provided him with a list of symptoms Paul was experiencing. These symptoms included difficulty breathing, anxiety, '*bad thoughts*', incoordination and dizziness, constipation, abdominal pain, difficulty urinating, inappetence, fatigue and difficulty swallowing. By this time, Paul would have been consuming the high dose paracetamol for 10 to 14 weeks beyond his discharge from Peninsula Hospital.

58. I sought the CPU's assistance to understand Dr Taylor's response to the list of symptoms and whether any of the symptoms ought to have prompted Dr Taylor to consider whether Paul was experiencing paracetamol-induced liver failure.

59. The CPU stated that with the benefit of hindsight, some of the symptoms likely represented Paul's development of paracetamol-induced liver failure, though qualified that none of the symptoms are specific to the same. It continued that in a patient with an extended psychiatric history and who was taking various medications, it can be difficult to ascertain which symptoms are due to organic pathology and which may be psychiatric in nature.

60. The CPU noted that during this period, Dr Taylor prescribed different medications including for diabetes (empagliflozin and metformin), buprenorphine (to manage opioid dependence) and benzodiazepines (alprazolam and nitrazepam).and opined that it cannot be said that on the basis of the symptoms that Paul presented with, Dr Taylor ought to have known, or considered, that Paul was experiencing or was beginning to experience paracetamol-induced liver failure, based on his reported symptoms.

THE SAFE AND PROPER USE OF DOSE ADMINISTRATION AIDS

61. Dose administration aids (**DAA**) are packaging systems – such as webster packs – which enhance the delivery of medication regimes by improving efficiency, safety and accurate administration.

62. In 2022, the federal Department of Health and Aged Care updated its guideline entitled, *'Medication Management in the Community'* (**the Guideline**). Various organisations, including the Pharmacy Board of Australia, the Pharmacy Guild of Australia and Pharmaceutical Society of Australia contributed to the development of the Guideline.

63. When addressing DAAs, the Guideline identified they are not an infallible system and acknowledged that changes in medications can occur at various times including at hospital discharge. In these circumstances, the Guideline warned that ceased medications can be erroneously included in DAAs.

64. It is imperative that DAAs are organised with precision and careful consideration. When individuals receive medications via DAAs, such as an in the instance of Paul, there is an inherent degree of reliance upon the skill and judgment of the pharmacist, and a belief that the medications contained in the DAA are appropriate and safe to ingest.

65. The Guideline indicates that *'pharmacists must use their professional judgment to determine which medicines to pack in an individual's DAA'.* There is no evidence that pharmacists dispensing Paul's medication turned their minds to the potential adverse effects of continuing to dispense paracetamol, even after having provided him with the maximum daily dose paracetamol for approximately 16 weeks.

66. There is no requirement that medications included in a DAA be prescribed. However, I consider that including medications in a DAA, without a prescription, risks shifting the clinical decision-making responsibility away from the individual's treating practitioner and into the hands of the pharmacist.

67. I find this fraught, particularly when, as in the current instance, the dispensing pharmacists did not contemplate the dose or duration of a potentially toxic medication, nor did they correspond with Paul's treating clinicians regarding the ongoing inclusion of this medication in the webster pack. On this issue, the Guideline emphasises the importance of *'timely and accurate communication'* between prescribers and pharmacists.

68. The importance of communication was further highlighted in the Royal Australian College of General Practitioners' journal – the *Australian Family Physician* – which reads:

> *'GPs and pharmacists have a responsibility to develop professional partnerships to support collective decision making regarding DAA commencement, and review medicine pack medications regularly to understand the prescription and non-prescription contents and ensure medications are ceased in a timely manner. When GPs and pharmacists work together, there is greater patient satisfaction and more medication management problems identified and resolved.'*[8]

69. Dispensing pharmacists have a crucial role in medication safety and management by querying the indication, dose and duration of a medication with the prescriber or the patient. Had the Pharmacy critically considered the dose and duration of paracetamol dispensing in Paul's DAA, and/or discussed it his prescribers, Paul was unlikely to have been provided with paracetamol after his prescription expired.

FINDINGS AND CONCLUSION

1. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

   a) the identity of the deceased was Paul Francis McHugh, born 8 December 1975;

   b) the death occurred on 8 December 2022 at ICU, Austin Hospital 145 Studley Road, Heidelberg, Victoria, 3084, due to *acute hepatic failure due to chronic paracetamol ingestion* and contributing factors of *chronic pain, acquired brain injury, Hepatitis C*; and

   c) the death occurred in the circumstances described above.

2. I have considered the circumstances leading to Paul Francis McHugh's death and find that his death occurred as a result of his consumption of a high dose of paracetamol for several weeks prior to his death, in the context of several comorbidities. I acknowledge that Paul Francis McHugh had a history of mental ill health and suicidality; however, there is no evidence before me to suggest that his death was intentional.

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[8] Barton, Twining and Walters 'Understanding the decision to commence a dose administration aid' (2017) 46(12) *Australian Family Physician.* Accessible here: https://www.racgp.org.au/afp/2017/december/understanding-the-decision-to-commence.

3. I acknowledge that paracetamol was initially prescribed to Paul Francis McHugh by practitioners of Frankston Hospital during his admission from June to July 2022, and that this dose was increased upon his discharge on 25 July 2022. I find that Peninsula Health's decision to prescribe paracetamol, for a short period of time, to manage symptoms associated with his chronic pain, was clinically indicated in the circumstances.

4. However, I find that, following his discharge, Paul Francis McHugh's regular pharmacy erred when they continued dispensing paracetamol for a period well beyond the initial prescription. I find that their actions deviated from acceptable practice when they purportedly formed their own belief as to Paul Francis McHugh's clinical needs rather than contacting his treating clinicians to ensure the appropriate medications were being dispensed. In doing so, they failed to adequately consider the risks of ongoing dispensing of paracetamol at a high dosage, including the possibility of liver injury.

5. I note in this regard that the pharmacists had contacted his treating clinicians in relation to ongoing inclusion of other prescribed medications in the webster pack (such as topiramate) but made no such enquiries in relation to the ongoing inclusion of paracetamol, even following the expiry of the prescription.

6. On the evidence before me, and to the coronial standard – the balance of probabilities – I am satisfied that Paul Francis McHugh's death could have been prevented had he not been provided with and ingested the ongoing and high-dose supply of paracetamol (at the maximum daily recommended limit) beyond the expiry of the prescription. To this end, I emphasise that patients are entitled to, and do, rely on the contents of dose administration aids (**DAAs**) which have been prepared by pharmacists whom patients expect have exercised care and diligence when doing so. For patients such as Paul Francis McHugh, who had an acquired brain injury and relied on his mother for care, the need for such diligence was paramount.

RECOMMENDATION

Pursuant to section 72(2) of the Act, I make the following recommendation connected with the death:

1. I recommend that the **Pharmacy Guild of Australia**: (i) create and implement a guideline relating to pharmacy review of the long-term dispensing of non-prescribed medications in dose administration aids; and (ii) circulate to its members the circumstances of Paul Francis McHugh's death as a case study for educational purposes.

I convey my sincere condolences to Paul's family for their tragic loss, and acknowledge the ongoing contributions of Rosalba, Paul's dedicated and loving mother, to the coronial investigation.

ORDERS AND DIRECTIONS

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

I direct that a copy of this finding be provided to the following:

Rosalba McHugh, Senior Next of Kin, c/o Brave Legal

Peninsula Health

Austin Health

The dispensing pharmacy, c/o Meridian Lawyers

The Pharmacy Guild of Australia

Pharmaceutical Society of Australia

The Royal Australian College of General Practitioners

Safer Care Victoria

The Therapeutic Goods Administration

Senior Constable Josh Bagdadi, Coroner's Investigator

Signature:

Ingrid Giles

Coroner

Date: 7 March 2025

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.