JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	SARAH HELEN LINTON, ACTING STATE CORONER
HEARD	**:**	30 JUNE 2025
DELIVERED	**:**	17 DECEMBER 2025
FILE NO/S	**:**	CORC 2033 of 2022
DECEASED	**:**	GILMORE, TERRANCE PATRICK

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Mr D McDonald assisted the Coroner

Mr C Beetham appeared for St John of God Health Care

Ms K Niclair and Dr A J Steinepreis for the Department of Justice, South Metropolitan Health Service and WA Country Health Service

Case(s) referred to in decision(s):

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Sarah Helen Linton, Acting State Coroner, having investigated the death of ***Terrance Patrick GILMORE*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on 30 June 2025, find that the identity of the deceased person was* ***Terrance Patrick GILMORE*** *and that death occurred on 27 July 2022 at Fiona Stanley Hospital, 102-118 Murdoch Drive, Murdoch, from complications, including infective endocarditis, acute renal failure and pancreatitis, with terminal palliative care, of staphylococcus aureus septicaemia in an elderly man with multiple medical comorbidities in the following circumstances:*

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INTRODUCTION

1. Terrance Gilmore was a 76 year old man who died on 27 July 2022 at Fiona Stanley Hospital from complications of staphylococcus aureus septicaemia, bacterial endocarditis and kidney failure.

2. Mr Gilmore was a serving prisoner at the time of his death, so he came within the definition of a 'person held in care' under the *Coroners Act 1996* (WA) and a coronial inquest into his death was, therefore, mandatory. I held an inquest on 30 June 2025. Following this inquest, I am required to comment on the quality of Mr Gilmore's treatment, supervision and care while in custody prior to his death.[1]

3. An independent medical review of Mr Gilmore's medical care raised some concerns about his early medical care in Bunbury, prior to being transferred to Fiona Stanley Hospital in Perth. No concerns were raised about his medical care once he was transferred to Perth. Accordingly, the primary focus of the inquest was Mr Gilmore's early medical care to consider whether earlier intervention could have potentially altered the rapid progression of Mr Gilmore's decline.

BRIEF BACKGROUND

4. Mr Gilmore was born on 1 September 1945 in Sydney, New South Wales. He later lived in Queensland before moving to Western Australia, where he lived in Rockingham. Although married three times, he had no biological children. He did have stepchildren. Mr Gilmore had no formal qualifications. He worked in various roles, including as a storeman, crane driver and underground miner before he stopped working in 2000 due to health issues. He received a disability support pension and then later the aged care pension after he turned 65 years old in 2010.[2]

5. On 20 August 2020, Mr Gilmore was charged with multiple sexual offences involving children. He was remanded in custody at Hakea Prison. At that time, he was 74 years old. During his admission assessment, Mr Gilmore disclosed a number of pre-existing medical conditions, including Type 2 diabetes mellitus, hypertension, kidney stones, arthritis and mobility issues associated with his left leg. He did not report any history of significant heart problems. Mr Gilmore disclosed a self-harm attempt using his insulin medication some six weeks prior. He had been hospitalised but recovered with treatment. He had also reportedly made threats to harm himself to the police, prior to arriving at the prison. As a result of the self-harm disclosure, he was initially placed in the prison's Crisis Care Unit for observation due to his possible risk to himself.[3]

6. After being closely monitored for a couple of days, Mr Gilmore's risk to himself was considered to have reduced sufficiently for him to move into the general population.[4]

[1] Sections 22(1)(a) and 25(3) *Coroners Act 1996* (WA).
[2] Exhibit 1, Tab 9, DIC Review Report.
[3] Exhibit 1, Tab 9, DIC Review Report and Tab 15.
[4] Exhibit 1, Tab 9, DIC Review Report.

7. On 27 July 2021, Mr Gilmore was convicted in the District Court of Western Australia of a number of offences. He was sentenced to a term of four years and six months' immediate imprisonment. His earliest eligibility date to be released on parole was 19 February 2023, taking into account time on remand. He initially returned to Hakea Prison to commence serving his sentence. Then, on 23 December 2021, he was transferred to Bunbury Regional Prison where he remained until just prior to his death.[5]

MEDICAL HISTORY

8. During his time in prison, Mr Gilmore was noted to be respectful towards prison staff and cooperative with health staff. He was diligent in attending medical appointments and was generally compliant with his recommended treatment, although he was noted to exhibit some resistance to using a walking frame for support (which was recommended) as he preferred the convenience of using a walking stick.

9. Noting Mr Gilmore was an older man at the time of his admission to prison, his medical history recorded he had a number of medical conditions:[6]

- Type 2 diabetes mellitus,
- Hypertension (high blood pressure),
- Anxiety with depression,
- Vitamin D and iron deficiency,
- Arthritis,
- Enlarged prostate,
- Previous Bilateral total hip replacement,
- Urolithiasis (kidney stones), and
- Vertigo.

10. Mr Gilmore was on a large number of regular medications to manage his conditions. He was recorded as an ex-smoker and had no history of illicit drug use, so he did not require any intervention in these areas.[7]

11. Mr Gilmore's diabetes was initially found to be poorly controlled, so he was placed on a Diabetes Care Plan and underwent regular health reviews with the prison nurse. He had a persistently raised albumin creatinine ratio, suggestive of kidney disease.[8]

12. Mr Gilmore was reviewed by allied health professionals, including being seen in 2020 and 2021 by a podiatrist and optometrist for routine diabetic foot and eye care, a physiotherapist given his history of falls and he also saw a dentist for routine checks.[9]

[5] Exhibit 1, Tab 9, DIC Review Report and Tabs 9.5 and 9.6.
[6] Exhibit 1, Tab 9, DIC Review Report and Tab 15.
[7] Exhibit 1, Tab 9, DIC Review Report and Tab 15.
[8] Exhibit 1, Tab 9, DIC Review Report and Tab 15.
[9] Exhibit 1, Tab 9, DIC Review Report and Tab 15.

13. During January 2022, Mr Gilmore attended the Bunbury Prison medical centre with minor issues including hypertension, raised glucose levels and an episode of dizziness. His blood pressure medications were increased and he was prescribed another medication to help manage his dizziness. Due to some of his blood test results, he was also referred for bowel cancer screening and to see a general surgeon who booked a gastroscopy and colonoscopy.[10]

14. Mr Gilmore's diabetes control remained suboptimal and he was commenced on Ozempic (semaglutide) for a period.[11]

15. Between 16 May 2022 and 28 June 2022 Mr Gilmore had a number of biopsies for skin lesions, which led to a squamous cell cancer being removed on 30 May 2022.[12]

16. On 31 May 2022 it was noted that Mr Gilmore had undergone a recent gastroscopy and colonoscopy to investigate his iron deficiency anaemia. It had shown mild gastritis but was otherwise normal.[13]

17. Records suggest Mr Gilmore was seen by a dentist three times while in custody, with the last time being for a routine check-up in November 2021 while still at Hakea Prison. It does not appear he was seen by a dentist again after transferring to Bunbury, although he did continue to have regular nursing and medical reviews and he was seen by a podiatrist in Bunbury. The dental review is relevant as it appears likely Mr Gilmore later developed sepsis on a background of a dental abscess, although he doesn't appear to have been complaining of dental pain in the lead up to his hospital admission.[14]

ADMISSION TO HOSPITAL IN BUNBURY

18. At 10.00 am on the morning of 29 June 2022 Mr Gilmore self-presented to the prison health centre. He complained of nausea and bile-stained vomiting since 2.00am. His observations were taken by a clinical nurse and noted to be stable. Mr Gilmore was given an anti-nausea medication, metoclopramide, and advised to return to his cell and rest, and to sip clear fluids as tolerated, given his recent vomiting. At 2.25 pm he was seen again by a nurse. He was still complaining of vomiting but on assessment he had no abdominal pain or tenderness. His nausea had resolved a little after taking the metoclopramide but he said he had been unable to eat or drink since breakfast. He denied chest pain but was feeling dizzy. Mr Gilmore's blood pressure was noted to be raised and his glucose level was high, so an e-consult with the prison doctor was requested.[15]

19. Shortly after, the nurse consulted a prison doctor via email for guidance. The doctor made a plan for Mr Gilmore to have BP checks, bloods and an ECG.[16]

[10] Exhibit 1, Tab 9, DIC Review Report and Tab 15.
[11] Exhibit 1, Tab 15.
[12] Exhibit 1, Tab 9, DIC Review Report.
[13] Exhibit 1, Tab 15.
[14] Exhibit 1, Tab 15.
[15] Exhibit 1, Tab 15.
[16] T 13 – 14; Exhibit 1, Tab 15.

20. The next day, being 30 June 2022, Mr Gilmore was reviewed by another prison doctor. The doctor documented Mr Gilmore had a one-day history of nausea/vomiting and dizziness on a background of a similar episode in January. He appeared tired and had an elevated temperature, high blood pressure and high glucose. Urinalysis showed glucose, protein, blood and a trace of ketones. A RAT test was negative. The doctor was concerned Mr Gilmore had an underlying infection and advised transfer to Bunbury Hospital Emergency Department.[17]

21. Mr Gilmore was transferred to Bunbury Hospital by ambulance at approximately 11.30 am that morning. In the Department of Justice's review into Mr Gilmore's death, it was identified that Mr Gilmore was not fitted with restraints on leaving the prison, but he was later restrained after the security was handed over to an external contractor, and he remained restrained until 4 July 2022, which the Department acknowledged was a breach of their policy and procedure. Mr Gilmore should not have been restrained given his significant medical/mobility issues. An External Movement Risk Assessment completed by prison staff had indicated there was no requirement for Mr Gilmore to be restrained but the restraints had been sent along with him, as was standard, and the external provider conducted its own risk assessment as part of their hospital security duties and added the restraints.[18]

22. It was noted that on 19 December 2023, after Mr Gilmore's death, changes were made to the procedures to clarify the position in relation to seriously/terminally ill prisoners and confirm with the security provider that restraints should not be applied unless an individual risk assessment determines otherwise and to ensure they have sufficient information to make an informed risk assessment. Amendments were also made to other documentation to ensure that prison officers are prompted to consider critical factors and ensure that the process is followed.[19]

INITIAL TREATMENT IN BUNBURY

23. Mr Gilmore was seen in the Emergency Department at Bunbury Hospital. He was noted to have symptoms of fever and vomiting on the background of longstanding dental pain that had been increasing over the previous weeks.[20]

24. While still at Bunbury Hospital, Mr Gilmore was noted to have a wide QRS complex with widespread ST elevation and an initial transient complete heart block, which was likely related to his infection although the infection was still to be identified. He underwent a CT scan of his chest, abdomen and pelvis on 30 June 2022, which showed pericardial effusion suggestive of pericarditis, small left basal lung atelectasis and left-sided pleural effusion. He was initially diagnosed with myopericarditis.[21]

[17] T 14 – 15; Exhibit 1, Tab 15.
[18] T 7 – 8; Exhibit 1, Tab 9 and Tab 16.
[19] Exhibit 1, Tab 9, DIC Review Report, p. 18.
[20] Exhibit 2.
[21] T 20; Exhibit 2.

25. Mr Gilmore was moved to St John of God Hospital (Bunbury) so he could receive cardiology care in the Coronary Care Unit. Mr Gilmore was in SJOGH (Bunbury) from 1 July 2022 to 4 July 2022. Mr Gilmore presented with acute kidney injury. Subsequently, his kidney function continued to decline.[22]

26. On 1 July 2022 it was recorded that his blood cultures had returned positive for Staphylococcus aureus, so he was commenced on an intravenous antibiotics. There is a high mortality rate associated with staphylococcal septicaemia. Unfortunately, Mr Gilmore's condition continued to deteriorate, with worsening renal impairment. Due to his failure to improve on appropriate therapy, a decision was made to transfer him to Fiona Stanley Hospital in Perth. He was transferred on 4 July 2022.[23]

TRANSFER TO FIONA STANLEY HOSPITAL

27. Mr Gilmore was admitted to the Coronary Care Unit (CCU) at Fiona Stanley Hospital (FSH). On admission Mr Gilmore's differential diagnosis included endocarditis/aortic root abscess. It was also noted that he had persistent complete heart block since 3 July 2022, pericardial effusion, oliguric acute kidney impairment, associated confusion and delirium and his blood sugar levels were labile. He reported poor vision, with intermittent double vision.[24]

28. On 4 July 2022 Mr Gilmore was listed as Stage Three terminally ill (likely to die within three months) on the Department's TOMS Terminally Ill Module. Following a risk assessment, all of Mr Gilmore's restraints were removed. The next day Mr Gilmore was escalated to Stage Four terminally ill (death is imminent) after a prison doctor spoke to a nurse at FSH, who indicated that whilst Mr Gilmore was stable, he had staphylococcus bacteraemia and acute renal failure and there was a risk of rapid deterioration. It was suspected that the cause of the infection was potentially a dental abscess. He was admitted to the Intensive Care Unit for ongoing care and dialysis.[25]

29. In the CCU on 4 July 2022, it was noted Mr Gilmore had reduced urine output, generalised limb weakness and was experiencing hallucinations. A transthoracic echocardiogram showed likely mitral valve endocarditis (caused by the staph aureus infection) along with severe mitral annular calcification and aortic calcification, which was deemed most likely inoperable as he wouldn't survive the operation. There was also pericardial effusion.[26]

30. Mr Gilmore's case was discussed with Cardiothoracic Surgeon Mr Labalestier and Mr Gilmore underwent insertion of a pericardial drain on 6 July 2022. He was subsequently admitted to the Intensive Care Unit (ICU). Staphylococcus aureus was cultured from the tissue. His intravenous antibiotic was changed due to the acute kidney failure, with input from the Infectious Diseases Team. There was concern his

[22] Exhibit 1, Tab 15; Exhibit 2; Exhibit 3.
[23] Exhibit 2.
[24] Exhibit 2.
[25] Exhibit 1, Tab 9, DIC Review Report.
[26] T 22; Exhibit 2.

Staphylococcus infection had spread, as he complained of back and bilateral hip pain, so a full body scan was recommended to see if he there was spinal infection. He later underwent scans on 20 and 22 July 2022, which were equivocal for infection in the hip.[27]

31. On 11 July 2022 the Department's Sentence Management Division submitted a Briefing Note to the Minister for Corrective Services in relation to Mr Gilmore's status as a terminally ill prisoner, prompting consideration of the Royal Prerogative of Mercy (RPOM). The recommendation to the Minister was that Mr Gilmore should not be released on the RPOM due to his outstanding treatment needs and lack of community support.[28]

32. On 12 July 2022 Mr Gilmore had a pacemaker inserted for his complete heart block and he was discharged from the ICU back to the CCU on 16 July 2022.[29]

33. By 18 July 2022 Mr Gilmore's condition had stabilised, his renal function had improved and he no longer required dialysis. He left the ICU and returned to the Critical Care Unit. Mr Gilmore was de-escalated to Stage Three terminally ill on the TOMS Terminally Ill Module but it was noted he was still unwell and would not be suitable for discharge back to prison for some time.[30]

34. Mr Gilmore suffered acute abdominal pain on 21 July 2022, which led to a diagnosis of acute pancreatitis. He also had ongoing deterioration in renal function and his delirium worsened. Mr Gilmore had undergone some haemodialysis and it was felt that he required more, but he had a poor overall clinical trajectory given his other complications. The Cardiothoracic Team felt that his cardiac disease was inoperable and his delirium and agitation continued to worsen but there were limits to the investigations that could be done to investigate the cause, given his poor health.[31]

35. However, on 25 July 2022, Mr Gilmore's circumstances changed again as he was diagnosed with an infected heart valve and he was assessed as an unsuitable candidate for a valve replacement. The palliative care team were engaged as it was estimated Mr Gilmore only had a few days left to live. Mr Gilmore's wife was advised of his poor prognosis that same day and she indicated she would come in to visit him. He was moved back to Stage 4 on the TOMS register.[32]

36. Mr Gilmore was managed on the cardiology ward on 26 and 27 July 2022, where he received palliative care for sepsis with multiorgan failure.[33]

37. Mr Gilmore was being guarded by Ventia security officers and at 6.20 pm they noticed that his breathing was slowing. Health staff were notified and a doctor came in and assessed Mr Gilmore. The doctor confirmed Mr Gilmore's death at 6.30 pm

[27] Exhibit 2.
[28] Exhibit 1, Tab 9, DIC Review Report.
[29] Exhibit 2.
[30] Exhibit 1, Tab 9, DIC Review Report.
[31] Exhibit 2.
[32] Exhibit 1, Tab 9, DIC Review Report.
[33] Exhibit 1, Tab 9, DIC Review Report.

and WA Police were notified of the death. Police officers attended later that evening to commence the mandatory coronial investigation into Mr Gilmore's death.[34]

CAUSE AND MANNER OF DEATH

38. A postmortem examination was conducted at the State Mortuary and on 29 December 2022, the forensic pathologist, Dr Daniel Moss, expressed the opinion that the cause of Mr Gilmore's death was complications, including infective endocarditis, acute renal failure and pancreatitis, with terminal palliative care, of Staphylococcus Aureus septicaemia in an elderly man with multiple medical comorbidities. After reviewing toxicology analysis results, Dr Moss also expressed the opinion the death was due to natural causes.[35]

39. I accept and adopt the opinion of Dr Moss as to the cause and manner of death.

TREATMENT, SUPERVISION AND CARE

40. Given the circumstances of his death, the primary focus of the inquest was the quality of the medical treatment and care provided to Mr Gilmore prior to his death. I consider it relevant to consider his care in the months or years leading up to his hospital admission, and as I have set out above, it is apparent that his health care during that time was diligent and attentive, including specialist and allied health care input as well as regular nursing reviews and medical reviews as needed by prison health staff. An internal review of the health services provided to Mr Gilmore identified that there were some potential improvements that could be made to health monitoring for other prisoners with some of Mr Gilmore's chronic health issues, but none of these appear to have been related to his death. His health management was at least commensurate with what Mr Gilmore would likely have been able to access in the community, if not potentially higher in the last six months of his incarceration while in Bunbury Prison.[36]

41. In a report provided by a Consultant Cardiologist from FSH who was involved in Mr Gilmore's care, it was identified that Mr Gilmore had sepsis, infective endocarditis, acute renal failure and multiple organ dysfunction and he had not been considered a suitable candidate for cardiac surgery. He deteriorated further, despite optimal care, and given his poor prognosis a decision had been made to institute palliative care, which had been provided until he passed away peacefully. No concerns have been raised in the evidence in relation to the medical care provided to Mr Gilmore at FSH.[37]

42. An independent medical expert, Renal Physician and General Physician Professor Neil Boudville, did, however, raise some concerns in relation to Mr Gilmore's medical management at SJOGH, prior to his transfer to FSH. The concerns related

[34] Exhibit 1, Tab 9, DIC Review Report.
[35] Exhibit 1, Tab 5 and Tab 6.
[36] Exhibit 1, Tab 15.
[37] Exhibit 2.

particularly to Mr Gilmore's fluid management and how it may have been connected with his renal issues. These concerns were explored at the inquest, during which proceedings SJOGH was represented by counsel.

43. In his report provided to the Court, Prof Boudville noted that the decision of fluid replacement for patients is often based primarily on clinical examination (including observations such as blood pressure and heart rate) in addition to kidney function blood test results. This is also combined with a review of the urine output for the patient, changes in their daily weight and their fluid balance (that is the amount of fluid given orally/intravenously versus the amount that is removed, primarily through urine output). Mr Gilmore showed worsening renal function from 1 July to 3 July 2022 and after reviewing the medical records, Prof Boudville considered his acute kidney injury was primarily driven by intravascular depletion and infective endocarditis. Mr Gilmore did receive some intravenous resuscitation over his four day admission at SJOGH, as well as a small amount before he was transferred from Bunbury Hospital, but it was likely not enough to bring Mr Gilmore into a euvolemic state and therefore may have contributed to his acute kidney injury. Prof Boudville calculated that Mr Gilmore was provided with approximately 5.7 litres of fluid at SJOGH and in his expert opinion Mr Gilmore probably required around twice that amount, most likely intravenously.[38]

44. In Prof Boudville's opinion, Mr Gilmore had a severe acute kidney injury, "almost as bad as you can get,"[39] by the time he was transferred to FSH and his mortality rate would have been extremely high at that time.

45. Prof Boudville acknowledged that it is difficult to know if improved fluid management would have changed the outcome, as Mr Gilmore was clearly very unwell with his bacteraemia and infective endocarditis, and was being exposed to other nephrotoxic agents (such as ibuprofen, the antibiotic vancomycin and an intravenous contrast for a CT scan) that can potentially damage the kidneys, as part of his treatment for his other serious medical issues. The fact he was sick enough to get acute kidney injury formed part of the context of his presentation to SJOGH, although in Prof Boudville's opinion his mortality risk rate would have been higher by the time he left given the severity of his kidney injury by that time.[40]

46. In his evidence at the inquest, Prof Boudville confirmed that it was hard for him to predict if better fluid management, and hence a less severe kidney injury, would have made any difference to the outcome for Mr Gilmore because he was very sick due to his septicaemia. He also noted that Mr Gilmore received dialysis at FSH, which appeared to resolve the kidney issue, but his heart issues were unable to be resolved and in his view the infective endocarditis was likely the most significant contributing factor to Mr Gilmore's death. [41]

47. As Dr Gunson, Deputy Director of Medical Services for the Department, observed, even without the development of acute kidney injury, Mr Gilmore was seriously

[38] T 31 – 32; Exhibit 1, Tab 11.
[39] T 33.
[40] T 26 – 33; Exhibit 1, Tab 11.
[41] T 36 - 37; Exhibit 1, Tab 11.

unwell due to a staphylococcal bacteraemia, which carries a high rate of mortality in its own right. With the development of infective endocarditis, this mortality rises further, and it was noted that in a patient such as Mr Gilmore, who was elderly and male with other co-morbidities, his risk of a poor outcome was higher still. His type 2 diabetes gave him an underlying vulnerability for renal dysfunction and sepsis, and although there were efforts made to manage his diabetes while he was in custody, Dr Gunson considered there were signs, in hindsight, that his renal function was perhaps abnormal prior to his hospital admission.[42]

48. Ultimately, I am satisfied that the care provided to Mr Gilmore was reasonable and appropriate. While a review showed more could have been done to manage some of his chronic health conditions while in custody, his management was at least commensurate with what he would have been able to obtain in the community. While his fluid management may not have been ideal for a period while in hospital in Bunbury, I do not consider there is evidence before me to conclude it directly impacted upon the outcome.

49. The Department's internal review found that Mr Gilmore's custodial management, supervision and care were generally in accordance with the Department's policy and procedures.[43] The issues of restraints was identified and I am satisfied that this was reflected upon and steps taken to make sure there is better communication with external security providers in the future, to avoid unnecessary use of restraints for ill prisoners.

50. At the conclusion of the inquest hearing, counsel for the Department expressed their condolences to Mr Gilmore's family on behalf of the Department, the WACHS and the South Metropolitan Health Service. It is apparent that there has been an appropriate level of reflection upon the care provided to Mr Gilmore while in custody, and there is no cause for me to make any recommendations in this case.

CONCLUSION

51. Mr Gilmore was an elderly man with a number of significant health issues when he came into prison for the first time at a later stage in his life. His health care was coordinated by the prison health staff, with appropriate input from external health providers, with a particular focus upon his diabetes and its complications. Mr Gilmore engaged willingly with his recommended treatment and generally seemed to be coping well until a second decline in his health in the middle of 2022.

52. Mr Gilmore was sent to Bunbury Hospital when it became apparent he might have an infection affecting his heart and possibly have suffered a heart attack. He was quickly admitted for intensive medical treatment. As part of an arrangement between Bunbury Hospital and SJOGH, which are co-located at the South-West Health Campus, Mr Gilmore was transferred to SJOGH so he could receive coronary care. There is evidence before me to indicate that while there was a focus upon his infection and its complications, including the cardiac implications, it seems

[42] T 9 - 11; Exhibit 1, Tab 15.
[43] Exhibit 1, Tab 9, DIC Review Report.

Mr Gilmore's need for aggressive fluid management was overlooked, resulting in a worsening of his already impaired kidney function.

53. After Mr Gilmore was transferred to FSH, he received appropriate treatment for his kidney injury by commencing dialysis, but he succumbed to his other serious health issues and died.

54. I am satisfied Mr Gilmore received a high standard of treatment, supervision and care while a prisoner at Hakea Prison and Bunbury Prison. After he was transferred to hospital, there were some issues with his restraints (although this was resolved before his death) and there were also some issues with his fluid management as part of his overall medical care, although this had no connection to his status as a prisoner.

55. Mr Gilmore had a number of significant co-morbidities, and I am satisfied that, in the end, he died as a result of natural causes due to complications from an infection on a background of these known health issues.

I certify that the preceding paragraph(s) comprise the reasons for decision of the Coroner's Court of Western Australia.

ACTING STATE CORONER S Linton

17 DECEMBER 2025