CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Deborah Spencer
Hearing dates:	11 December 2020
Date of findings:	29 January 2021
Place of findings:	Coroners Court of New South Wales, Lidcombe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – manner of death, alcohol-related fall, homicide, blood alcohol concentration, hyoid bone fracture
File number:	2016/00159603
Representation:	Mr S Kelly, Coronial Advocate Assisting the Coroner
Findings:	I find that Deborah Spencer died on 23 May 2016 at Nepean Hospital, Kingswood NSW 2747. The cause of Deborah's death was blunt head injury, with hyoid bone fracture being a significant condition contributing to the death. The available evidence does not allow for any finding to be made as to the manner of Deborah's death.
Recommendation:	I recommend that the NSW Commissioner of Police cause the investigation into the death of Deborah Spencer be referred to the State Crime Command Homicide Squad for the allocation of specialist investigators to review the matter and to assist in the ongoing investigation. I further recommend that a copy of the brief of evidence and transcript of the *Inquest into the death of Deborah Spencer* be provided to the Homicide Squad for this purpose.

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Introduction

1. On the morning of 22 May 2016 Deborah Spencer was found lying on the ground at an outdoor location in Penrith, unconscious and unresponsive. After being taken to hospital, it was identified that Deborah had sustained fatal head injuries. Sadly, Deborah's condition did not improve and she died the following day.

2. The subsequent police investigation revealed that Deborah was last known to be alive on the evening of 21 May 2016. Exactly what occurred between this time and when Deborah was discovered the following morning is not well understood. The available evidence raises both the possibility that Deborah may have either suffered an accidental fall, or that she may have been involved in an episode of interpersonal violence, resulting in her death.

Why was an inquest held?

3. A Coroner's function and the purpose of an inquest are provided for by law as set out in the *Coroners Act 2009* (**the Act**). One of the primary functions of a Coroner is to investigate the circumstances surrounding a reportable death. This is done so that evidence may be gathered to allow a Coroner to answer questions about the identity of the person who died, when and where they died, and what the cause and the manner of their death was. The manner of a person's death means the circumstances surrounding their death and the events leading up to it.

4. Section 6(1)(a) of the Act defines a reportable death to be one which occurs in circumstances where a person died a violent or unnatural death. As Deborah died from traumatic injuries her death was not due to natural causes, making it a reportable death. Further, section 27(1)(a) of the Act provides that an inquest is mandatory if it appears to a coroner that a person died or might have died as a result of homicide. In this case, the available evidence raises the possibility that Deborah may have been involved in an episode of interpersonal violence, and therefore might have died as a result of homicide. It is therefore mandatory to hold an inquest into Deborah's death.

5. In this context it should be recognised at the outset that the operation of the Act, and the coronial process in general, represents an intrusion by the State into what is usually one of the most traumatic events in the lives of family members who have lost a loved one. At such times, it is reasonably expected that families will wish to attempt to cope with the consequences of such a traumatic event in private. The loss experienced by family members does not diminish significantly over time. Therefore, it should be acknowledged that both the coronial process and an inquest by their very nature unfortunately compel a family to re-live distressing memories and to do so in a public forum.

6. It should also be noted at the outset that although the evidence gathered during a coronial investigation may give rise to the appearance that a person has died as a result of homicide, such a conclusion (if one is eventually made) does not impose any criminal liability on any person. Indeed, section 81(3) of the Act precludes a coroner from making a finding that indicates, or in any way suggests, that a criminal offence has been committed by any person.

Deborah's life

7. Understanding the impact that the death of a person has had on their family only comes from knowing something of that person's life and how the loss of that life has affected those who loved that person the most. Therefore it is extremely important to recognise and acknowledge Deborah's life in a brief, but hopefully meaningful, way.

8. Deborah was born in the United Kingdom and came to Australia in 2001, after forming a relationship with David Spencer. In 2003 Deborah and Mr Spencer married and purchased a townhouse in Penrith. This relationship ended in 2013, and Deborah and Mr Spencer separated, although Deborah continued to live in the townhouse.

9. Sometime around December 2014 Deborah met Raymond Jenner at a Christmas function. They commenced a relationship a short time later, and Mr Jenner moved in with Deborah at the Penrith townhouse. However in February 2016 Deborah was evicted from her home following default on her mortgage payments. Following her eviction, Deborah and Mr Jenner went to live with Mr Jenner's parents at their home in South Penrith.

Previous history of domestic violence

10. On 4 March 2016 Deborah was involved in an incident during which Mr Jenner allegedly assaulted both her and his father at his parents' home in South Penrith. Police were notified and following the incident Deborah participated in an electronically recorded interview in which she alleged that Mr Jenner had attempted to strangle her and made threats to kill her. Deborah alleged that Mr Spencer had grabbed her by the neck and hit her head on a table.

11. According to records made by police, a red mark was observed on the left side of Deborah's neck, together with finger marks on the right side of her neck. During the interview Deborah reported that Mr Jenner had allegedly acted in a similar manner previously, although no details were provided of these alleged incidents.

12. It should be noted that Mr Jenner's father also participated in an electronically recorded interview on 4 March 2016 in which he similarly alleged that Mr Jenner had threatened to kill him, and also choked him.

Events of 21 May 2016

13. On Saturday, 21 May 2016, Deborah and Mr Jenner attended the Penrith Hotel (also known as the Top Pub). They were regular patrons of the hotel and were known to attend there on a daily basis. Shortly before 3:00pm Mr Jenner asked a hotel staff member for some paper cups, explaining that he and Deborah were going to buy some cask wine from a supermarket. Deborah and Mr Jenner left the hotel a short time later. At about 3:02pm CCTV cameras captured Deborah purchasing a four litre cask wine from the ALDI supermarket in Penrith. Deborah left the supermarket and walked in the direction of Doonmore Street, Penrith.

14. It appears that Deborah and Mr Jenner then went to an area underneath the Lemongrove Bridge. This area is known locally as a location for people to gather, drink alcohol and socialise. Corey Burnie-Stafford and Robert Rumsby, two acquaintances of Deborah and Mr Spencer, saw them near the Lemongrove Bridge sometime around 4:30pm to 5:00pm. Mr Burnie-Stafford reportedly observed that Mr Jenner was extremely intoxicated, and that Deborah was similarly affected and unable to stand up. Mr Burnie-Stafford described Deborah at one point to be lying on her back near a retaining wall.

15. It appears that Deborah and Mr Jenner remained at the location during the course of the evening. They were reportedly last seen by Mr Rumsby as he was riding his bike over the bridge on his way home at about 10:00pm. At this time, Mr Rumsby reported that Deborah was still lying on the footpath, but was conscious and aware of her surroundings. Mr Rumsby made an offer to Deborah and Mr Jenner that they could stay in his garage that night, and told them to call him when they arrived at his address so that he could let them into the garage. Mr Rumsby then left the Lemongrove Bridge area to go home.

16. At 10:50pm Mr Jenner called Mr Rumsby on his mobile phone to advise that Deborah had suffered a fall, and that he would arrange for a taxi to take them to Mr Rumsby's home. However, neither Deborah or Mr Jenner ever made their way to Mr Rusmby's home that night.

17. Instead, Mr Jenner reported that he left Deborah at the Lemongrove Bridge and went to a friend's (Maxwell Hilton) house in Penrith, where he slept the night in a garage.

Events of 22 May 2016

18. Mr Jenner reported that he left Mr Hilton's house at around 6:00am on 22 May 2016 in order to buy some cigarettes from a petrol station. Whilst on his way there, Mr Jenner reported finding Deborah still lying on the footpath and unconscious at the Lemongrove Bridge area.

19. At around 7:00am Matthew Clinton was walking near the Lemongrove Bridge area when his attention was drawn to some noise below the bridge. He saw Mr Jenner attending to Deborah, who were still lying on the ground, and attempting to wake her. The Clinton saw that Mr Jenner had what appeared to be some blood on his left arm, and that Deborah had what appeared to be a black eye. Mr Clinton observed Mr Jenner to subsequently walk to a service station on Henry Street, Penrith, and then return a short time later with a sports drink. Mr Clinton subsequently left the location and attended Penrith police station where he reported what he had observed.

20. At around the same time another passer-by, Kenneth Pavy, was also walking near the Lemongrove Bridge area. Sometime after 7:09am Mr Pavy saw a male person matching Mr Jenner's description attending to Deborah who lying on the ground, and attempting to wake her by patting her on the shoulder and calling out her name (which Mr Pavy believed was Diane or Debbie). Mr Pavy saw that Deborah had a bruise and swelling to the right side of her face, including a black eye, and that her mouth was open with what appeared to be blood residue on the inside of both of her lips. Mr Pavy also saw that Deborah's head was supported by the bladder of a wine cask. Mr Pavy believe that Deborah was still breathing as he saw the rise and fall of her chest. He asked Mr Jenner what was going on, and Mr Jenner responded by saying that he did not know, and that he had simply found

Deborah lying at the location. Mr Pavy enquired whether Mr Jenner had called anyone, and Mr Jenner indicated that he had not because his mobile phone battery was flat. Mr Pavy left the location and walked a short distance to Evan Street where he called emergency services.

21. At 7:37am NSW Ambulance paramedics attended the location where Deborah was found to be unconscious and lying in a lateral/fetal position, with her head resting on the bladder of an inflated wine cask. Deborah was subsequently taken to Nepean Hospital where on admission she was noted to have a Glasgow Coma Scale score of 3 with evidence of head trauma. A CT of the brain revealed a large right-sided subdural haematoma, with evidence of parenchymal injury, mass effect and subfalcine and uncal herniation. A slightly displaced fracture of the right nasal bone was also noted, together with superficial soft tissue contusion.

22. Given the extent of the head trauma it was determined that Deborah had sustained an unsurvivable injury, and was not a candidate for surgical intervention. Deborah was subsequently transferred to the intensive care unit and placed on advanced life support. Deborah's condition deteriorated and she progressed to clinical brain death the following day. On the evening of 23 May 2016 life support measures were drawn and Deborah was pronounced life extinct at 6:25pm.

What was the cause of Deborah's death?

23. Deborah was later taken to the Department of Forensic Medicine where an autopsy was performed on 25 May 2016 by Dr Istvan Szentmariay, forensic pathologist. The autopsy identified the following significant pathology:

    (a) a fractured hyoid bone over the left side of the neck with no recognisable injuries involving the surrounding soft tissues of the anterior neck;

    (b) a large right-sided subdural haemorrhage along with a focal left frontal contusion and diffuse subarachnoid haemorrhage, which were noted to all be traumatic changes;

    (c) a nasal bone fracture with minimal displacement;

    (d) a relatively high blood alcohol concentration (**BAC**) of 0.173 g/100mL taken from antemortem blood collected at 8:15am on 22 May 2016 at hospital (**the antemortem BAC**);

    (e) a BAC of 0.008 g/100mL taken from a postmortem right subdural sample (**the postmortem BAC**); and

    (f) numerous superficial blunt injuries to the head and neck area, torso and extremities, with some extending into deeper soft tissues.

24. In the autopsy report dated 5 September 2017 Dr Szentmariay described the fracture of the hyoid bone as "*an alarming finding*", noting that it is a strong indication that blunt force was applied to that area. Dr Szentmariay ultimately opined that the cause of Deborah's death was blunt head injury, with hyoid bone fracture being a significant condition contributing to the death.

Results of the police investigation

25. Police formed a strike force to investigate Deborah's death. A summary of relevant aspects of the police investigation is set out below.

    (a) Police investigated the movements of Mr Jenner on the evening of 22 May 2016 after he reportedly left to Deborah at the Lemongrove Bridge area sometime after 10:00pm. Mr Jenner reported to police that he slept that night in a garage at Mr Hilton's home. Mr Hilton and another resident, Vernon Anderson, informed police that they were home all night on 21 May 2016 and did not see Mr Jenner. However, it is noted that Mr Hilton's garage is located at the base of the unit block where he lives, and that Mr Jenner reported not speaking with anyone that night. When police attended the garage they noted that it was locked but that the garage door could be easily opened. Although Mr Jenner told police that there was a mattress inside the garage, police found it to be empty except for a bucket and toilet roll.

    (b) After speaking to a number of Deborah's friends and associates, police established that Deborah drank alcohol on a daily basis and was known to fall over when intoxicated. It was reported that Deborah had previously sustained a number of injuries as a result of these alcohol-related falls. Indeed, Mr Anderson informed police of an incident on 17 April 2016 where Deborah fell down a set of stairs whilst intoxicated and needed to be taken to hospital by ambulance. Hospital records indicate that on this occasion Deborah was noted to be heavily intoxicated and sustained a loss of consciousness for 1 to 2 minutes after falling down a flight of approximately 14 steps. Deborah reported tenderness around the thoracic spine but denied any cervical neck pain. It was noted that she had nil observable neurological deficits and that she was able to move her limbs independently. As a result, she was discharged the following day.

        Other hospital records indicate that Deborah had sustained a much earlier fall on 28 August 2011. This also resulted in a presentation to hospital where Deborah was described to have collapsed outside a hotel and sustained a loss of consciousness for approximately five minutes.

    (c) When police spoke to Mr Jenner at the scene on 22 May 2016 he indicated that he found Deborah whilst on his way to the service station. Mr Jenner said that Deborah was unconscious, and that he placed the cask wine bladder under her head as a pillow. Mr Jenner also said that he wiped some blood from the Deborah's head.

        When later questioned by a different police officer, Mr Jenner reported that after he discovered Deborah lying on the ground he had a brief conversation with her during which he asked if she was alright, and she told him to leave her alone.

    (d) Investigating police later conducted an electronically recorded interview with Mr Jenner, who reported that he drank a significant amount of alcohol (more than nine or 10 schooners of beer) on a daily basis. When questioned about the events of 21 May 2016, Mr Jenner reported drinking with Deborah at the Penrith Hotel between about 12:00pm and 4:00pm, before going to purchase some cask wine at the Aldi supermarket. Mr Jenner said that he consumed about

half the cask wine before getting into a minor argument with Deborah which did not involve any physical violence. Mr Jenner told police that he left Deborah at the Lemongrove Bridge area at around 9:00pm. He said that he asked Deborah to come with him but that she declined to do so. Mr Jenner initially denied having sexual intercourse with Deborah on 21 May 2016, but later agreed that he did so.

As to the events of 22 May 2016 Mr Jenner said that when he found Deborah he thought that she was asleep, and did not know that she was unconscious until paramedics arrived at the scene. However, earlier in the interview (and also when questioned by police at the scene) Mr Jenner said that he attempted to call his parents so that they could assist in driving Deborah to hospital.

(e) Investigating police later conducted a second electronically recorded interview with Mr Jenner. During this interview Mr Jenner was asked about some scratches to his left hand, and said that he sustained the injuries when trying to lift Deborah up on 22 May 2016. Mr Jenner also told police that Deborah had fallen over whilst intoxicated on the evening of 21 May 2016.

Results of the coronial investigation

26. In an attempt to determine the cause and manner of Deborah's death, assistance was sought from a number of medical professionals as part of the coronial investigation. Associate Professor Darren Roberts, a clinical pharmacologist and toxicologist, was instructed to provide an expert report. He also gave evidence during the inquest together with Dr Szentmariay, and Dr James Raleigh, a radiologist who reported on the postmortem CT scan.

27. Associate Professor Roberts was asked a number of questions in relation to both the antemortem BAC and the postmortem BAC in an attempt to establish whether Deborah was intoxicated at the time she sustained a blunt force head injury, and whether this injury could be attributed to an alcohol-related fall. Associate Professor Roberts explained both in his report and in evidence that the antemortem BAC is likely to represent the minimum BAC at the time of the injury, with the actual BAC at the time of injury is likely to be higher.

28. However, Associate Professor Roberts opined that the BAC at the time of injury cannot be accurately ascertained from the information available at postmortem. Associate Professor Roberts explained that this is because "*attempts to back extrapolate from a known concentration at a known time, to an earlier time are fraught with error, particularly when the timeframe is long, such as 46 hours*" in Deborah's case. Associate Professor Roberts also indicated that "*precise estimation of [BAC] at a given time point is complicated by individual variability in body and metabolism characteristics (eg. age, sex, body mass index, liver health, state of nourishment, state of hydration and basal metabolic rate), variability in mass or concentration of alcohol present in beverages (eg. beer, wine, spirits), and the biological matrices sampled to determine the blood alcohol concentration*".

29. As a result, Associate Professor Roberts opined that it is not possible to ascertain when Deborah sustained the blunt force injury, whether she consumed any alcohol after sustaining this injury, and when she may have resumed consuming any alcohol following this injury. Associate Professor

Roberts was requested to offer an opinion as to Deborah's likely BAC at 10:00pm on 21 May 2016, based on the antemortem BAC, and assuming that no alcohol was consumed after this point in time. Associate Professor Roberts explained that using back extrapolation techniques (noting the above limitations and that caution must be exercised when interpreting any result) it is most likely that Deborah's BAC was between 0.423 g/100mL (based on the higher rate of alcohol elimination) and 0.353 g/100mL (at the average rate of alcohol elimination). Associate Professor Roberts gave evidence that offering an opinion as to the degree of intoxication of an individual based on these calculations is also difficult. This is because any assessment of intoxication depends on the tolerance of an individual, with naive users of alcohol being obviously more affected. Associate Professor Roberts was only able to provide a general comment that a BAC of 0.3 g/100mL for most individuals results in impaired cognition, impaired mobility and an increased risk of falls.

30. In evidence Dr Raleigh was asked to interpret not only the postmortem CT scan results, but also earlier CT scans performed on Deborah at hospital on 22 May 2016, 17 April 2016 and 21 August 2011. Dr Raleigh gave evidence that it is not possible to date the nasal fracture observed postmortem because such fractures are common and often do not heal in the same way as peripheral bones. Dr Raleigh explained that nasal fractures often maintain their appearance for years. Similarly, Dr Raleigh explained that it is not possible to determine the age of the hyoid bone fracture seen postmortem. However, Dr Raleigh gave evidence that the hyoid bone fracture was probably not acute as he observed possible evidence of healing in one of the images taken during the postmortem CT scan.

31. Further, Dr Raleigh explained that the anterior hyoid was excluded in the CT scans performed on 17 April 2016 and 21 August 2011. In addition images from the earlier 2011 scan were markedly degraded by movement artefact. As a result, Dr Raleigh expressed the opinion that "*it is not possible to confidently confirm or refute*" whether the hyoid bone fracture was present during the 21 August 2011 CT scan. This of course means that it is not possible to conclusively determine, from a radiology perspective, whether the hyoid bone fracture occurred someone on 21 or 22 May 2016, or at an earlier point in time.

32. Dr Szentmariay gave evidence that he identified a number of injuries to Deborah during the autopsy. He said that overall some of these injuries were associated with Deborah's alcoholic lifestyle whilst some were not. In addition, some injuries were noted to be superficial and others were deeper injuries and, ultimately, some injuries had no recognisable pattern.

33. As to the hyoid bone fracture Dr Szentmariay said that he observed no signs of healing macroscopically, and identified no injuries of the superficial neck muscle or thyroid cartilage. On this basis, he explained that the fracture represented isolated trauma, making it difficult to interpret. Dr Szentmariay went on to explain that in homicide cases injuries are often seen to either side of the neck or to the hyoid cartilage, although such injuries are not present in Deborah's case. He went on to explain that if the hyoid bone fracture was a consequence of force applied to the neck one would generally expect more injury to be identified. As to the age of the injury, Dr Szentmariay explained that this is also difficult to estimate. However, he expressed the opinion that the injury could be up to a week old, but was more likely a few days old at most (at the time of the autopsy).

34. In evidence Dr Szentmariay was also asked about the subdural and subarachnoid haemorrhages observed at autopsy. Dr Szentmariay explained that at autopsy he observed a comparatively small brain and stretched out bridging veins, common findings in individuals with a history of alcohol abuse. As a result, even minor trauma can cause the veins to move and in turn cause subdural bleeding. Dr Szentmariay explained that in such cases significant blunt force is not required to cause such subdural bleeding.

35. Ultimately, Dr Szentmariay expressed the view that based on the head injuries observed at autopsy it is not possible to indicate whether the injuries were the result of an accidental fall or an episode of interpersonal violence (such as Deborah being pushed or punched). Dr Szentmariay also indicated that he could not say whether the injuries observed at autopsy were the result of a single traumatic event or were representative of repetitive trauma. However, Dr Szentmariay opined that the injuries (relevantly the nasal fracture, brain injury and conclusion to the back of the head) were not consistent with a single impact fall.

What was the manner of Deborah's death?

36. This is the primary question which the coronial investigation and inquest sought to answer. The available evidence raises the possibility the fatal head injury which Deborah sustained was either the result of an accidental fall associated with alcohol use, or the result of an episode of interpersonal violence in the form of a push or strike.

37. As to the possibility of alcohol-related fall, the following is noted:

    (a) According to friends and associates, Deborah was noted to have a history of such falls which often resulted in injuries;

    (b) Back extrapolation of the antemortem BAC (acknowledging the associated limitations) suggests that Deborah possibly had a BAC of at least 0.3 g/100mL at the time she sustained the head injuries, to the extent that her mobility was impaired and she was at increased risk of falls;

    (c) There is possible evidence of healing, from a radiological perspective, in the hyoid bone fracture suggesting that it is not an acute injury, with the possibility that it may have been present at an earlier time prior to 21 May 2016 unable to be excluded;

    (d) No associated injury was observed to the hyoid bone fracture, making it difficult to interpret and inconsistent with what is ordinarily to be expected in the usual case of such injuries associated with interpersonal violence; and

    (e) The possibility that the injuries observed at autopsy were the result of an accidental fall and a single event cannot be excluded.

38. As to the possibility of an episode of interpersonal violence, the following is noted:

(a) There was an alleged history of domestic violence between Deborah and Mr Jenner, including an incident on 4 March 2016 when Mr Jenner allegedly grabbed Deborah by the neck;

(b) Mr Jenner provided inconsistent accounts to police regarding when he last saw Deborah, his movements after he left Deborah, the circumstances in which he found Deborah on the morning of 22 May 2016, whether Deborah was conscious or unconscious at the time that he found her, and whether he sought any immediate assistance upon discovering Deborah;

(c) The possibility that the injuries observed at autopsy were the result of an episode of interpersonal violence cannot be excluded; and

(d) The consolation of injuries observed at autopsy (in particular the head and intracranial injuries) are unlikely to be explained by a single impact fall.

39. Having regard to all of the available evidence, it has not been possible to reach a conclusion, even on the balance of probabilities, as to the manner of Deborah's death. The available evidence leaves open the possibility that Deborah might have died as a result of an accidental alcohol-related fall, or as a result of homicide in the form of an episode of interpersonal violence. As to the latter, the evidence is even less clear as to whether any possible episode of interpersonal violence consisted of a push or strike, or a combination of one or more of such acts of violence. Therefore, in the circumstances, it is most appropriate to record an open finding as to the manner of Deborah's death.

40. As the possibility of the manner of Deborah's death being due to homicide remains open, it is desirable that further police investigation be conducted in order to potentially confirm or exclude this as a possibility. During the inquest, the police officer in charge of the investigation, Detective Senior Constable Richard Iles, gave evidence that, to date, no formal assistance or advice has yet been sought from the New South Wales Police Force Homicide Squad. Given the complex nature of some of the evidence referred to above, it would appear that the specialist assistance and advice that the Homicide Squad could provide to the investigation into Deborah's death would be beneficial. Therefore, it is desirable to make the following recommendation.

41. **Recommendation:** I recommend that the NSW Commissioner of Police cause the investigation into the death of Deborah Spencer be referred to the State Crime Command Homicide Squad for the allocation of specialist investigators to review the matter and to assist in the ongoing investigation. I further recommend that a copy of the brief of evidence and transcript of the *Inquest into the death of Deborah Spencer* be provided to the Homicide Squad for this purpose.

Findings

42. Before turning to the findings that I am required to make, I would like to thank Mr Stephen Kelly for his assistance during both the preparation for the inquest, and the inquest itself. I also thank Detective Senior Constable Iles for his role in the police investigation and for compiling the brief of evidence.

43. The findings I make under section 81(1) of the Act are:

Identity
The person who died was Deborah Spencer.

Date of death
Deborah died on 23 May 2016.

Place of death
Deborah died at Nepean Hospital, Kingswood NSW 2747.

Cause of death
The cause of Deborah's death was blunt head injury, with hyoid bone fracture being a significant condition contributing to the death.

Manner of death
The available evidence does not allow for any finding to be made as to the manner of Deborah's death.

Epilogue

44. On behalf of the Coroners Court of NSW I extend my sincere and respectful condolences to Deborah's family and friends for their painful and tragic loss. It is hoped that the recommendation that has been made in this inquest will assist in being able to determine more precisely the circumstances surrounding Deborah's death, and the manner of her death.

45. I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
29 January 2021
Coroners Court of New South Wales