Judgment, findings and verdict in the Inquest touching upon the death of Gilbert Giles

This Inquest was formally opened and adjourned by my predecessor HM Coroner Trevaskis on 27th January 2011.

It was resumed by me on 5th June 2012 after a lengthy police investigation.

I repeat what I said a few days ago. It has been and is my duty to fully fairly and fearlessly examine the circumstances of the death of Gilbert Giles, to consider the evidence and record my findings (known as my verdict).

However this is not a trial. A Coroner's Inquest is inquisitorial in nature. Its purpose is not to apportion blame but to investigate and record facts in its duty to ascertain how the deceased came by his death.

The Rules are very specific as to what the task of the Coroner is.

As there is no jury in this case I am not required to sum up the case but I consider it appropriate that I should set out the evidence that I have considered in this case, my findings in respect of it and my reasons for such findings.

Rule 32 of the Coroner's Rules sets out what questions I must try to answer. They are:

Who the deceased was
How when and where the deceased came by his death
The particulars for the time being required to be registered concerning the death.

At the previous hearing before HM Coroner Trevaskis evidence was received and I have confirmed and do confirm that the deceased was Gilbert Giles.

He was born on 18th March 1947 in Aberdeen. He was therefore 63 at the time of his death. At the time of his death he was working as a General Farm Hand and lived at Chartres on West Falkland.

Having so I confirmed those matters I must now consider what answers are appropriate to the other questions. How, when and where did Mr Giles dies.

I have received a considerable amount of evidence in this case.

I have heard from, Lionel Hansen, Juan Hobman, Anthony Hirtle, Dr Rebecca Edwards, Jacqueline Allen, Alaistair Minto – who answered very few questions relying as he was entitled to do on his right not answer questions which might incriminate him. I have also heard from PC Moorhouse.

I have received documentary evidence in the way of statements from the following people

Marie-Paul Guillamot, Marilous Delignieres, Susan Hirtle, John Maskell-Bott, Sarah Maskell-Bott, Andrea Barlow exhibiting a signed note from Dr Diggle, Thomas Keenan, Benjamin Cockwell, Alaistair Marsh, Stuart Parratt, John Snow and the pathologist Dr John Clark, who reported following the post mortem examination which took place on 29th January 2011 at the KEMH in Stanley.

I have also received statements attaching exhibits, a map of the road prepared by Anthony Chaloner, photographs from PC McDade and Military Police Officer David Clare, hospital printouts relating to blood alcohol levels of Mr Giles and Mr Minto, and the interview held under caution with Mr Minto on 27th April 2011.

The documents were admitted following no objection having being raised from any of the interested persons.

I do not propose to rehearse all that has been said by every witness or what is said in every document. There have been some discrepancies between witnesses and some discrepancies as between what witnesses said in evidence and what they may have

said in earlier Police statements. We are now well over a year from the incident that took Mr Giles life and some discrepancies are to be expected.

From all this evidence I have come to a number of findings of fact and conclusions deriving therefrom

1. The deceased Gilbert Giles was as of 22nd January 2011 living at Chartres in West Falkland. He was friends with Alaistair Minto and had been for some years. At some point they left in a red Landrover F290C to go to Hill Cove – to, as Mr Minto said himself to "get more beer".
2. Mr Minto was to say in police interview that he had been drinking before leaving Chartres. He said he had a couple. I do not have evidence as to whether Mr Giles had been drinking at that stage.
3. However, by the time they arrived at Hill Cove store to be served by My Hansen I am satisfied that both had been drinking. Mr Hansen said that he was sure both had had a drink. Indeed after they had bought two cases of beer each they went to the Landrover and Mr Hansen said that he saw both of them drinking a can whilst sitting in the vehicle itself. He was also clear that Mr Minto was behind the wheel at that point. Mr Hansen thought this was mid morning although he had said 4pm in his original statement. Mr Minto says it would have been afternoon. I am inclined to view, bearing in mind the other timings in the case that it was more likely to have been in the afternoon. As I have said after well over a year it is not surprising that details such as timings may not be well remembered. Despite the question of the times I am satisfied that Mr Hansen was accurate about both Mr Minto and Mr Giles having had a drink in the Landrover before setting off.
4. The Landrover then headed for Westley – the home of Juan Hobman. Again Mr Minto accepted in interview that he had been drinking on the way. He was to say that he had "a couple of cans on the way to Westley". I am satisfied that Mr Minto was driving at this stage. He told the Police that he had been.
5. At Westley both Mr Giles and Mr Minto entered the home of Mr Juan Hobman. Both had beers with them. They then had 2 or 3 beers each and stayed about 1 ½ to 2 hours. Mr Hobman was to say that Gil was a bit drunk as he was talkative. He said that the expressions he had used in his police

statement as to them being three sheets to the wind, was probably accurate. He said they were hammered but they were on their way there.

6. Mr Hobman said that he was sufficiently concerned about the state of intoxication that he offered them a bed for the night but they declined and were adamant they were going back. It is right to note that this was not in Mr Hobman's original police statement. He also commented on Mr Minto driving away but he thought slipping a gear as he did so.
7. The Landrover then headed off back to Chartres – the crash happened not that far away from their destination. They must have travelled some distance as Mr Hobman thought it would take about an hour to get from Westley to Chartres.
8. The Landrover left that road. That is of course clear. It left at the bottom of a downhill slope in the road, a descent. To each side was a steep drop pitted with boulders and rocks. There were no barriers at this point.
9. The evidence I have received from Mr Parratt, an accident reconstructionist expert from the UK describes how in his opinion the Landrover in effect launched from the road, flew through the air for approximately 14 metres, landed on its front end, and then as a result of the momentum built up effectively somersaulted before landing on its wheels again. The evidence I have seen in my view supports this contention.
10. The damage done to the vehicle was extensive.
11. Perhaps interjecting at this point, from the photographs of the vehicle I have seen and the nature and the position that Mr Minto and Mr Giles were both found in by Marie-Paul Guillomot I have no doubt that neither was wearing a seatbelt at the time. I also have no doubt that Mr Minto had been driving the Landrover when it left the road. He was to tell Dr Edwards as much and he was seen by Mr Hobman driving away from Westley.
12. The exact time of this occurrence is not clear. The witnesses use both Camp and Stanley time. From what Mr Hobman said about them arriving at 4.30 and staying two hours, and from doing the best that I can from the other timings provided I am of the view that the crash occurred at some time around 6pm.

13. It would have been some time before Dr Edwards received the telephone call seeking her help which she, in my view accurately, puts at about 8.20pm Stanley time.
14. It is likely that Mr Giles lived for a short time after Marie-Paul Guillamot and her daughter found him. Sadly, however the evidence is clear that he died soon after they had arrived. This is supported by the evidence of Mr Hirtle who arrived relatively soon thereafter but who could find no pulse, and also that of the Maskell-Botts. When Dr Edwards arrived she confirmed that Mr Giles had died. She also expressed the opinion that he had died at least an hour before her arrival. Dr Edwards declared death at 2140 (Stanley time). Dr Edwards took the decision to move Mr Giles body away from the scene at the same time that Mr Minto was taken to Hill Cove to meet up with the helicopter that had been dispatched. For the avoidance of doubt, and although a body should ordinarily not be moved without the permission of the Coroner I am entirely satisfied that no prejudice was done to this inquiry, and that bearing in mind that the body had already been moved in order to administer assistance to Mr Minto, that this was a proper action to take.
15. As we know Mr Giles body was airlifted to Stanley, along with the injured Mr Minto. A post mortem took place on 29th January, carried out by forensic pathologist Dr John Clark.
16. Dr Clark concluded that Mr Giles died as a result of neck and chest injuries due to a road traffic accident in which he was a passenger.
17. There is no direct evidence as to how the crash happened. Mr Minto told police he could not remember and has declined to answer any questions as to this aspect following the warning I gave to him in respect of self incrimination. There were no eye witnesses. I must therefore rely upon circumstantial evidence which is what it says it is, evidence of circumstances. This allows a tribunal to draw such inferences as are proper bearing in mind that they should treat such evidence with care and caution.
18. I am satisfied so that I am sure that Mr Minto was driving at a time when he had consumed a considerable amount of alcohol to the extent that his driving ability would have been impaired.
19. The court heard evidence from Jacqueline Allen about blood alcohol tests of both Mr Minto and Mr Giles and was provided with print out results. Let me

say that I treat these print outs with a degree of caution. The sample which was purportedly taken from Mr Giles at post mortem gave a reading of 0.00 which is clearly contrary to the other evidence. Part of the reading also indicates that the sample was tested before it was received by the laboratory which clearly indicates potential human error. A suggestion for this was given in the way that it may have been stored improperly. This is merely speculation. The lack of any form of continuity documentation has not allowed for this to be looked at in detail. It may be that the wrong sample was considered. Again speculation. It may be that the machine was not working properly although test samples gave appropriate results. No adequate explanation has been provided. To be fair to Miss Allen she was only asked to specifically try and recall her involvement in the sampling of the blood samples in March of this year and was relying on what the usual practice was as opposed to specific recollection. Thus I am cautious when considering other samples.

20. As to the reading relating to Mr Minto a document was originally provided by Dr d'Ambrumenil as an exhibit to his statement, a statement which I have not admitted. I have grave concerns about that document. It had no times on it and indicated that the result was reported in May which cannot be right. It is appropriate to provide such an item for an evidential purpose. However I have received another printout the detail on it reflecting a test on 23rd January 2011, which is consistent with the events as we know happened. This indicated that the blood alcohol reading was 341.00. This is therefore over 4 times the legal limit of 80ug in blood. It is also noteworthy that this was not taken for several hours (probably about 6 hours) after the crash.
21. Whilst I do therefore treat the print out with a little caution the evidence in relation to alcohol and the state of intoxication on the part of Mr Minto is not merely provided by the blood alcohol reading.
22. I take into account the following evidence – Mr Minto in police interview says that he had "a couple of beers" before leaving Chartres. Mr Hansen says he saw him drinking another at Hill Cove. Mr Minto says in interview that on the track to Westley he had "a couple of cans". Mr Hobman says that they all had 2 or 3 cans at Westley. That is 7 or 8.

23. The state and level of intoxication of Mr Minto is supported by Mr Hobman's description of him and Mr Giles being three sheets to the wind (not hammered but they were no their way), by Mr Hirlte who said he guesses he did smell alcohol, and to the evidence of Dr Edwards who said he was slurring his words and smelled strongly of alcohol and that he admitted drinking alcohol, although the slurring has to be seen in the context of a possible head injury. She was able to say however that he was under the influence of alcohol.
24. I also bring to mind the evidence of Mr Hobman that he saw or heard MR Minto slipping a gear and the fact that Mr Hobman was sufficient concerned to invite them to stay.
25. Taking all the evidence together I am entirely satisfied so that I am sure that Mr Minto was intoxicated to a level where his judgment and driving ability would have been impaired at the time of the crash.
26. I have heard evidence about the condition of the car. I have considered the evidence of PC Moorhouse presented, as it was, by photographs. He described the vehicle as dangerous. I agree.
27. It was clear that rear nearside wheel had no brakes - they had been deliberately removed and the caliper crimped. The rear offside had the rubber part of the shock absorbers missing. The front left wheel had brake pads secured with a nail with no returning clip, a broken suspension spring, a blown damper which was full of oil. The front right had rusty suspension pins. Other defects related to a fractured and poorly repaired exhaust, a hole in the chassis, and at least one defective seatbelt. And perhaps most extraordinary of all that there were different wheel sizes in both diameter and width on the rear axle.
28. The defects in the vehicle were such that UK tests would not have been passed. Reminding myself that UK standards are not incorporated into Falklands Law I also asked about the minimum standards applied to register a car to drive on the East. It would have passed even these basic tests. PC Moorhouse said it was probably the worse vehicle that he had ever seen.
29. I have heard about the state of the road environment. Mr Hirtle was vociferous about the poor state of the road on the West in general and expressed his view that they had not been built properly in the first place. A glance at the photographs shows the poor quality of the road at the point of the crash. It was rough and rocky. In addition Stuart Parratt identified a further

specific problem with a cross fall (which I understand to mean camber). Having looked at the photographs I have to say that this defect in the road would not have been immediately obvious to anyone driving along.

30. In addition I received evidence about the weather conditions at the time from the Meterologist, Thomas Keenan. He said that working from readings taken at MPA and extrapolating backwards there may have been gusts of up to 37 or 39 knots at around this time in Hill Cove. He said "Hill Cove was not in the lea of high ground during this period however the gusts of nearly 40 knots could have an adverse effect on driving conditions depending on the type of vehicle and experience of the driver in those conditions". Of course the incident was not in Hill Cove itself. Mr Minto I have no doubt having lived in the Islands for many years would have had experience of such conditions. In addition I have heard no evidence of this being an issue from anyone who was at the scene on that night. The weather was described by many witnesses as beautiful, warm and clear day. Anthony Hirtle says it was beautiful and hot. Mr Keenan does not make it clear that there were no other weather conditions that would have adversely affected driving conditions. On balance I do not think that the weather has played a part in this crash.
31. I have considered the appropriate verdict in this case. I have considered Unlawful Killing by reason of gross negligence manslaughter on the part of Mr Minto relating to his driving of the Landrover in the condition he was in driving the vehicle in the condition it was in.
32. For the verdict of Unlawful Killing to be returned the Court must be satisfied of a number of things and must apply the criminal standard of proof. The test to be applied was out by the House of Lords in the case of R v Adomako (1994) 3 All ER 79.
33. Applying that test I must be satisfied so that I am sure of the following
    i. That the driver of the vehicle (Mr Minto) owed a duty of care to Mr Giles
    ii. That Mr Minto breached that duty of care
    iii. That the breach caused or significantly contributed to the death of the victim (I emphasise that the breach need not be the only cause)

iv. That the death should be categorised as gross negligence, and therefore a crime

34. In respect of (i) I am satisfied so that I am sure that Mr Minto as the driver of the Landrover owed a duty of care to Mr Giles as his passenger. The fact that Mr Giles may have been intoxicated or was not wearing a seatbelt or got into a vehicle knowing of Mr Minto's state or even being aware of the condition of his own vehicle does not in law absolve Mr Minto owing such a duty of care.
35. In respect of (ii) I must consider whether I can be sure that Mr Minto was in breach of that duty of care in that his driving fell below the stated expected of a reasonably competent driver for the following reasons.
36. In relation to the state of the vehicle in order for Mr Minto to be in breach of his duty of care on this basis I would have to be sure not only that the vehicle was in a dangerous state but that (bearing in mind it was not his vehicle) he knew that the vehicle was in the dangerous state it was undoubtedly was.
37. I note that Mr Minto has done some work on the vehicle, on his own admission and the evidence of Mr Hobman but there is no evidence that he had done such work recently or it involved the major defects identified by PC Moorhouse. Whilst I am extremely sceptical that any person could drive a vehicle in this condition without being aware of the defects and I am satisfied that it is more likely than not that he know of the state of the vehicle I am not on the evidence satisfied so that I am sure that he knew of the nature or extent of the dangerous defects. I cannot therefore regard this as a breach of the duty of care owed to establish a verdict of unlawful killing.
38. The other possible breach of duty of care relates to driving in the state of intoxication that I find ~Mr Minto to have been in. I am satisfied so that I am sure that in driving with the amount of alcohol that he had consumed MR Minto was indeed in breach of the duty of care. No reasonably competent driver would have driven in these circumstances. Therefore in respect of this breach I must consider the next aspect of the test set out above.
39. In respect of (iii) I must consider whether the alcoholic state I find that Mr Minto was in, caused or significantly contributed to the crash. For a verdict of unlawful killing I must be sure that it did. It does not have to be the only cause but it must be a significant cause.

40. In considering this I must look at the other potential causes. In essence, is it possible that something else or a number of other things (other than the alcoholic state of Mr Minto) cause the crash or may have caused the crash and that the alcoholic state of Mr Minto had nothing to do with it. In other words is it possible that the accident may have happened even if Mr Minto had been entirely sober.
41. In relation to whether I can be sure that the accident was caused or significantly contributed to by Mr Minto's level of intoxication I have considered the photographs and the plan which shows a number of tyre tracks. Mr Parratt attributes two of them to the Landrover. They appear to go as tracks to the edge of the road and the markers in green paint that were put down by the military police officer as to where he considered that the Landrover went off the road. They appear to me to be tracks left by a vehicle driving off the edge. Mr Hirtle put forward his hypothesis that Mr Minto had fallen asleep at the wheel. If he had this would be a breach of the duty of care he owed whether such tiredness was due to lack of sleep or whether it was alcohol induced. One understands why one might form such a conclusion from looking at the photographs and having regard to the speed he was travelling, especially when considering that Mr Minto is said to usually drive slowly. Mr Parratt has sought to calculate the speed from looking at the resting place of the Landrover and extrapolating backwards. He put the speed at between 32 mph and 44 mph. The theory of Mr Hirtle is of course a hypothesis only. He is no expert and does not profess to be. However whilst there is no obvious skid mark to the untrained eye one must be careful not to conclude everything from photographs only without regard to all the opinions expressed. For instance, Mr Parratt, an expert in the field, describes a yaw – that is a slight slide in the tracks according to Mr Parratt, perhaps suggesting that this was not someone merely driving off the road.
42. Mr Parratt says that the mechanical defects in the vehicle may have been contributable to the collision. He says that "if the driver had applied a reasonable level of braking, the defect to the rear nearside brake may have caused the vehicle to veer to the offside".
43. He also comments on the state of the road. Mr Parratt thought that this might have played some part but only in conjunction with other factors and not of its

own in the crash. He says "if the driver were braking due to the slope angle of the road, the cross may have played a part in the collision. The possible deviation experienced should not be sufficient to cause a vehicle to veer off the road, however if combined with other factors, such as the braking defect descried above, it could affect the potential outcome".

44. I must therefore ask myself whether the factors I have identified or any other factors completely independent of Mr Minto's level of intoxication or any combination of those factors did **or may**, on the evidence, have caused the accident.
45. As Mr Parratt was to say, a view endorsed by PC Moorhouse, that there are several factors that may be considered to be contributable to the collision, the variety of mechanical defects (which he may not have known about), the gradient and cross fall of the road, the ethanol reading of the driver, but concludes "I have not been able to identify a definitive cause of the collision".
46. On the evidence I have heard I cannot rule out that the accident might have occurred as a result of another factor or factors independent of the level of intoxication. I therefore cannot be sure that the intoxication of MR Minto actually caused or contributed to the death.
47. I am therefore not satisfied to the criminal standard that the verdict of unlawful killing is made out.
48. I therefore go on to consider Accidental Death and an Open Verdict but I do not consider that these short form verdicts as they have become to be known properly and adequately set out my findings and I have therefore decided to set out my verdict in narrative form.
49. Whilst I am not sure as to what cause or contributed to the crash I am satisified that it more likely than not that the alcoholic state of Mr Minto was a significantly contributory cause of the crash, it is certainly possible, indeed it is probable that it was. Similarly I am satisfied that it is likely the crash was caused or contributed to by the defects to the vehicle and the standard and defect to the road. I therefore conclude these factors in my verdict.
50. Finally I do note that despite the road having deep dips or ravines at either side where the accident took place there was no form of barrier at all. This meant that should a vehicle loose control at the bottom of the hill, on a poor surface that it was, where there was a cross fall, nothing would ameliorate the

consequences and the overwhelming likelihood would be that it would career over the edge and down a considerable distance which is precisely what occurred here. If a vehicle was to leave the road at this point the chances of death would be significantly higher than on other area of the road. Although the lack of barrier did not cause the actual incident, once the vehicle had left the road I am satisfied that the lack of any form of barrier meant that the accident would catastrophic and so caused or significantly contributed to death as a consequence. Similarly the lack of wearing of seatbelts also in my judgment was a factor in reducing the chances of survival. I include these matters in my verdict.

The rules make it clear as to the nature of what can be recorded in my verdict.
Rule 38 says that
"no verdict shall be framed in such a way as to appear determine any question of:-

(a) Criminal liability on the part of a named person, or
(b) Civil liability"

I must therefore record in my verdict the facts as I have found them and in doing so must not offend this rule.

I therefore read out the details as set out in the Inquisition.

Gilbert Giles died at around 6pm on 22nd January 2011 at a location just the off road known as the Hill Cove Road on West Falkland, Falkland Islands as the result of a motor crash.

Mr Giles had been the passenger in his own Landrover registration F290C which was being driven by another.

Both Mr Giles and the driver had been drinking heavily. Neither were wearing a seatbelt.

When the vehicle launched from the road, it flew through the air approximately 14 metres, landed on its front end, and then as a result of the momentum built up effectively somersaulted before landing on its wheels again. When the vehicle left the road it was likely to have been travelling at between 32 and 44 mph.

The vehicle was being driven in a dangerous condition. Defect included it having no brakes on one of the wheels, a broken suspension on another, and defective shock absorbers on another.

No definitive cause of the crash could be ascertained.

However, it is likely that the following individually or cumulatively caused or contributed to the crash

a) ***The impairment of driving ability and judgement on the part of the driver of the Landrover due to alcohol consumption***
b) ***The poor mechanical condition of the Landrover***
c) ***The state of the road environment and in particular a specific adverse cross fall***

It is likely that the following cause or contributed to the death

a) ***The fact that Mr Giles was not wearing a seatbelt***
b) ***The lack of any form of barrier on the particular area of road.***

Gilbert Giles died as a result of injuries he sustained as a result of a motor crash.

I do not leave this Inquest there however.

I have heard a considerable amount of evidence which has given me, as it would any right minded person, cause for concern.

Rule 39 of the Falkland Islands Coroner's Rules states
"If the Coroner believes that action should be taken to prevent the recurrence of fatalities similar to that in respect of which the inquest is being held he may announce at the inquest that he is reporting the matter in writing to the person or authority who may have power to take such action and he may report the matter accordingly".

I have decided to report a number of matters to the authorities in this case and to share the evidence that I have heard with them in an attempt to minimalise the chances of such tragedy occurring again.

In reporting the matter let me stress that I cannot dictate what action if any should be taken. That is for the authorities.

But the Coroner is charged with doing what he can to prevent fatalities and it is a fundamental right of the Coroner and a fundamental duty to do what the Coroner can to alert people to problems and to urge that consideration be given to attending to them.

The Falkland Islands Constitution enshrines many rights. Many Human Rights. None of those rights is greater than that set out at Section 2 of Chapter 1 – the right to life.

What does that mean?

The right to life has been interpreted to mean a number of things.

Of particular significance to this hearing is that

- It means that the state must establish a framework of law, precautions, procedures and means of enforcement which will, to the greatest extent reasonably practicable, protect life.
- The state must therefore do what is reasonable to protect and maintain the lives of its people.

In this Inquest I have heard how the law relating to the road traffic matters has seemingly passed the West by. It is difficult to imagine as to why this should be so. The road upon which this tragic incident occurred was a road to which the public have access. Why then should the law not apply to such a road wherever it is in the Falkland Islands.

I appreciate that not many people live or visit the West. I appreciate that you may travel for many miles and may hours without meeting another person. However I fail to understand was to why this might be a justification for failing to have laws which apply equally throughout the Islands, laws which deter, laws which bring to justice those who are culpable in answer for their actions…

In the case I have just heard the crash was not caused between two vehicles but a person was killed, a passenger.

In addition of course we know that Marie-Paul Guillomot and her daughter, her child were driving on the same rough road that a Landrover, a Landrover in dangerous condition were driven by an intoxicated driver was driving along a short time before.

The Landrover left the road but if it hadn't and had met those totally innocent people we can only speculate as to what might have happened and whether the tragedy here would have been even greater.

I have heard that it is possible to drive along a road to which the public have access, a road which has been provided by the Government which is obliged under the Constitution to do what is reasonable to protect the life of its citizens,

Whilst completely drunk,

In a vehicle that is dangerous,

At whatever speeds one wishes to and

If something was to go wrong, without any insurance to assist those who might be left with the consequences of a fatality or serious injury

Yet there is no law or regulation or procedure which seeks to prevent this. Whilst is would be naïve to suggest other than that enforcement might be a challenge. If a law existed that would allow an offender to be brought to book it might prove to act as some deterrent. If nothing else such an application of laws would express the collective view that such behaviour is not appropriate in a modern society.

I will therefore be writing to the relevant authorities by way of the Chief Executive inviting such authorities as are appropriate to consider whether and what regulations should be put in place in this respect.

On a more specific point I will be writing to the Director of PWD to inform him of the evidence I received about the state of the roads in the West, the reference made by Mr Hirtle to what might be an accident blackspot namely Goorse Bush pass, and to the

concerns highlighted by this Inquest as to the lack of barriers at any point on the roads and the specific cross fall identified on the stretch of road involved in this incident.

During this Inquest I have noted the presence of Mr and Miss Sutcliffe and the way they have displayed quiet dignity during what must have been a difficult time in the Courtroom. I particularly thank Miss Sutcliffe for the assistance she provided to my predecessor and myself in liaising with Mr Giles family in the UK during the time since his death.

I offer my sincere condolences to them and ask that they are passed on to the extended family of Mr Giles.

Can I also say that in all the evidence I have heard I have been reminded of the spirit of compassion, community and humanity of people. I was truly impressed at the way that the people of the West responded without hesitation to call for help. In particular I commend the actions Marilou Delingeries, who was but 16 years of age and yet responded so well and impressively to what was required of her.

Can I also thank PC Moorhouse who has acted as Coroner's Officer in this hearing and to Sgt Street and the other officers of the RFIP who have assisted in helping Coroner Trevaskis and myself in the investigation of this matter.

This Inquest is now closed.