CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Yongxing Wang
Hearing dates:	5 – 7 February 2018
Date of findings:	23 February 2018
Place of findings:	NSW Coroners Court - Glebe
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – cause and manner of death - was hypoxic brain injury caused by opioid overdosing – interaction of morphine with oxycodone - were dosages of morphine appropriate – were there adequate medical records regarding treatment of deceased – privilege in relation to self-incrimination - referral of transcript to the Medical Council of NSW.
File number:	2014/00243397
Representation:	Counsel Assisting the Coroner: Ms D Ward of Counsel, i/b Crown Solicitor's Office. Dr Kit Lam: Mr D Jordan of Senior Counsel, i/b Avant Law. Dr Lydia Lam: Mr R Sergi of Counsel, i/b HWL Ebsworth Lawyers.

Findings:	**Identity** The person who died was Yongxing Wang, born on 17 February 1935. **Date of death**: Yongxing Wang died on 25 August 2014. **Place of death**: Yongxing Wang died at St George Hospital, Kogarah NSW 2217. **Cause of death:** Yongxing Wang died as a result of hypoxic brain injury due to cardio-respiratory arrest caused by opioid toxicity. **Manner of death**: Yongxing Wang died in circumstances where morphine with which he had been injected interacted with oxycodone to cause cardio-respiratory arrest.

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Section 81(1) of the *Coroners Act 2009 (NSW)* [the Act] requires that when an inquest is held, the Coroner must record in writing his or her findings as to various aspects of the death.

These are the findings of an inquest into the death of Yongxing Wang.

The Inquest

1. An inquest is different to other types of hearings. It is neither criminal nor civil in nature. It does not determine whether a person is guilty of an offence and does not make determinations and orders that are binding on parties.

2. The Coroner is required to confirm that a particular death occurred and make findings as to the identity of the person who died, the date and place of death, and the cause and manner of the death. In addition under section 82 of the Act the Coroner may make recommendations that are necessary or desirable in relation to any matter connected with the death, including health and safety.

Introduction

3. On 25 August 2014 Mr Yongxing Wang aged 79 years died in the Intensive Care Unit of St George Hospital, Kogarah NSW. He had been taken there by ambulance the previous morning, after his daughter Jie found him lying unconscious in his bed at his apartment in Allawah. Jie and her husband Mr Zhi Hua Li attended the inquest and gave oral evidence. It was apparent that the couple, in particular Jie, continue to be deeply distressed by the loss of Mr Wang.

The autopsy report

4. A post mortem examination was conducted by forensic pathologist Associate Professor Johan Duflou. Dr Duflou found the direct cause of Mr Wang's death was hypoxic brain injury due to cardio-respiratory arrest.

5. Toxicological analysis of Mr Wang's antemortem blood samples had detected '*relatively high'* levels of conjugated morphine, and low levels of free morphine and oxycodone. Dr Duflou thought it likely the antecedent cause of death was an overdose of opioids, but he recommended expert toxicological evidence be obtained as to the significance of Mr Wang's blood sample results. This evidence is discussed below.

Issues at inquest

6. The issues which arose for consideration at the inquest were as follows:

    - Whether Mr Wang's hypoxic brain damage was due to an opioid overdose.

- How much oxycodone and morphine did Mr Wang consume in the days leading up to his death, and how did he obtain them?

- Having regard to evidence that on 23 August Dr Kit Lam administered two doses of morphine to Mr Wang, how much morphine did he administer and were the dosages appropriate in all the circumstances?

- Were the medical records of Dr Lydia Lam and Dr Kit Lam regarding their care of Mr Wang in August 2014 adequate?

Background

7. Mr Wang emigrated to Australia from China in 1999 with his wife Wenxian Le. The couple's daughter Jie, also known as Wendy, had emigrated to Australia ten years earlier, and she and her husband Zhi Hua Li sponsored her parents' migration to Australia. In 2007 Mr Wang and his wife moved into an apartment at Allawah, not far from where Jie and her husband live in Carlton.

8. Sadly in April 2013 Mr Wang's wife died of ovarian cancer. Mr Wang grieved her death and his GP Dr Lydia Lam recorded that in the following months he was assisted with counselling sessions from a clinical social worker. In early 2014 Dr Lydia Lam considered he was gradually recovering from his bereavement. After the death of Wenxian Le a flatmate came to live with Mr Wang at the Allawah apartment.

9. Up until a few days prior to his death Mr Wang enjoyed relatively good health. His daughter and son in law described him as an active man who regularly rode his pushbike to the shops for groceries, enjoyed hiking and socialising with friends in the local community, and capably attended to his own cooking and housekeeping needs.

10. Dr Lydia Lam provided evidence as to Mr Lam's medical history. Dr Lydia Lam works as a GP at Healthpac Medical Centre in Hurstville. She knows the Wang family quite well, having commenced treating Mr Wang and his wife when they arrived in Australia in 1999. She described Mr Wang's medical conditions as follows:

    - a degenerative spinal disease which emerged in 2002. This involved disc protusion and nerve root compression in the lumbar spine L4 and L5 segments.

    - ischaemic changes and significant cervical narrowing of the foraminal canal, both revealed in an MRI conducted in 2013. The foraminal canal is a

passageway on either side of the cervical spine. When narrowed it can result in nerves becoming pinched, leading to chronic pain.

- hypertension since at least 1999. Echocardiograms conducted in 2011 and 2013 showed mild dilation of the aortic root and ascending aorta, and mild aortic regurgitation. In June 2014 Mr Wang's cardiac condition was assessed as stable.

- minor gastroenterological and hearing issues.

Events of 21 and 22 August 2014

11. On Thursday 21 August 2014 Mr Wang hurt himself while pumping one of the tyres of his pushbike. He rang his daughter Jie and told her he had pain in the back of his leg. That afternoon she drove him to see Dr Lydia Lam at the Healthpac Medical Centre. Jie reported that her father appeared to be in pain and was moving more slowly than usual, but was able to get in and out of the car without assistance.

12. Dr Lydia Lam's note of the consultation records that she referred Mr Wang to her husband Dr Kit Lam for a CT of his lumbar spine *'+/- injection'*. Dr Kit Lam practices as a radiologist at the nearby Cross Radiology, Hurstville. Dr Lydia Lam also prescribed the medications Celebrex (a non-steroidal anti-inflammatory drug) and Lyrica (a drug used for pain caused by neurologic diseases).

13. I note at this point there is no evidence that Dr Lydia Lam's care and treatment of Mr Wang on 21 August was deficient in any respect; nor that the medications she prescribed for him were in any way inappropriate.

14. After the consultation Jie and her father walked to The Cross Radiology to see Dr Kit Lam. There the CT scan was performed and Mr Wang made an appointment to attend the following morning for a cortisone injection. Jie took her father back to his home, having arranged that her husband Zhi Hua Li would collect him the following day for the cortisone injection.

15. The following morning was Friday 22 August. Jie visited her father early and made him some toast for breakfast. She found he still had pain in his upper leg but he was able to move about. Shortly afterwards Mr Wang's son in law Zhi Hua Li collected Mr Wang as arranged and took him to Dr Kit Lam's surgery for his cortisone injection. Mr Li thought his father-in-law was moving more slowly than usual and appeared to be in pain. Mr Li did not go into the consulting room with Mr Wang.

16. When Mr Wang came out Zhi Hua Li found he was moving even more slowly and was complaining of being in more pain than previously. Zhi Hua had to help him in and out of his car and into his apartment, which Zhi Hua said was unusual.

17. According to Dr Kit Lam's notes of Mr Wang's visit, he delivered an injection of dexamethasone and xylocaine to Mr Wang's left L5 nerve root. However he was unable to do so in relation to the left L4 nerve root due to a large vein lying adjacent to the nerve. This caused blood to flow into the needle and Dr Kit Lam had to abandon the attempt.

18. When Jie finished work that afternoon she visited her father to find him in worse pain. While she was there Mr Wang rang Dr Kit Lam at his home and was told he would visit later that evening with some pain medication.

19. Jie ensured she was present when Dr Kit Lam attended her father that night at about 10pm. According to Jie, when Dr Kit Lam arrived he explained to her father that he did not give him his cortisone injection that afternoon because when he inserted the needle it reached a vein. Jie said Dr Kit Lam had brought some pain medication but then he noted it was the same medication his wife Dr Lydia Lam had prescribed that morning. Dr Kit Lam promised to call Mr Wang the next morning.

Events of 23 and 24 August 2014

20. The following morning was Saturday 23 August. When Jie visited her father she found he was in worse pain, lying in bed and reluctant to move. She made him some breakfast, returning at lunchtime to hear that Dr Kit Lam intended to visit to give Mr Wang some morphine.

21. Dr Kit Lam attended at about 2pm and Jie observed him give her father two injections to the left leg. One he said was morphine, the other a drug to counter its side effects. According to Jie, prior to doing so Dr Kit Lam rang someone on his mobile phone while looking at a pamphlet. Jie was unable to understand what was said on the phone because it was in Cantonese. Jie said that after administering the injections Dr Kit Lam promised to return later that night to administer more morphine.

22. Jie called in on her father at about 4pm that afternoon but he was asleep in bed. When she returned at 5pm he was still asleep. She said it was unusual for her father to sleep in the afternoon. She woke him to feed him some soup and rice, noting that he was very drowsy. A couple of friends arrived to visit Mr Wang, but he continued to be very drowsy. As Jie described it: '*He would respond when spoken to however you could tell he wanted to go to sleep'*.

23. When Jie returned that evening at 8pm Mr Wang was again asleep. According to Jie this too was unusual because he generally went to bed at about 11pm. Jie woke him and took him to the toilet, commenting that she needed to support him as he seemed *'a little bit wobbly*'. He wanted to go back to sleep, so she left at 9pm, asking Mr Wang's flatmate to open the door for Dr Kit Lam who was expected at about 10pm.

24. Jie rang her father's flatmate at about 10.15pm. She was told that Dr Kit Lam had attended and given Mr Wang another injection, and that he was now sleeping.

25. The following day Jie went to her father's apartment at about 6.50am. Mr Wang was lying on his bed with his eyes shut. He was foaming from the mouth. In great distress Jie phoned her husband and then rang emergency services. Zhi Hua arrived quickly, and immediately commenced CPR.

26. When ambulance paramedics arrived very shortly afterwards Mr Wang was unconscious, and despite numerous attempts they were unable to get a patent ECT airway. He was rushed to St George Hospital, arriving at about 7.50am.

27. Once at St George Hospital Jie told medical staff that doctors had given her father morphine. Shortly afterwards Dr Kit Lam and Dr Lydia Lam arrived at the hospital. According to Jie and Zhi Hua, Dr Lydia Lam hugged Jie and said she was sorry. Jie and Zhi Hua both stated that Dr Kit Lam told Jie he had given her father 30mgs of morphine '*the first time'*, and 20mgs the second time.

28. Despite the efforts of clinicians at St George Hospital Mr Wang suffered further cardiac arrests. He did not recover and he died at 5pm the following day, 25 August.

Expert evidence

29. At the inquest the Court heard expert medical evidence from:

- Dr Tim Ho, Pain Management and Rehabilitation Specialist

- Associate Professor Alison Jones, Specialist Physician and Clinical Toxicologist.

30. The two medical experts gave their evidence in conclave. Their evidence is of most relevance to the issue of whether an opioid overdose caused Mr Wang's hypoxic brain damage. This is discussed below.

Other evidence

31. Dr Kit Lam and Dr Lydia Lam did not give oral evidence at the inquest. They had each notified through their respective counsel that if required to give evidence in relation to their treatment of Mr Wang for the period 22-24 August 2014, they would invoke the privilege in respect of self-incrimination pursuant to section 61 of the Act. Dr Kit Lam notified that the privilege would also be invoked for matters relating to his treatment of Mr Wang on 21 August. For reasons which are explained at par 63 below the Court determined that the interests of justice did not require either witness to give evidence.

32. Dr Kit Lam did not provide a statement for the coronial investigation. A statement of Dr Lydia Lam was tendered, providing details of her treatment of Mr Wang up until and including his consultation with her on 21 August 2014. Her statement did not deal with any subsequent events.

33. I turn now to deal with the issues examined at the inquest.

Did an opioid overdose cause Mr Wang's hypoxic brain damage?

34. It was the expert opinion of both Professor Jones and Dr Ho that opioid toxicity was the most probable cause of Mr Wang's respiratory arrest and hypoxic brain damage.

35. Both morphine and oxycodone were found in Mr Wang's antemortem blood samples, which had been extracted at 8.33am on 24 August 2014. Professor Jones advised it was not possible to determine from the toxicology results how much of each drug he had ingested. Furthermore, neither drug was found in potentially lethal concentrations. Nevertheless in Professor Jones' opinion, although each of the two drugs was found in only therapeutic concentrations the effects of the two when combined would have been additive, to cause respiratory sedation or suppression. This was also the opinion of Dr Ho.

36. Professor Jones stated that Mr Wang had risk factors which made him more susceptible to the adverse effects of opioids. These were:

    - his status as an opioid naïve patient

    - his history of ischaemic heart disease and coronary artery disease (the latter noted post mortem), giving him an increased risk of arrythymias due to opioids

- at 79 years his increased susceptibility to sedation and renal dysfunction, meaning that morphine's active metabolite would be more slowly eliminated from the blood, increasing its sedatory effect.

37. At the inquest Senior Counsel for Dr Kit Lam asked Professor Jones whether evidence that Mr Wang enjoyed good renal function would cause her to alter her opinion that opioid toxicity was the probable cause of his death. Senior Counsel pointed further to some commentary to the effect that patients of Chinese ethnicity had a higher rate of clearance of intravenously delivered morphine than did Caucasian patients.

38. Professor Jones responded that these factors did not make it significantly less likely that opioid toxicity was the cause of Mr Wang's death. Her opinion was based on a range of factors, including Mr Wang's opioid naivety but also the following:

- Jie's report of her father's somnolence from 5pm onwards on 23 August, according to which he was drowsy and wanting to return to sleep. Somnolence, Professor Jones explained, was an early warning sign of respiratory depression.

- The prologue of sedation following ingestion of opioid drugs, and the timing of the respiratory arrest relative to opioid dosing, were features consistent with opioid toxicity as the cause of the respiratory arrest.

39. Dr Ho concurred that Mr Wang's status as an opioid naïve patient together with his old age rendered him at high risk of opioid induced side effects. In circumstances where he had been observed to be sedated on the afternoon and evening of 23 August, the second injection of morphine was '*highly likely'* to cause progression from sedation to respiratory suppression.

40. In their evidence at the inquest both experts endorsed the guidelines for medication dosage provided in the Australian Medical Handbook. According to these guidelines, patients aged between 70 and 85 years in need of pain relief by way of morphine are recommended to receive doses of between 2.5mg – 5mgs every two hours. The range is designed to allow clinicians to adjust the dosage for an elderly patient's individual characteristics, including degree of pain, opioid naivety, and renal impairment.

41. Professor Jones acknowledged that Mr Wang had been in considerable pain, making pain relief an appropriate concern for his doctors. She and Dr Ho concurred however that administration of opioids at a patient's home was a

riskier undertaking than in a hospital setting, because the former did not have patient safety mechanisms in place to monitor the patient's response.

42. The above evidence amply supports a finding on the balance of probabilities that opioid toxicity was the antecedent cause of Mr Wang's hypoxic brain damage.

How much oxycodone and morphine did Mr Wang consume?

43. Given that a finding as to cause of death is able to be made, resolution of this question is not strictly necessary. Nevertheless I will summarise the evidence regarding the circumstances in which Mr Wang came to receive these two opioids in the days leading up to his death.

44. As regards Mr Wang's ingestion of morphine, this consisted of:

- the evidence of Jie, summarised at pars 21 and 24 above, that Dr Kit Lam administered two intramuscular injections of morphine to her father at about 2pm and 10pm on 23 August

- the evidence of Jie and Zhi Hua that at the hospital on 24 August Dr Kit Lam told them he had administered 30mgs of morphine '*the first time'* and then 20mgs the second time.

- records of St George Hospital to the effect that on 23 August Mr Wang had been given 30mg morphine at lunchtime that day, and a further 20mgs at 10pm. The source for this information is not known.

- the response provided by The Cross Radiology to an Order For Production, that the practice did not keep drugs of addiction or injectable analgesics and that '*the morphine used in this case for Mr Wang was from Healthpac Medical Centre'.*

- records produced by Healthpac Medical Centre indicating that Dr Kit Lam signed the practice's Drug Register as a person who on 23 August had taken from its Supply Bag two 30mg ampoules of morphine for Mr Wang.

45. The evidence therefore strongly supports the conclusion that on 23 August 2014 Dr Kit Lam injected Mr Wang with two doses of morphine, being 30mgs and 20mgs respectively.

46. Mr Wang's antemortem blood samples established that in addition to morphine he had ingested a quantity of oxycodone. However the circumstances surrounding his consumption of this drug are less clear.

47. The evidence establishes that in the days leading up to his death Mr Wang was using Endone, an oxycodone-based medication. The likely source of the Endone was unused medication which had been prescribed to Mr Wang's late wife, and had been left in their home after her death.

48. Jie's statements make no reference to her father using this medication. However according to contemporaneous notes made by Detective Senior Constable Madden, on 25 August 2014 Jie told him she had given her father the following:
    - an unknown tablet of pain-killer and a tablet of Endone on the evening of 21 August
    - a tablet of Endone on the evening of 22 August
    - a tablet of Endone and '*one of the other tablets'* on the morning of 23 August.

49. Furthermore, according to a Report to the Coroner prepared by DSC Madden, Jie told him that on the evening of 22 August she had left the part-used packet of Endone on her father's bedside table. It is unknown if Mr Wang took more of the tablets himself: it is possible he did, as according to Jie her father generally attended to his own medication.

50. It is therefore not possible on the evidence to establish the quantity of oxycodone Mr Wang took or was given. Professor Jones was unable to do so on the basis of the toxicological results; and such is the lack of clarity from other sources that it is possible only to find that an amount of oxycodone was ingested by Mr Wang, but that the amount and times at which it was ingested remain unknown.

51. As a further matter, DSC Madden's Report To the Coroner includes the statement that on the evening of Thursday 22 August Jie received phone advice from Dr Kit Lam that her father could take an Endone tablet every four hours for his pain. According to DSC Madden, Jie told him this at the hospital on 25 August. However DSC Madden's contemporaneous notes of that conversation do not include this detail; nor is it referred to in Jie's evidence. The state of the evidence is such that no conclusion can be made in relation to it.

How much morphine did Dr Kit Lam administer to Mr Wang on 23 August, and were the dosages appropriate in all the circumstances?

52. Although toxicological analysis cannot determine the amount of morphine administered to Mr Wang on 23 August, as noted above the evidence indicates it is likely to have been an amount of 30mgs followed by an amount of 20mgs.

53. There is no evidence that the doses administered were recorded by Dr Kit Lam or by anyone else. Nor is there evidence of any documentation recording Dr Kit Lam's two visits, or his assessment of Mr Wang prior to administering the doses.

54. There is no eye witness or documentary evidence of Mr Wang's condition at the time of the second dose. While Mr Wang's flatmate may have been able to provide information about this, police enquiries have been unable to identify or locate him.

55. However having regard to Jie's observations, in Professor Jones' opinion between the hours of 5pm and 8pm Mr Wang was showing signs of '*clinically obvious somnolence'*. On the basis of those earlier signs, as well as the factors referred to above of Mr Wang's age, his status as an opioid naïve patient, his simultaneous use of another opioid, and the absence of any patient safety mechanisms to monitor his response to the morphine doses, the two expert witnesses concurred that the dosages were inappropriate.

Question of referral to the NSW Medical Council

56. At the close of the evidence Counsel Assisting submitted it may be appropriate for the Court to provide a transcript of the evidence in this inquest to the Executive Officer of the Medical Council of NSW. A Coroner is able to do this pursuant to section 151A(2) of the *Health Practitioners Regulation National Law (NSW)*, if the Coroner has:

'...reasonable grounds to believe the evidence given … in proceedings conducted before the coroner may indicate a complaint could be made about a person who is registered in a health profession…'

57. The effect of such action is that a complaint is taken to have been made to the Medical Council of NSW.

58. The grounds for complaint include that a practitioner is not competent because he or she lacks knowledge or skill, or that his or her knowledge, skill, judgment or care is significantly below the standard to be expected. If the practitioner is

found not to be competent, disciplinary powers include the suspension or cancellation of the practitioner's registration.

59. Significantly, in order to take such action a Coroner need only have reasonable grounds to believe the evidence may indicate such a complaint could be made. It is a relatively low threshold, reflecting the strong focus of the *Health Practitioner Regulation National Law* upon public health and safety. In the submission of Counsel Assisting, this threshold would be met in relation to both Dr Kit Lam and Dr Lydia Lam.

60. Regarding Dr Lydia Lam, Counsel Assisting pointed to evidence she had given access to the Supply Bag of her practice to a person outside that practice; and that her patient notes relating to Mr Wang contained no record that he had been given drugs falling within Schedule 8 to regulations under the *Poisons and Therapeutic Goods Act 1966.* Schedule 8 drugs include morphine and oxycodone.

61. In relation to Dr Kit Lam Counsel Assisting noted there was no evidence he had made any record of his two home visits to Mr Wang, or of his administration of a Schedule 8 drug, or of the basis on which he determined the doses to be appropriate. The evidence, as noted, indicates the doses were not appropriate.

62. In considering whether there are reasonable grounds to believe the evidence in this inquest may indicate a complaint could be made about Dr Kit Lam and Dr Lydia Lam, I have had regard to the fact that I did not have the benefit of hearing evidence from either practitioner.

63. As mentioned, both doctors notified that if called to give evidence at the inquest they would invoke the privilege in respect of self-incrimination. I accepted the submission of Counsel Assisting that in those circumstances the interests of justice did not require them to give evidence, having regard to:

- the nature of the inquest, being principally to establish cause and manner of death. These matters were able to be established from other sources of evidence. The evidence which Dr Kit Lam and Dr Lydia Lam might be expected to give, going to the basis on which they had made their decisions, would not be strictly relevant to these matters.

- the effect of their giving evidence at the inquest under protection of a certificate. Pursuant to s61(7) of the Act the effect would be to preclude in any disciplinary proceedings the use against them not merely of that evidence, but also of any information or document obtained as a direct or indirect consequence of their having given that evidence.

64. In summary, having regard to the real possibility that the conduct of Dr Kit Lam and Dr Lydia Lam would be found to warrant professional scrutiny in the interests of public health and safety, the Court was concerned not to jeopardise that process by requiring them to give evidence which was likely to be of limited utility to the inquest.

65. In considering the question of referral this Court has also taken into account that in their treatment of Mr Wang there is no evidence the two doctors acted in anything other than good faith, and with the desire to assist their patient in dealing with significant pain.

66. Nevertheless it could not be submitted on behalf of the two doctors, and indeed it was not submitted, that the evidence in the inquest could not provide the basis for a reasonably grounded belief that it may indicate a complaint could be made about them. Counsels for the two doctors offered no submissions on the subject, making it clear this was not to be taken as an implicit acceptance that such referral was appropriate.

67. On the basis of the evidence I have set out above at par 61, I have reasonable grounds to believe the evidence given in this inquest may indicate a complaint could be made about Dr Kit Lam concerning his care and treatment of Mr Wang during the period 22 to 24 August 2014.

68. On the basis of the evidence set out at par 60, I have reasonable grounds to believe that evidence given in this inquest may indicate a complaint could be made about Dr Lydia Lam concerning her care and treatment of Mr Wang during the period 22 to 24 August 2014.

69. I therefore direct that a transcript of the evidence at the inquest, including a copy of these findings, be forwarded to the Executive Officer of the Medical Council of NSW, pursuant to s151A(2) of the *Health Practitioner Regulation National Law (NSW)*.

70. In closing I thank everyone who has assisted at this inquest, including the Officer in Charge, the witnesses and the legal representatives involved. I thank in particular Counsel Assisting and her instructing solicitor for their excellent assistance.

71. On behalf of all at the Coroners Court, I hope Mr Wang's family will accept my most sincere sympathy for their loss.

Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

Identity
The person who died was Yongxing Wang, born on 17 February 1935.

Date of death
Yongxing Wang died on 25 August 2014.

Place of death
Yongxing Wang died at St George Hospital, Kogarah NSW 2217.

Cause of death
Yongxing Wang died as a result of hypoxic brain injury due to cardio-respiratory arrest caused by opioid toxicity.

Manner of death
Yongxing Wang died in circumstances where morphine with which he had been injected interacted with oxycodone to cause cardio-respiratory arrest.

I close this inquest.

E Ryan

Deputy State Coroner
Glebe

Date