STATE CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of Hilary GORDON-SQUIRE
Hearing Dates:	25 February 2025
Date of Findings:	30 July 2025
Place of Findings:	Coroner's Court of New South Wales at Lidcombe
Findings of:	Magistrate Joan Baptie, Deputy State Coroner
Catchwords:	CORONIAL LAW – Unascertained death
File Number:	2020/00327476
Representation:	Mr D Welsh, Coronial Advocate Assisting the Coroner
Findings	The deceased person was Mr Hilary Gordon-Squire

He died on 16 November 2020

The place of his death was 7/15 Wylde Street, Potts Point

The cause of his death was pneumonia, due to chronic lung disease with atherosclerotic cardiovascular disease as a contributing factor

The manner of his death was misadventure (drug toxicity impacting underlying natural causes).

Section 81(1) of the Coroners Act 2009 (NSW) 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 Mr Gordon-Squire.

Introduction

1.1 This inquest concerns the death of Mr Hilary Gordon-Squire.

1.2 Mr Gordon-Squire was born on 25 June 1955. At the time of his death, he was 65 years of age. Mr Gordon-Squire was located at his home on 16 November 2020. He resided in an apartment complex at 15 Wylde Street, Potts Point. He had resided in his apartment for around twenty years.

1.3 The identity of Mr Gordon-Squire and the location of his death are not in dispute. This inquest has focused on the manner and cause of his death, together with the date of his death.

2. **The legislative requirement for an Inquest**

2.1 A coroner is required to investigate all reportable deaths and to make findings as to the person's identity, as well as when and where the person died. A coroner is also required to identify the manner and cause of the person's death. In addition, a coroner may make recommendations, based on the evidence deduced during the inquest, which may improve public health and safety.

2.2 In Mr Gordon-Squire's case, an inquest was considered to be mandatory, pursuant to section 27 (1) (d) of the *Coroners Act* NSW 2009, where "it appears to the coroner concerned that the manner and cause of the person's death have not been sufficiently disclosed."

2.3 During these proceedings, evidence was received in the form of statements and other documentation, tendered in Court, and admitted into evidence. In addition, oral evidence was received from the officer in charge of the investigation, Senior Constable Cameron Schulte, as well as expert evidence from the forensic pathologist, Dr Rebecca Irvine.

2.4 All the material placed before the Court has been thoroughly reviewed and considered.

3. **Mr Gordon-Squire's life**

3.1 Mr Gordon-Squire resided independently.

3.2 He had been married but subsequently divorced some time ago. He had no known dependents.

3.3 He was known to be a private person, although he had a close friendship with a former school friend, Mr Segall and a workmate, Mr Basevski.

3.4 Mr Gordon-Squire had been employed at Bayside Council as a traffic controller and mechanical sweeper operator until shortly before his death, due to his declining health.

3.5 He had a medical history which was significant for chronic lung disease, attributable to his lengthy and chronic history of cigarette smoking. He is reported to have smoked 20 – 30 cigarettes per day, with another report indicating that he would consume approximately 50 packets per year.

3.6 He was also reported to have experienced frequent bouts of depression, however, he did not seek any medical assistance or treatment.

3.7 Mr Gordon-Squire was described as a highly ethical man. He was an avid reader, with a keen interest in history and biographies. His greatest pleasure in life was reading. He had been a member of the Sydney Council Public Library and the NSW State Library for 30 years.

4. **Mr Gordon-Squire's medical history**

4.1 Mr Gordon-Squire attended the Darlinghurst Medical Centre for his primary care. In 2020, he is documented as having attended the practice on four occasions.

4.2 On 2 February and 27 April 2020, he attended the practice, complaining of respiratory issues. He advised the doctor that he was smoking two cigarettes a day. He was prescribed medication on these occasions.

4.3 He also attended on 4 June 2020, reporting shortness of breath in the mornings whilst at work.

4.4 On 13 September 2020, he attended the practice and was prescribed Champix and complained of some sleep disturbance.

5. **Admission to St Vincent's Hospital**

5.1 On 5 April 2020, Mr Gordon-Squire was brought in by ambulance and admitted to St Vincent's Hospital complaining of worsening breathlessness and chest tightness, orthopnoea and paroxysmal nocturnal dyspnoea since 30 March 2020. It was also noted that he was suffering from hypertension, chronic sinusitis and allergic rhinitis.

5.2 On presentation, he was noted to be tachycardic and hypertensive.

5.3 He was diagnosed with a likely viral exacerbation of chronic obstructive pulmonary disease (COPD)/Asthma.

5.4 He was discharged from hospital on 8 April 2020.

5.5 The hospital records note that he also presented to the Emergency Department on 3 April 2020, however, self-discharged the same day.

5.6 His medical records disclosed an extensive history of asthma related health problems with likely COPD due to his smoking history. He was also noted to be suffering from hypertension, chronic sinusitis and allergic rhinitis. He was regularly prescribed aspirin, Atrovent and salbutamol.

6. **Events on 16 November 2020**

6.1 On 7 November 2020, Mr Gordon-Squire and Mr Segall met for dinner at Mumma's Pizza in Darlinghurst. Mr Gordon-Squire's demeanour at dinner did not give Mr Segall any cause for concern. The two men would usually speak on a daily basis.

6.2 13 November 2020, Mr Gordon-Squire returned a set of keys to Mr Segall, together with a note which stated, “Thank you dear, but I shall not be using them any longer.”

6.3 Mr Segall began calling Mr Gordon-Squire repeatedly on his mobile phone, and also attended at his apartment complex, and attempted to gain access by buzzing the apartment intercom, without success. He also noted that Mr Gordon-Squire’s vehicle was still located in the same position it had been on 13 November 2020 and the apartment blinds had been closed for the last three days.

6.4 On 16 November 2020, Mr Segall contacted police, indicating his concerns for his friend’s welfare.

6.5 At 6.35pm, Senior Constable Cameron Schulte and Constable Joshua Jeffery attended at the apartment complex and were admitted to the building by one of the neighbours. They knocked on the door of Mr Gordon-Squire’s apartment and after receiving no response, they entered the apartment through an unlocked front door.

6.6 The police located him in the living room, sitting upright on a couch, with his head slumped to the right and down onto his chest. The police could hear him “making short, shallow, laboured breathing”, however he was unresponsive. The police moved him onto the floor where he regurgitated fluid. Constable Jeffery cleared his airway and again checked his breathing. By this time, Mr Gordon-Squire was not breathing and the police commenced CPR until the arrival of paramedics.

6.7 He was declared deceased at 7.21pm by attending paramedics.

6.8 Police noted that the apartment was very orderly. On the coffee table in front of him, there was a collection of items including a briefcase that set out his personal identification and banking details, together with directions for the return of property. His personal belongings were packed into boxes and large bags and were stacked together. The fridge was sealed with tape, with a sign directing that the fridge should be given to a particular person.

6.9 Police also located an advanced directive. They also located three inhalers with Atrovent and Symbicort medication, an empty Panafcort (prednisolone) container (25mg) prescribed to Mr Gordon-Squire in the kitchen garbage bin, paracetamol, ibuprofen and aspirin tablets and one unidentified inhaler.

6.10 Police did not locate any obvious poisons or toxins, although one container was labelled antifreeze. A ceramic cup had been placed in the wastepaper basket within the unit. This cup was not retained or forensically tested.

6.11 Police located his mobile phone; however, the contents were not forensically analysed, and the phone was returned to Mr Basevski, who disposed of the phone shortly afterwards.

6.12 In oral evidence, Senior Constable Schulte indicated that it was his "personal belief" that Mr Gordon-Squire had taken his life intentionally considering the arrangement of the room including obviously the items that he had listed to be provided to this person and that person, the next of kin et cetera. It didn't appear that that arrangement was accidental".

7. **Dr Irvine– expert opinion on cause of death**

7.1 Dr Rebecca Irvine, Senior Staff Specialist Forensic Pathologist, performed an autopsy on 24 November 2020. Dr Irvine prepared a postmortem report dated 23 June 2021 and gave oral evidence on 25 February 2025.

7.2 Dr Irvine confirmed in her report that the examination "revealed an older man with no significant injury. The lungs were congested, particularly the right; this is a non-specific postmortem finding. The deceased had at least moderate chronic lung disease. There was significant narrowing of two of the main coronary arteries which supply the heart muscle with blood and oxygen. The liver showed some fatty change, and there appeared to be some degree of fibrosis within the pancreas. There was, however, no gross acute lesion which could explain his death."

7.3 Dr Irvine referred to the biochemical examination that she had conducted which "showed a significant decomposition pattern, so results should be interpreted with caution". Dr Irvine noted that "within that limitation, there was no evidence of significantly increased blood glucose around the time of death, or derangement of sodium metabolism. Renal function studies (creatinine and urea) were significantly increased; this is indicative of renal failure, but it is unclear if this is acute, chronic or acute-on-chronic."

7.4 Dr Irvine explained that Mr Gordon-Squire "had moderate to severe chronic lung disease and the coronary artery disease. On further testing he had quite significant renal damage and on examination of tissue from his liver he had what we call central lobular necrosis. Most commonly these are findings associated with a low flow state or shock for some period of time. He also had extensive pneumonia which in this circumstance is most typical of aspiration due to decreased mental status over a period of time. Basically it appeared that this man had lingered for some time, hours to days".

7.5 In her report, Dr Irvine indicated that she was able to rule out the use of the ingestion of antifreeze and organophosphate poisoning, as well as the ingestion of a corrosive substance. Dr Irvine also commented that the ingestion of sodium nitrate was also unlikely, "although the methaemoglobin is somewhat high, postmortem analysis is not reliable for this, and there were no other findings at the scene or on the body to suggest that it was used."

7.6 Dr Irvine explained in her report that the "toxicological examination showed only two forms of benzodiazepines and doxylamine; the latter is also used as an anti-emetic medication, and is commonly taken with lethal ingestions for that reason. Even assuming these drugs were present in a much higher concentration during the hours prior to death, benzodiazepines on their own are not often the cause of fatal toxicity."

7.7 Dr Irvine continued to explain in her oral evidence that on the "toxicological examination he only showed low levels of two types of benzodiazepines and this is a class of drug associated with promotion of sleep or relief of anxiety and, as I said, he also had the medication that's often used to prevent vomiting. I checked what we call his cholinesterase activity to ensure that he had not taken any type of herbicide or pesticide and that was normal so that doesn't seem to be a possibility. Interestingly, I checked his methaemoglobin which is an indirect measurement that may suggest the use of sodium nitrate, which is a food preservative which is quite toxic, and which is currently promoted online for self-deliverance. It's widely available from organisations for that purpose but it's also used as food preparation and can be bought without any sort of restriction. His methaemoglobin level was 10% so he definitely had methemoglobinemia which is when his haemoglobin becomes blocked and unable to deliver oxygen to the tissues; this is similar to carbon monoxide". Dr Irvine noted that it was not at a toxic level.

7.8 Dr Irvine noted that there are a significant number of poisons, toxins, illicit and prescribed medicines which are not detected with standard toxicological testing. Dr Irvine gave oral evidence that she had also considered "mushroom toxicity because the changes in his liver and kidney are associated with that type of poisoning and they take a period of time to develop. People don't die immediately because of poison mushroom ingestion. As I said previously, though those changes in the liver and the kidney may be simply due to him dying over a period of time."

7.9 In her report, Dr Irvine stated, "To complicate the situation further, it is possible that the deceased's death was completely natural (albeit coincidental), or that he was particularly sensitive to the respiratory

depressive effects of the benzodiazepines because of his severe underlying lung disease".

7.10 Dr Irvine gave oral evidence, stating that there are two possible causes of his death. The first possible cause of his death was "pneumonia, due to chronic lung disease, with atherosclerotic cardiovascular disease as a contributing condition. The second possibility on the available evidence would be the deliberate ingestion of two types of benzodiazepines, which in combination would enhance the sedating effects, and although the levels were very low on testing, they almost certainly would have been much higher in the preceding hours or days. In addition, it is possible that he was "quite susceptible to these effects because of his underlying lung disease."

7.11 Later in her evidence, Dr Irvine returned to the issue of the possible ingestion of sodium nitrate and noted that there "are reported cases of people surviving, although that's usually with medical support, but there's two things that bother me about this being sodium nitrate and one is that he is a man with underlying comorbidities and he lived for, as we said, hours to days so he must have taken a small amount which is unusual because it's quite available." Dr Irvine continued "it's not a rare substance, it's not a hard-to-get medication so I'd be very surprised if he only took a small amount and then discarded the rest. The other thing that gives me pause is that he certainly didn't conceal the fact that this may have been an attempt to self-harm. I mean he packed up all his belongings for heavens sakes so why would he be so meticulous to either conceal the fact that the purchased sodium nitrate or to dispose of the container. So if it wasn't for that I might be more inclined to favour sodium nitrate."

8. **Considerations as to Time of Death**

8.1 Senior Constable Schulte and Constable Jeffery were able to confirm that Mr Gordon-Squire was still breathing when they first located him in his apartment. It would appear that he stopped breathing shortly afterwards and was declared deceased a short time later by attending paramedics.

9. **Considerations as to the Cause of Death**

9.1 The evidence confirms that Mr Gordon-Squire had a number of severe medical conditions, including chronic lung disease.

9.2 His apartment appeared to have been carefully curated to assist with the disposal of his personal effects in the event of his death. Unfortunately, his mobile phone was not interrogated and there is therefore no available evidence to suggest his motivation to self-harm.

9.3 Similarly, there is no evidence which confirms that he had accessed any substance which may have caused his death. A ceramic mug was located in a wastepaper bin but was not retained for testing. It was Dr Irvine's opinion that this cup should have been tested for the presence of sodium nitrate.

9.4 The evidence indicates that Mr Gordon-Squire had been immobilised for some hours or days prior to his discovery by police.

9.5 Dr Irvine opined that "the circumstances are strongly suggestive of a toxic ingestion, likely with a survival period of several hours during which the deceased developed pneumonia, an acute kidney injury, and shock liver."

9.6 Dr Irvine noted that she could not discount that possibility that Mr Gordon-Squire's death was "completely natural (albeit coincidental), or that he was particularly sensitive to the respiratory depressive effects of the benzodiazepines because of his severe underlying lung disease."

9.7 Dr Irvine considered at length the possible ingestion of sodium nitrate, given the raised levels of methaemoglobin, however, raised her concern that the amount of sodium nitrate that he potentially consumed was small. In addition, the scene at his apartment did not disclose the presence of additional sodium nitrate. Dr Irvine commented that given the rest of the scene, it would seem improbable that he had attempted to conceal his use of sodium nitrate.

9.8 Dr Irvine commented that the combined effects of ingesting two different types of benzodiazepine in association with his severe underlying lung disease may have had resulted in an adverse impact on him.

9.9 I am required to be satisfied on the balance of probabilities that the cause of Mr Gordon-Squire has been established on the available evidence. Although the scene of his death appeared to be consistent with a person contemplating self-harm, I cannot discount that his death was the result of

an exacerbation of his underlying natural disease, caused by the ingestion of the two types of benzodiazepines.

10. **Consideration as to the manner of death**

10.1 In relation to the manner of Mr Gordon-Squire's death, I note that the evidence suggests that he was contemplating self-harm prior to the attendance of the police on 16 November 2020.

10.2 In *R v London Coroner; Ex parte Barber* [1975] 1 WLR 1310 at 1313, Lord Widgery CJ said: [P]erhaps one of the most important rules that coroners should bear in mind…[is] that suicide must never be presumed. If a person dies a violent death, the possibility of suicide may be there for all to see, but it must not be presumed merely because it seems on the face of it to be a likely explanation. Suicide must be proved by the evidence, and if it is not proved by evidence, it is the duty of the coroner not to find suicide, but to find an open verdict…".

10.3 In my view, it is sufficient and appropriate in the discharge of my statutory function pursuant to the Act to find that Mr Gordon-Squire's death was as a result of an attempt to end his life by taking prescription medication, however, this resulted in exacerbating his underlying severe health issues. The manner of his death will be recorded as the deliberate ingestion of substances which caused the exacerbation of natural disease.

11. **Acknowledgements**

11.1 I would like to thank Mr Welsh, Coronial Advocate, for his assistance in preparing and presenting this matter.

12. **FINDINGS**

I make the following findings pursuant to section 81 of the *Coroners* Act 2009 (NSW):

The identity of the deceased

The deceased person was Hilary Gordon-Squire

Date of Death

On 16 November 2020

Place of Death

7/15 Wylde Street, Potts Point

Cause of Death

Pneumonia, due to chronic lung disease with atherosclerotic cardiovascular disease as a contributing factor

Manner of Death

Misadventure (drug toxicity impacting underlying natural causes)

I now close this inquest

Magistrate Joan Baptie

Deputy State Coroner

30 July 2025

Coroners Court of New South Wales