CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Gwenith Elkington
Hearing dates:	14 September 2021
Date of findings:	28 September 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
File number:	2015/282722
Representation:	Mr J Harris, Counsel Assisting, instructed by Ms T Howe (Crown Solicitor's Office)
Non-publication orders:	Pursuant to s.74(1)(b) of the *Coroners Act 2009* the publication of any matter (including the publication of any photograph or other pictorial representation) that identifies MHJ is prohibited.

Findings:

I find that Gwenith Elkington died on 25 September 2015 at Royal Prince Alfred Hospital, Camperdown NSW 2050. The cause of Gwenith's death was acute cerebral bleed.

The acute cerebral bleed was a direct result of blunt trauma to the right occipital/parietal region of Gwenith's head as a consequence of an accidental fall on 21 September 2015 resulting in a contra coup haemorrhagic contusion to the opposite left frontal and temporal lobes of the left cerebral hemisphere. On the evening of 23 September 2015, or in the early hours of 24 September 2015, there was a late, major haemorrhagic progression of this contusion, potentiated by Gwenith's coagulopathy as a result of liver cirrhosis, and possibly also by atherosclerotic cerebrovascular disease. This haemorrhage, together with associated brain swelling, caused significant mass effect and shift of brain structures. The significance of these events on 23/24 September 2015, and the progression of Gwenith's initial injury, were not readily appreciated at the time resulting in medical assistance not being immediately sought, although it is most likely that such medical assistance would not have, tragically, materially altered the clinical outcome.

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1. Introduction

1.1 On the morning of 24 September 2015 Gwenith Elkington was taken by ambulance to hospital in a critical condition with a significant intracranial injury. This injury had occurred some three days earlier as a result of an accidental fall at home. Tragically, Gwenith's condition did not improve and she was pronounced life extinct on 25 September 2015.

1.2 Subsequent investigations sought to understand the sequence of events between when Gwenith sustained her injury and when she was taken to hospital, and whether her transfer to hospital could have occurred any earlier. These investigations raised a number of questions regarding the days and hours leading up to Gwenith's transfer to hospital, the sudden deterioration of her condition, and whether this deterioration could have prompted any action that might have averted the eventual tragic outcome.

2. Why was an inquest held?

2.1 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.

2.2 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 evidence gathered during the course of the police investigation into Gwenith's death gave rise to the appearance that her death may have been a result of homicide. This is because the investigation raised questions about possible actions that were not taken, or actions that might have been taken at an earlier point in time, by a person who observed firsthand the circumstances surrounding Gwenith's sudden deterioration overnight on 23/24 September 2015. If the evidence were to establish that a person did not take action (for example, to seek medical assistance for Gwenith), and that this inaction substantially or significantly contributed to Gwenith's death, then the manner of death might be characterised as being a result of homicide. It is therefore mandatory to hold an inquest into Gwenith's death.

2.3 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.

2.4 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.

3. Gwenith's life

3.1 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 Gwenith's life in a brief, but hopefully meaningful, way.

3.2 Gwenith was born in Singapore on 2 June 1955. She later married her husband, Thomas, and together they had a son, Scott. Gwenith's father was a harbourmaster and he often delighted Gwenith with stories of his experiences, opening her mind to other countries and cultures. This sparked a sense of adventure in Gwenith and a desire to see the world.

3.3 After completing her schooling, Gwenith embarked on her own adventures, travelling and exploring abroad extensively. Scott recalls fond memories of his mother telling him of her experiences living out of a duffel bag whilst backpacking independently throughout Europe and Asia, and how these experiences gave her resilience and shaped her worldview that she would always remember and draw upon in life. Indeed, Gwenith's travels constantly fuelled her desire to experience and learn from different cultures and ways of life.

3.4 Despite this insatiable sense of adventure, Gwenith was also grounded and cognisant of the demands and needs of everyday life. She was a devoted and nurturing mother, making many sacrifices to ensure that Scott was provided with all available educational and cultural opportunities during his upbringing.

3.5 Sadly, Thomas died from stomach cancer in 2002. Following this, Gwenith showed remarkable resilience and selflessness in continuing to provide for Scott. Gwenith held strong beliefs that individuals are a combination of their cultural experiences and she sought to share that belief with her friends, family and, most importantly, with Scott.

3.6 There is no doubt that Gwenith was, in all senses, a lover of life. To know that her own life was so tragically cut short, and in such devastating circumstances, is truly heartbreaking.

4. Gwenith's medical history[1]

4.1 Gwenith generally lived a healthy lifestyle but reportedly had a lengthy history of heavy alcohol consumption on a daily basis. This consumption increased over time, particularly following Thomas' passing. As a result of this heavy alcohol use, Gwenith also had other health issues including severe weight loss, liver problems, and issues with her balance and coordination.

[1] This factual background has been drawn from the helpful submissions of Counsel Assisting.

4.2 Gwenith also had a history of falls, some of which were alcohol-related, with most requiring presentation to hospital:

(a) On 21 June 2012 Gwenith suffered an alcohol-related fall and presented to hospital with a forehead laceration where investigations did not identify any internal bleeding.

(b) On 21 August 2012, Gwenith presented to hospital after vomiting blood and underwent an endoscopy.

(c) On 20 June 2013 Gwyneth attended her general practitioner (**GP**) after suffering another fall which resulted in a right-sided scalp haematoma.

(d) In August 2014 Gwyneth was admitted to hospital on a background of "alcohol abuse", where she was reportedly diagnosed with liver cirrhosis and mild brain damage. Gwenith's GP subsequently advised her to reduce her alcohol consumption.

(e) On 1 March 2015 Gwyneth was again admitted to hospital following another fall which was described as being attributed to heat exhaustion and/or a fainting episode.

(f) After travelling to Dubai on 16 April 2015 Gwenith suffered another fall requiring stitches to her head and a computed tomography (**CT**) brain scan.

4.3 This last fall resulted in Gwenith returning to Sydney prematurely on 19 April 2015. After initially being reluctant to attend hospital, Scott arranged for an ambulance and Gwenith was admitted to hospital on 20 April 2015. Gwenith reported experiencing a seizure the day after arriving in Dubai, following hallucinations and a fall resulting in a head strike and her biting her tongue. A CT scan revealed a large subgaleal haematoma in the posterior left parietal region, but no skull fracture.

4.4 Gwenith was later discharged on 22 April 2015, when it was noted that she had cerebellar degeneration secondary to alcohol use. Gwenith was also noted to be at risk of further falls and alcohol withdrawal, and was again advised to reduce her cease alcohol use with a referral made to drug and alcohol services.

4.5 In the months preceding Gwenith's death, friends and neighbours reported seeing Gwenith in an increasingly dishevelled state. By June 2015, Scott noted that his mother appeared frail unwell, although her health improved somewhat following this. When Scott last saw his mother on 17 September 2015 he described her as looking "*healthy, and [she] was pretty lively and happy*", and that it appeared she "*didn't have a care in the world*".

5. Gwenith's relationship with MHJ

5.1 Gwenith first met MHJ in 2012 and later formed a relationship with him. The nature of this relationship and Mr MHJ'ss actions in the days leading up to Gwenith's death, and the days after it, are centrally important to the issues examined by the inquest.

5.2 Mr MHJ was originally from New Zealand, although he travelled frequently to a number of countries, including Argentina, Chile, India, Russia, the Czech Republic and United Kingdom. Until at least 2011, Mr MHJ was living in Surrey in the United Kingdom with his third wife.

5.3 On 29 April 2011, Mr MHJ was charged in the United Kingdom with offences relating to the sexual exploitation of a mentally ill woman, with these offences having occurred over a period between 2004 and 2011. Mr MHJ was subsequently granted bail and given permission to travel to New Zealand to visit his daughter who was reportedly terminally ill. However, this proved to be incorrect and Mr MHJ was later rearrested but again granted conditional bail in August 2011.

5.4 Gwenith met Mr MHJ online in 2012, although Scott believes that his mother did not meet Mr MHJ in person until late 2012 or early 2013. Immigration records show that Mr MHJ was in Australia between 2 and 8 March 2013. This was followed by a number of further intermittent trips to Australia between May 2013 and May 2015, with most being for relatively short periods of no more than two weeks. Following this, Mr MHJ had two longer stays in Australia, the first being approximately two months from May 2015 and the second being approximately three weeks from August 2015.

5.5 The nature of the relationship between Gwenith and Mr MHJ During this period of time is not entirely clear. Telephone records indicate that they remained in contact and that an intimate relationship developed at least from 2015. Other evidence also indicates that in 2015 Mr MHJ spent a total of about four months living in Gwenith's home.

5.6 As noted above, Gwenith travelled to Dubai in April 2015 with the intention of travelling on to India in order to meet Mr MHJ. However, this meeting never occurred as Gwenith returned to Sydney prematurely following her fall.

5.7 A trial in relation to Mr MHJ's criminal charges was scheduled to proceed on 20 April 2015. However, Mr MHJ did not appear at his trial and the charges were ultimately proved against him in his absence. In December 2015 Mr MHJ was convicted and, one month later, in January 2016 he was sentenced to 6 years imprisonment. A warrant was subsequently issued for Mr MHJ's arrest.

6. Gwenith's financial affairs

6.1 Up until 2014 Gwenith's only income was from a superannuation fund managed by the firm of a financial advisor, Hamish McIntosh (**Mr McIntosh**). After these funds became exhausted Gwenith was left with her home, a three bedroom duplex in East Ryde (**the duplex**), as her only major financial asset. By early 2015 Gwenith made a decision to sell the duplex, and approached Mr McIntosh for assistance. Mr McIntosh referred Gwenith to a solicitor (and distant cousin), John McIntosh, then of Emprise Legal (**Emprise**).

6.2 On 10 May 2015 Gwenith entered into a contract to purchase a new car, a Ford Focus (**the Focus**). Sometime around 9 July 2015, Gwenith, Mr MHJ and Mr McIntosh met for lunch and discussed disbursement of the proceeds from the sale of the duplex. Gwenith indicated that she intended to use the proceeds to pay off some debts, buy a car, transfer $540,000 into a superannuation fund, with the remainder to be placed in a term deposit. There was also some discussion about Gwenith

and Mr MHJ buying a house together and travelling. Around the same time, Gwenith sent Scott a text message indicating that she intended to give him $30,000 to $50,000 from the sale of the duplex, but that he was not to tell anyone. This last comment is likely to be a reference to Mr MHJ, who had previously indicated his disapproval of Scott receiving any money from the proceeds of sale. The duplex was subsequently sold at auction on 11 July 2015 for $1.215 million.

6.3 In May 2012 Gwenith had executed a will nominating Scott as trustee and sole beneficiary. Sometime in May 2015 Mr MHJ reportedly asked Scott about the will, and also about a power of attorney and the possibility of Gwenith entering rehabilitation. In August 2015 there was some discussion between Mr MHJ and Mr McIntosh regarding who should be appointed as executor of Gwenith's will. Despite these discussions Gwenith did not execute a new will. However on 11 August 2015 she signed an enduring power of attorney, appointing Mr MHJ. On 18 August 2015 Gwenith reportedly arranged a $70,000 dollar loan against the proceeds of sale of the duplex. However, it is unclear whether this sum was advanced and what happened to it.

7. The events of September 2015

7.1 Mr MHJ left Australia on 24 August 2015 to travel to Miami, where it appears he met his wife, before returning to Australia on 15 September 2015. On 20 September 2015 Mr MHJ exchanged messages with Mr McIntosh in which he referred to his desire to obtain an annuity from Gwenith's pension and term deposit. Mr MHJ and Mr McIntosh discussed arrangements to meet on 30 September 2015.

21 September 2015

7.2 The sale of the duplex was due to complete on 21 September 2015. At around 10:00am that day removalist arrived at the duplex in order to pack up Gwenith's property. Mr MHJ greeted the removalist and began showing them around the property. After about 15 minutes, Gwenith's voice was heard from the bathroom. Mr MHJ went to the bathroom and the removalists heard him asking what had happened, and making references to there being "*a lot of blood*" and the need to take Gwenith to hospital. Mr MHJ later told the removalists that Gwenith had hit her head on the bathroom floor tiles and needed to be taken to hospital.

7.3 Gwenith later went downstairs, wearing a dressing gown with a towel around her head. The removalists noted that there was dried blood on her hair, and that she appeared vague and confused. The removalists continued packing the duplex for the rest of the day. According to one of the removalists, Mr MHJ repeatedly suggested to Gwenith that she should attend hospital, however Gwenith declined to do so.

7.4 At some point during the afternoon, one of Gwenith's friends arrived at the duplex, and had some champagne with Gwenith. The new owners of the duplex also attended. However Mr MHJ refused them admission and the property settlement was postponed to the following day.

7.5 The removalist completed the packing up of property by that evening. Gwenith and Mr MHJ left the duplex and went to stay in a bed and breakfast (**the B&B**) that had been booked in Glebe. Upon arrival, Gary de Garis, the B&B owner, noted that Gwenith appeared disorientated and confused,

and that Mr MHJ did all of the talking. After settling in to the B&B, Gwenith sent a text message to her friend, suggesting that they should meet up on the weekend.

7.6 Later that evening, Mr MHJ asked Mr de Garis to print out some documents for him. These were sent by email later that night and consisted of four authorities, which appear to have been drafted by Emprise, to transfer money from a trust account:

(a) $540,000 to a superannuation fund, as had been discussed around 9 July 2015;

(b) $22,000 to a car dealership in relation to the Focus;

(c) Sums of $42,505 and $483,981.48 to be paid into accounts belonging to Mr MHJ.

7.7 Subsequent examination of Mr MHJ's computer indicate that the sum of $42,505 related to an invoice issued by Mr MHJ for work that he asserted he performed in preparing the duplex for sale. Whilst the reason for the transfer of $483,981.48 is unclear, records that were subsequently found on Mr MHJ's computer appear to suggest that this amount was to compensate Mr MHJ for not being able to work whilst he and Gwenith travelled together, and that he would be provided with an allowance of $500 per week.

22 September 2015

7.8 The following morning, Mr MHJ reportedly saw a 10cm pool of blood on Gwenith's pillow after she woke up. Gwenith reportedly told Mr MHJ that this was blood she had not washed out of her hair following her fall in the bathroom the previous day.

7.9 Gwenith and Mr MHJ went downstairs to breakfast where Mr de Garis gave Mr MHJ the four trust account authorities that he had printed off. Mr MHJ asked for a pen and had a Gwenith sign them. These authorities were later sent to Emprise, with the signatures of both Gwenith and Mr MHJ, and bearing the date of 23 September 2015.

7.10 During the course of the day, Gwenith made a number of phone calls to Ryde Council and Australia Post, whilst Mr MHJ contacted Mr McIntosh and the real estate agent handling the sale of the duplex. That afternoon, Gwenith and Mr MHJ may have gone house hunting. Later that day, Gwenith sent a number of messages to a friend about staying at the B&B, and about some items at the duplex. Gwenith also called another friend in the evening and left a message.

23 September 2015

7.11 According to Mr MHJ, when Gwenith woke the next morning she complained of a headache and there was more blood on the towel on her bed. Mr MHJ said that he gave Gwenith some ibuprofen. Phone records indicate that Gwenith subsequently exchanged a number of text messages with her friends from about 5:30am.

7.12 At around 7:30am a representative from the car dealership called Gwenith but she did not answer. Phone records reveal that a message was sent from Gwenith's phone indicating that she was

driving at the time. A second call was made to Gwenith at around 8:30am indicating that the Focus was going to be put back on the market. Gwenith asked for this not to occur and asked that the sales representative speak to Mr MHJ.

7.13 Gwenith and Mr MHJ had breakfast that morning before going out. Mr MHJ informed Mr de Garis that there was a "*small spot of blood*" on the pillowcase. Mr de Garis later check the bedroom and found extensive bloodstains covering the whole of one side of the bed. He removed the sheets, considering them to have been ruined, and disposed of them. Mr de Garis also located an empty bottle of wine in the bin.

7.14 At around 1.11pm Gwenith had a photo taken for a new driving licence. The photo did not depict the injury to the back of her head.

7.15 Later that afternoon Gwenith and Mr MHJ returned to the B&B where they were confronted by Mr de Garis. He informed them they could no longer stay at the B&B due to the ruined bedlinen, and told Gwenith that she needed medical attention. Mr MHJ was initially reluctant to assist with this, but eventually relented and agreed to take Gwenith to see a doctor. It appears that arrangements were made for Gwenith to attend Drummoyne Medical Centre (**the Medical Centre**) later that afternoon.

7.16 At around 3:48pm Mr MHJ called Emprise, and was reportedly angry and rude, demanding to speak to someone because the settlement money from the duplex had not yet cleared. John McIntosh later returned Mr MHJ's call around an hour later, and advised that the settlement money would be cleared within 24 to 48 hours. Mr MHJ described being under "*enormous pressure*" from the car dealership.

7.17 At around 5:13pm Mr MHJ sent a text message to Mr McIntosh indicating that he and Gwenith were content with the B&B and that Gwenith was "*happy but tired*".

7.18 Gwenith and Mr MHJ later attended the medical centre at around 5:23pm where Gwenith was seen by Dr Peter Davidson. Gwenith reported that she had suffered a fall some two weeks earlier and had started bleeding from the scalp that day, dismissing the injury as not serious. On examination, Dr Davidson observed a large scalp haematoma but found no neurological abnormality. Dr Davidson directed a nurse to clean the wound and advised Gwenith to seek medical attention if she developed symptoms suggestive of worsening head injury. During the course of this consultation, Mr MHJ reportedly informed Dr Davidson that he had some previous experience in dealing with head injuries.

7.19 A nurse assisted Gwenith by washing the wound site, and applying gauze and cutifilm, and a crepe bandage. Gwenith was also given a pressure bandage with instructions to apply this after she had showered. Dr Davidson also prescribed Gwenith with temazepam (a medication used to treat insomnia which had previously been prescribed to her).

7.20 Gwenith and Mr MHJ later returned to the B&B. At around 7:30pm Mr de Garis took some takeaway food to them, together with a bottle of wine. Gwenith received the food as Mr MHJ was asleep at

the time. Mr de Garis noticed that there was already another bottle of wine in the room, and did not see a bandage on Gwenith's head. This was the last time that Gwenith was seen conscious.

24 September 2015

7.21 According to Mr MHJ, Gwenith appeared to be talking in her sleep at some point during the evening of 23 September 2015 or into the early hours of 24 September 2015. Gwenith then suddenly vomited and, according to Mr MHJ, vomited six times over the following three hours (although Mr MHJ later informed paramedics that she had only vomited twice). Mr MHJ also reportedly observed Gwenith to be displaying seizure-like activity as "*she would have these episodes where she woke up and held her fist in the air*".

7.22 Despite the advice of Dr Davidson on 23 September 2015, Mr MHJ did not seek medical assistance. Instead, by his own account, he calmed Gwenith down and "*let her rest*". Mr MHJ also explained that he considered the vomiting to have possibly resulted from the takeaway food and, when later questioned by a police officer, implied that he derived some comfort from the fact that Gwenith "*had just seen a doctor*" on the afternoon of 23 September 2015.

7.23 At around 8:40am Mr MHJ received two phone calls in relation to transfer of funds for the purchase of the Focus. Mobile phone records indicate that there was no other prior activity on the phones of Gwenith and Mr MHJ, apart from Mr MHJ obtaining a password for his phone account at around 2:27am.

7.24 At around 9:00am Mr MHJ went downstairs to breakfast on his own, leaving Gwenith in bed where she was reportedly snoring. On Mr MHJ's account he returned to the bedroom approximately 30 minutes later and found that Gwenith was "*breathing a lot more rapidly*".

7.25 Eventually, at around 10:11am, Mr MHJ called the Medical Centre and spoke with a nurse who instructed him to attempt to rouse Gwenith. When Mr MHJ reported that he was able to do so, the nurse instructed Mr MHJ to contact Triple Zero. Mr MHJ did so at 10:20am.

7.26 NSW Ambulance paramedics arrived at the B&B at 10:34am where they found Gwenith to be unconscious (with a Glasgow coma score of 4), and with elevated blood pressure and heart rate, and a temperature of 38.6°C. Mr MHJ informed the paramedics that:

(a) in the previous 24 hours Gwenith had been increasingly confused with an unsteady gait and complaining of headache;

(b) between about 12:00am and 2:00am on 24 September 2015 Gwenith had multiple episodes of vomiting blood and two tonic (sudden tension or stiffness) seizures; and

(c) Gwenith subsequently appeared to go to sleep

7.27 Gwenith was conveyed by ambulance to Royal Prince Alfred Hospital (**RPAH**) arriving at 11:23am. Once there, investigations revealed a large left intracranial bleed with midline shift but no

associated fracture. A chest x-ray revealed aspiration pneumonia. Mr MHJ contacted Scott at 1:39pm to advise him of his mother's condition, and he attended the hospital shortly afterwards.

8. Subsequent actions taken by Mr MHJ

8.1 From the time of the arrival of the paramedics at the B&B until Gwenith's tragic death, Mr MHJ took a number of actions in relation to various financial matters.

24 September 2015

8.2 At around 11:17AM on 24 September 2015, whilst Gwenith was on her way to hospital, John McIntosh sent an email to Mr MHJ advising that the settlement funds from the sale of the duplex had not yet cleared. At around 1:43pm, shortly after advising Scott of his mother's condition, Mr MHJ contacted John McIntosh with a request to be advised once the funds had been disbursed. John McIntosh emailed Mr MHJ again at around 3:42pm to advise that the settlement funds were likely to clear overnight.

8.3 Sometime during the afternoon Mr MHJ made a call to his daughter in New Zealand, who is believed to be a lawyer. This call was facilitated by a social worker who recorded that Mr MHJ wanted to ensure that Gwenith's "*will was upheld*".

8.4 Later that evening Gwenith's treating team at RPAH advised Scott and Mr MHJ that Gwenith's injuries were considered to be non-survivable. By this time Gwenith was to be supported overnight in the intensive care unit, with further tests to be performed the following day.

25 September 2015

8.5 On the morning of 25 September 2015 Mr MHJ made a number of phone calls regarding the purchase of the Focus and settlement funds from the sale of the duplex. In essence, Mr MHJ conveyed his concerns to John McIntosh that he was under pressure to pay for the Focus and that Gwenith was losing interest on the settlement funds. At no stage did Mr MHJ make any mention of what he had been informed by doctors the previous evening regarding Gwenith's condition and prognosis. Later that day Mr MHJ returned to the B&B to collect his belongings.

8.6 At around 2:15pm John McIntosh called Mr MHJ to advise that the deposit funds had cleared and that this could be released to pay for the Focus. Mr MHJ asked if this money could be transferred over the weekend, although this was considered unlikely. Mr MHJ subsequently discussed dinner plans with both John McIntosh and Hamish McIntosh, and again no mention was made of Gwenith's condition and prognosis.

8.7 At around the same time, clinicians at RPAH certified that Gwenith had suffered brain death. Scott subsequently gave consent for life support measures to be withdrawn, and Gwenith was tragically pronounced life extinct at 2:38pm.

8.8 Shortly before 5:00pm, John McIntosh sent an email to Mr MHJ confirming that the payment had been made to the car dealership.

26 & 27 September 2015

8.9 Over the weekend, Mr MHJ stayed with Scott and conveyed certain instructions regarding financial matters. In particular, Mr MHJ told Scott not to inform Emprise of Gwenith's passing as he believed that Emprise would want to get "*a piece of the action*" (taken to be a reference to any legal fees for probate). Mr MHJ also expressed the view that he did not consider Gwenith's previous will to be valid, and that she was in the process of creating a new will with Mr MHJ as executor.

28 September 2015

8.10 At around 8:30am on 28 September 2015 the car dealership confirmed with Mr MHJ that the funds for the purchase of the Focus had been received. Mr MHJ made arrangements to pick up the Focus later that day.

8.11 Concerned about his discussions with Mr MHJ over the weekend, Scott decided to contact Hamish McIntosh at around 11:00am. By that time, police had already informed Mr McIntosh of Gwenith's death. Scott subsequently contacted Emprise to advise them of Gwenith's passing. As a result transfers from Gwenith's funds were frozen.

8.12 After calling Emprise at around 11:52am, Mr MHJ subsequently attended the car dealership at 12:30pm. He advised that Gwenith was "*at home*" and that he had a power of attorney. Mr MHJ forwarded a copy of the power of attorney from Gwenith's email account, and informed the car dealership that he and Gwenith intended to go to New Zealand to meet his family.

8.13 After the paperwork for the purchase of the Focus was processed, police confronted Mr MHJ and arrested him, later charging him with an offence of obtaining property by deception, namely using the power of attorney to obtain the Focus (**the fraud offence**). Whilst at the car dealership, Mr MHJ made a number of comments including that Scott had asked him to collect the Focus on his behalf, and that he was under no obligation to inform the car dealership of Gwenith's passing as it was "*none of their business"*.

9. Criminal proceedings against Mr MHJ

9.1 Mr MHJ subsequently pleaded not guilty in relation to the fraud offence. The matter proceeded to a defended hearing on 11 March 2016, and later concluded on 6 May 2016 when a magistrate determined the fraud offence proved. Mr MHJ was subsequently bail refused and sentenced on 24 June 2016 to 6 months imprisonment (commencing on 6 May 2016) with a two month non-parole period.

9.2 Extradition proceedings were commenced and Mr MHJ was subsequently extradited to the United Kingdom on 14 December 2016 in relation to perjury charges. The available information indicates that Mr MHJ served a custodial sentence, and then departed the United Kingdom. At the time of the inquest, Mr MHJ's whereabouts were not known.

10. What was the cause of Gwenith's death?

10.1 Following her death, Gwenith was taken to the Department of Forensic Medicine where a postmortem examination was performed by Dr Istvan Szentmariay, forensic pathologist, on 29 September 2015. The autopsy identified the following:

(a) a swollen area of the right posterior parietal scalp surrounded by an area of haemorrhage;

(b) widespread subgaleal and lesser periosteal haemorrhage beneath a nearly vertical, linear undisplaced fracture of the skull measuring 8cm in length;

(c) markedly swollen left hemisphere of the brain with a noticeable midline shift to the right;

(d) focal subarachnoid haemorrhage in the left temporal lobe;

(e) routine toxicology identified numerous therapeutically used medications (diazepam/nordiazepam, ibuprofen and citalopram) at non-toxic blood levels, with no detectable alcohol.

10.2 Ultimately, Dr Szentmariay opined that the cause of Gwenith's death was acute cerebral bleed.

10.3 Further examination was conducted by Associate Professor Michael Buckland, a neuropathologist. In his neuropathology report, Associate Professor Buckland identified the following:

(a) large acute intracerebral haemorrhage with subarachnoid and intraventricular extension, and mass effect;

(b) bilateral transtentorial herniation and left cerebellar tonsillar herniation;

(c) posterior subdural haematoma of a few days of age; and

(d) evidence of injury to the frontal, parietal and occipital regions on the left, of months to years of age.

10.4 Relevantly, Associate Professor Buckland noted that the left cerebellar subdural haemorrhage is consistent with the history of trauma to the back of the head a few days prior to death, namely the fall suffered by Gwenith in the bathroom on 21 September 2015. In addition, Associate Professor Buckland noted that the large lobar haemorrhage is acute and "*it may represent a late haemorrhagic transformation of a contusion acquired during the [21 September 2015] fall, or may be secondary to hypertensive cerebrovascular disease*". Associate Professor Buckland noted that there was no evidence of a second traumatic event.

10.5 The postmortem examination findings and evidence relating to the circumstances of Gwenith's death were reviewed by Professor Michael Besser, emeritus consultant neurosurgeon. Professor Besser expressed the following views:

(a) Gwenith sustained a blunt trauma to the right occipital/parietal region of her head on 21 September 2015 resulting in a contra coup haemorrhagic contusion to the opposite left frontal and temporal lobes of the left cerebral hemisphere. Professor Besser explained that this occurs *"when the soft cortex of the brain contacts the sharp, hard surfaces of the inner skull as movement of the brain occurs from the force of the blow*". In this regard Professor Besser noted that the underlying skull fracture seen at autopsy confirms the significant force involved in the injury.

(b) Sometime during the evening of 23 September 2015, or in the early hours of 24 September 2015, Gwenith experienced a late, major haemorrhagic progression potentiated by her coagulopathy as a result of liver cirrhosis and possibly also by atherosclerotic cerebrovascular disease given her history of smoking and recent hypertension. This haemorrhage, together with associated brain swelling, caused significant mass effect and shift of brain structures. Professor Besser explained that haemorrhagic progression of a contusion several hours or days after trauma is a well described injury in academic literature.

(c) Professor Besser opined that the 23/24 September 2015 event resulted in "*raised intracranial pressure, exacerbated by hypoxia from seizures and vomiting with aspiration, compromise blood supply to the brain leading to brain stem compression with tonsillar herniation at the level of the foramen magnum, and brain death*".

(d) Professor Besser noted that the previous injuries to the brain (particularly in the left occipital lobe, and also over the frontal and parietal regions) are evidence of multiple previous head injuries, probably as a result of numerous falls. Given the absence of areas of regional softening or necrosis, Professor Besser considered it unlikely that this chronic damage played any role in the acute haemorrhage leading to Gwenith's death.

10.6 Ultimately, Professor Besser noted that the intracerebral haemorrhage in Gwenith's dominant hemisphere "*was so severe that survival, let alone functional recovery, was barely tenable*". On this basis, Professor Besser considered in unlikely that any other medical intervention or treatment at around 11:00am on 24 September 2015 would have altered the clinical outcome.

10.7 Notwithstanding the above however, Professor Besser noted that *"one could speculate that if medical attention had been sought during the night when there was repeated vomiting and seizures, prior to loss of consciousness and pupillary changes, the clinical outcome might have been different*". Professor Besser explained that Gwenith's episodes of vomiting were likely due to raised intracranial pressure, and that aspiration of vomitus (due to an unprotected airway during the seizure-like episodes) constituted an additional hypoxic insult, resulting in further brain swelling compromising brain function. Professor Besser opined that early hospitalisation "*may have prevented some of these events from occurring leading to a different outcome*".

11. Manner of death

11.1 The available evidence establishes that overnight on 23 and 24 September 2015 Gwenith suffered haemorrhagic progression of an earlier traumatic brain injury that occurred on 21 September 2015

as a result of her accidental fall at home. There is no evidence to suggest that Gwenith suffered a subsequent fall or second traumatic injury.

11.2 However, the question that arises from the expert opinion expressed by Professor Besser is whether some action might have been taken, prior to when Mr MHJ made the Triple Zero call at 10:20am on 24 September 2015, that would have likely altered the eventual outcome. Looked at another way, the issue is whether any inaction to seek medical assistance for Gwenith prior to that point in time contributed to her eventual death. If there is any evidence of such inaction, then it suggests that the manner of Gwenith's death should be properly characterised as being a result of homicide.

11.3 In this regard it is important to be clear that, consistent with section 81(3) of the Act, any potential finding of homicide as the manner of death does not in any way suggests that an offence has been committed by any person. Rather, a finding of homicide indicates that the actions or inaction of one person materially contributed to the death of another person.

Factors relevant to consideration of the possibility of homicide

11.4 There are several factors in this case which give rise to consideration of the possibility of homicide, namely:

(a) Mr MHJ was aware of Gwenith's fall in the bathroom on 21 September 2015, and that she had subsequently complained of headache, and showed signs of confusion and an unsteady gait;

(b) Mr MHJ was aware that Gwenith's head injury continued to bleed on 22 and 23 September 2015;

(c) Despite this awareness, Mr MHJ did not initially suggest that Gwenith seek medical attention, or seek medical attention on her behalf, until Mr de Garis urged them do to so (over Mr MHJ's apparent reluctance) on 23 September 2015;

(d) Dr Davidson's advice on the afternoon of 23 September 2015 to both Gwenith and Mr MHJ was for Gwenith to seek medical attention if she developed any symptoms suggestive of worsening head injury;

(e) Mr MHJ asserted to Dr Davidson that he had experience in dealing with head injuries, having previously worked within a defence force setting ("*or something to this effect*"), and that he (Mr MHJ) would know what to do if Gwenith's symptoms changed;

(f) Mr MHJ was the only person who observed Gwenith's symptoms overnight on 23/24 September 2015;

(g) Mr MHJ was the only person overnight on 23/24 September 2015 in a direct position to seek medical attention for Gwenith, or to assist her with seeking medical attention;

(h) The impression of one of the paramedics who attended the B&B on the morning of 24 September 2015 was that "*it seemed that [Mr MHJ] felt guilty about not calling [NSW Ambulance] sooner*".

11.5 Set against the above matters is the following relevant evidence:

(a) When Gwenith was examined by Dr Davidson no neurological abnormality was noted and Gwenith was only provided with wound care for her head injury;

(b) Mr MHJ told police that Gwenith had "*just seen a doctor*" only a matter of hours prior to her deterioration overnight on 23/24 September 2015, suggesting that he derived some comfort from the fact that Gwenith's condition was not considered serious at that time;

(c) There are inconsistencies in the accounts provided by Mr MHJ to (i) the nurse at the Medical Centre when he called on the morning of 24 September 2015; (ii) to the attending paramedics; and (iii) to police; meaning that there is no reliable evidence as to the precise nature of Gwenith's symptoms overnight on 23/24 September 2015, and in circumstances where Mr MHJ could not be called to give evidence at the inquest;

(d) The timing of when Gwenith's symptoms were observed by Mr MHJ, and their frequency and duration, also cannot be reliably established on the available evidence;

(e) Mr MHJ expressed a belief that Gwenith's vomiting episodes, at the least, could be attributed to the takeaway food which they both consumed on the evening of 23 September 2015;

(f) According to Mr MHJ's account, which has not been tested, he provided assistance to Gwenith overnight on 23/24 September 2015 by helping to calm "*her down and let her rest*";

(g) According to Mr MHJ's account, which again has not been tested, he left Gwenith in the bedroom at around 9:00am on 24 September 2015 when she was snoring and not displaying any adverse symptoms;

(h) When Mr MHJ subsequently returned to the bedroom approximately half an hour later he, on his account, recognised a deterioration in her condition (due to her rapid breathing) and contacted the Medical Centre of his own accord at around 10:11am.

11.6 What emerges from the above evidence is a lack of clarity as to precisely when Gwenith began to show symptoms suggestive of a worsening of her head injury, whether the significance of these symptoms were recognised and appreciated by a person in Mr MHJ's position, and whether Gwenith was rendered incapable by these symptoms of seeking medical attention herself, or requesting that Mr MHJ seek medical assistance on her behalf. This means that there is no cogent evidence upon which a conclusion could be reached that inaction overnight on 23/24 September 2015 in relation to seeking medical assistance for Gwenith materially contributed to the eventual outcome.

Timing of possible medical intervention

11.7 Relevant to the above issue is the timing of any potential medical intervention. First, it should be noted that Professor Besser's general view is that earlier medical intervention increases the prospects of an improved outcome. Second, it appears that there may have been an opportunity for earlier medical intervention, in the form of presentation to hospital, on the afternoon of 23 September 2015 at the Medical Centre. However, there is some doubt regarding this timing as Dr Davidson was not provided with an accurate chronology of Gwenith's previous head injury. Although the fall in the bathroom had only occurred two days earlier on 21 September 2015 Dr Davidson was advised by Gwenith (in the presence of Mr MHJ) that she had suffered "*a fall 2 weeks prior*". The difference in timeframes is significant given Professor Besser's evidence that the classical timeframe for a haemorrhagic contusion injury to enlarge and deteriorate is approximately 48 to 72 hours from the time of the initial injury.

11.8 Relevantly, Professor Besser gave evidence that if Gwenith had presented to hospital during the afternoon of 23 September 2015 (or earlier) then:

(a) her skull fracture would have "*almost certainly*" been identified;

(b) she would have been assessed and carefully observed for at least 24 hours and probably longer;

(c) her coagulation factors (proteins) would have been assessed, with the likelihood that she would be given additional factors and therapies to address these issues;

(d) surgical intervention may have been indicated if the haemorrhagic contusion worsened or if Gwenith showed evidence of declining function.

11.9 Ultimately, Professor Besser opined that even if Gwenith had presented to hospital shortly after suffering the head injury, haemorrhagic progression of the injury may still have occurred. However, Professor Besser noted that careful control and correction of Gwenith's coagulopathy would have mitigated the risk of this occurring to a degree.

11.10 As already noted above, Professor Besser considered it "*very unlikely*" that any other medical intervention or treatment at around 11:00am on 24 September 2015 would have altered the clinical outcome. In evidence, Professor Besser was asked whether the prospect of a different outcome might have been possible if medical intervention or treatment had occurred at an earlier point in time. Professor Besser considered that if intervention and hospitalisation occurred at the time of Gwenith's vomiting episodes and seizure activity then there was "*some prospect*" that the outcome may have been different, although he considered that this was "*probably not likely*". Professor Besser went on to explain that the combination of vomiting, seizure activity and loss of consciousness would lead to Gwenith's airway being unprotected resulting in aspiration in the lungs (with evidence of this seen when Gwenith was presented to hospital on 24 September 2015). This in turn results in hypoxia, contributing to brain swelling and the eventual poor outcome.

Conclusions

11.11 The expert evidence therefore establishes that even if medical treatment or intervention had occurred prior to 11:00am on 24 September 2015, and accepting the general proposition that the earlier the intervention the better the prospects of an improved outcome, it is unlikely that this would have altered the subsequent course of events. This in turn means that it is most likely that the absence of any action overnight on 23/24 September 2015 to seek medical assistance or intervention did not substantially or significantly contribute to Gwenith's death.

11.12 Again, it should be noted that consideration of the possibility of such action being taken assumes that Gwenith lacked capacity to do so herself, or to request that such action be taken, and that this is an issue that is not without some doubt. This is because of the absence of a reliable body of evidence from which an accurate chronology of events overnight on 23/24 September 2015 can be drawn. In essence, the only evidence as to this period of time comes from the account of Mr MHJ which has already been identified as inconsistent, untested and potentially self-serving.

11.13 Having regard to the above matters, the available evidence does not demonstrate the manner of Gwenith's death to be as a result of homicide in the sense that inaction in seeking medical assistance substantially or significantly contributed to death. Rather, the manner of Gwenith's death can be described as the consequences of an accidental injury on 21 September 2015 which subsequently resulted, via a natural cause process, in haemorrhagic progression of the injury on 23/24 September 2015.

12. Findings

12.1 Before turning to the findings that I am required to make, I would like to acknowledge, and express my gratitude to Mr Jake Harris, Counsel Assisting, and his instructing solicitor, Ms Tracey Howe of the NSW Crown Solicitor's Office. I am extremely grateful for the sensitivity and empathy that they have shown throughout the course of this sad and troubling matter.

12.2 I also thank Detective Senior Constable Martin Wilson for his diligent efforts during the investigation into Gwenith's death and for compiling the initial comprehensive brief of evidence.

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

Identity

The person who died was Gwenith Elkington.

Date of death

Gwenith died on 25 September 2015.

Place of death

Gwenith died at Royal Prince Alfred Hospital, Camperdown NSW 2050.

Cause of death

The cause of Gwenith's death was acute cerebral bleed.

Manner of death

The acute cerebral bleed was a direct result of blunt trauma to the right occipital/parietal region of Gwenith's head as a consequence of an accidental fall on 21 September 2015 resulting in a contra coup haemorrhagic contusion to the opposite left frontal and temporal lobes of the left cerebral hemisphere. On the evening of 23 September 2015, or in the early hours of 24 September 2015, there was a late, major haemorrhagic progression of this contusion, potentiated by Gwenith's coagulopathy as a result of liver cirrhosis, and possibly also by atherosclerotic cerebrovascular disease. This haemorrhage, together with associated brain swelling, caused significant mass effect and shift of brain structures. The significance of these events on 23/24 September 2015, and the progression of Gwenith's initial injury, were not readily appreciated at the time resulting in medical assistance not being immediately sought, although it is most likely that such medical assistance would not have, tragically, materially altered the clinical outcome.

13. Epilogue

13.1 It is most distressing to know that Gwenith, with her limitless sense of adventure and a constant desire to experience all that life has to offer, lost her own life in such sudden and tragic circumstances. However, there is no doubt that Gwenith has left behind a legacy and a zeal for life that will continue to endure.

13.2 On behalf of the Coroners Court of NSW I extend my sincere and respectful condolences to Scott, the other members of Gwenith's family, and Gwenith's loved ones and friends for their painful and tragic loss.

13.3 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
28 September 2021
Coroners Court of New South Wales