IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 4627

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the Coroners Act 2008

Inquest into the Death of: DEREK HAMILTON

Findings of:	**AUDREY JAMIESON, CORONER**
Delivered on:	18 May 2017
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	18 May 2017
Police Coronial Support Unit:	Leading Senior Constable King Taylor, Assisting the Coroner
Appearances:	Mrs Jan Moffatt, Solicitor, Grindal & Patrick Lawyers on behalf of NorthWestern Mental Health

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I, AUDREY JAMIESON, Coroner having investigated the death of **DEREK HAMILTON**

AND having held an Inquest in relation to this death on 18 May 2017
at Southbank
find that the identity of the deceased was **DEREK HAMILTON**
born on 13 June 1968
and the death occurred on 9 September 2014
at the Northern Hospital, 185 Cooper Street, Epping Victoria 3076
from:

1 (a) CEREBRAL ISCHAEMIA
1 (b) COMPRESSION OF THE NECK IN CIRCUMSTANCES OF HANGING

in the following summary of circumstances:

At approximately 6.00am on 8 September 2014, Derek Hamilton (**Mr Hamilton**), an involuntary inpatient at the Northern Hospital Psychiatry Unit Two, was located unresponsive in his room. He was slumped behind the doorway, with a sheet around his neck. Mr Hamilton was resuscitated and transferred to the Northern Hospital's Intensive Care Unit, where his condition was considered non-survivable. At 10.30pm on 9 September 2014, Mr Hamilton's life support was withdrawn and he was declared deceased.

BACKGROUND CIRCUMSTANCES

1. Mr Hamilton was 46 years of age at the time of his death. Mr Hamilton lived at the Bell Rydges Hotel complex in Preston; he had previously been a registered nurse and most recently worked at a distribution business in the hospitality industry. He was divorced and estranged from his family. Mr Hamilton's medical history included previous diagnoses of cluster B personality disorder and recurrent depressive disorder.

SURROUNDING CIRCUMSTANCES

2. On Thursday 31 July 2014 at approximately 6.30am, Mr Hamilton telephoned "Lifeline" and expressed suicidal ideation, in the context of an inability to cope with work demands. He also claimed to have injected propofol and fentanyl. Emergency services were contacted and police attended Mr Hamilton's premises shortly afterwards. A sign on his door read 'don't enter gas inside'. Metropolitan Fire Brigade members entered the room and located Mr Hamilton in bed, with a face mask attached to a helium cylinder. Mr Hamilton was

unconscious, but breathing and was taken by ambulance to the Austin Hospital Emergency Department (**ED**).

3. At 11.15pm, Mr Hamilton was placed on an Assessment Order under the *Mental Health Act 2014* and was transferred to the Northern Hospital Psychiatry Unit Two as an involuntary patient. Upon admission, pharmaceuticals including vials of potassium chloride and propofol were found in his belongings. He was prescribed mirtazapine, with psychotherapy assessments. On 22 August 2014, lithium was added to Mr Hamilton's medications, but it was ceased due to adverse effects. Mr Hamilton's mood showed improvement, but he continued to describe suicidal ideation without active intent or plans.

4. On Monday 8 September 2014 at 3.00am, Registered Psychiatric Nurse (**RPN**) Karen Birrell and Enrolled Nurse Ricky Poorun conducted routine checks of the patients in the Unit and Mr Hamilton was recorded as breathing and sleeping in his bed in Room 31 at this time.

5. At 6.00am, Registered Psychiatric Nurse Samuel Abraham was conducting the routine checks when he found Mr Hamilton's door to be unlocked but difficult to open, with resistance. He heard a thud while opening the door and located Mr Hamilton lying behind the door; he was in a slouched position with his legs partially outstretched. A chair was located beside him. He appeared to have hanged himself using a bedsheet.

6. RPN Abraham was unable to find signs of life; he called out for co-workers to press the duress alarm and call a "code blue", and commenced cardiopulmonary resuscitation (**CPR**). Resuscitation efforts continued for 45 minutes; Mr Hamilton's pulse returned and he was intubated. Police attended, including Crime Investigation Unit (**CIU**) detectives.

7. At approximately 7.05am, Mr Hamilton was transferred to the Northern Hospital Intensive Care Unit (**ICU**). He was diagnosed with a severe hypoxic brain injury and his condition failed to improve.

8. On 9 September 2014 at 10.30pm, Mr Hamilton's life support was withdrawn and he was declared deceased.

JURISDICTION

9. Mr Hamilton's death was a reportable death under section 4 of the *Coroners Act 2008* (**the Act**), because it occurred in Victoria and was considered unexpected, unnatural or to have resulted, directly or indirectly, from an accident or injury, or because immediately before the death, Mr Hamilton was a patient within the meaning of the *Mental Health Act 2014*.

PURPOSE OF THE CORONIAL INVESTIGATION

10. The Coroners Court of Victoria is an inquisitorial jurisdiction.[1] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[2] The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances, but is confined to those circumstances sufficiently proximate and causally relevant to the death and not merely all circumstances which might form part of a narrative culminating in death.[3]

11. The broader purpose of coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by Coroners, generally referred to as the 'prevention' role.[4] Coroners are also empowered to report to the Attorney-General on a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[5] These are effectively the vehicles by which the prevention role may be advanced.[6]

12. It is not the Coroner's role to determine criminal or civil liability arising from the death under investigation. Nor is it the Coroner's role to determine disciplinary matters.

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[1] Section 89(4) *Coroners Act 2008*.
[2] Section 67(1) of the *Coroners Act 2008*.
[3] This is the effect of the authorities- see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy v West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).
[4] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, in contrast to the *Coroners Act 1985* where this role was generally accepted as 'implicit'.
[5] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations respectively.
[6] See also sections 73(1) and 72(5) of the Act which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

13. Section 52(2) of the Act provides that it is mandatory for a Coroner to hold an Inquest into a death if the death or cause of death occurred in Victoria and a Coroner suspects the death was as a result of homicide, or the deceased was, immediately before death, a person placed in custody or care, or the identity of the deceased is unknown.

14. The identity of Mr Hamilton was not in dispute, and his death was not considered to be a homicide. However, he was a person placed in "*care*" as defined by section 3 of the Act, as he was immediately before his death a patient within the meaning of the *Mental Health Act 2014*; an involuntary or compulsory patient. Therefore, it was mandatory to conduct an Inquest into the circumstances of Mr Hamilton's death, pursuant to section 52(2).

15. This finding draws on the totality of the material; the product of the coronial investigation into the death of Mr Hamilton. That is, the court records maintained during the coronial investigation, the Inquest Brief and further material sought and obtained by the Court.

16. In writing this finding, I do not purport to summarise all of the evidence, but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity. The absence of reference to any particular aspect of the evidence does not infer that it has not been considered.

STANDARD OF PROOF

17. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining whether a matter is proven to that standard, I should give effect to the principles enunciated in *Briginshaw v Briginshaw*.[7] These principles state that in deciding whether a matter is proven on the balance of probabilities, in considering the weight of the evidence, I should bear in mind:

    - the nature and consequence of the facts to be proved;
    - the seriousness of an allegation made;
    - the inherent unlikelihood of the occurrence alleged;

[7] (1938) 60 CLR 336.

- the gravity of the consequences flowing from an adverse finding; and
- if the allegation involves conduct of a criminal nature, weight must be given to the presumption of innocence, and the court should not be satisfied by inexact proofs, indefinite testimony or indirect inferences.

18. The effect of the authorities is that Coroners should not make adverse findings against or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

FORENSIC PATHOLOGY INVESTIGATION

Identification

19. A Statement of Identification was completed by Mr Hamilton's friend Darcy Shew, at the Northern Hospital on 9 September 2014. Mr Hamilton's identity was not in dispute and required no further investigation.

Medical cause of death

20. On 11 September 2014, Associate Professor (A/Prof) David Ranson, Deputy Director of the Victorian Institute of Forensic Medicine, performed an external examination upon the body of Mr Hamilton, reviewed a post mortem computed tomography (CT) scan and medical records from the Northern Hospital, and referred to the Victoria Police Report of Death (Form 83). A/Prof Ranson observed an abrasion on Mr Hamilton's neck and the CT scan showed evidence of pleural effusions, some pulmonary oedema and gross cerebral swelling in keeping with the history of cerebral ischaemia. Toxicological analysis of Mr Hamilton's post mortem blood detected medications which A/Prof Ranson observed were most probably administered therapeutically. A/Prof Ranson ascribed the cause of Mr Hamilton's death to cerebral ischaemia, secondary to compression of the neck in circumstances of hanging.

VICTORIA POLICE INVESTIGATION

Attendance at the Northern Hospital Psychiatry Unit Two

21. Following the incident, police attended the Northern Hospital at approximately 9.25am on 8 September 2014. Mr Hamilton's room was processed as a crime scene by the Whittlesea CIU and photographed. Police did not identify any evidence of third party involvement. Several sheets of paper containing handwritten poetry were located on Mr Hamilton's bedside table. The poems were depressive in nature and appeared to imply suicidal ideation. Scissors were found in a cardboard box on the floor.

Inquest Brief

22. First Constable Bianca Scarfe[8] was nominated to be the Coroner's Investigator[9] and she prepared the Inquest Brief. The Inquest Brief initially contained statements made by, *inter alia*, Mr Hamilton's friend Darcy Shew and NorthWestern Mental Health staff Consultant Psychiatrist Dr Sanjeewanie Karunaratne, Registered Psychiatric Nurses (**RPN**) Samuel Abraham, Karen Birrell and Gary D'Vaz, and Enrolled Nurse (**EN**) Ricky Poorun. Additional statements were subsequently obtained from Nurse Unit Manager (**NUM**) at the Northern Hospital Psychiatry Unit Ian Bennet, Leading Senior Constable (**LSC**) Sally Rooks, Detective Senior Constable (**DSC**) Mark Di Clemente, DSC Michelle Campbell and Constable Melisa Steer. Medical records from the Northern Hospital were also obtained.

23. Friend Darcy Shew stated that he had known Mr Hamilton for four years. He described Mr Hamilton as *'usually fairly happy'* but observed that he had recently been unhappy and stressed by his work at a distribution company.

24. Consultant Psychiatrist Dr Sanjeewanie Karunaratne stated that upon admission to the Northern Hospital Psychiatry Unit Two, Mr Hamilton described hopelessness, helplessness and suicidal thoughts. He presented with dysphoric affect and ongoing suicidal ideation. Mr

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[8] I note that First Constable Scarfe is now Senior Constable Scarfe.

[9] A Coroner's Investigator is a member of the police force nominated by the Chief Commissioner of Police or any other person nominated by the Coroner to assist the Coroner with his/her investigation into a reportable death. The Coroner's investigator takes instructions directly from a Coroner and carries out the role subject to the direction of a Coroner.

Hamilton reported having no contact with his family for some time, but later agreed for the treating team to communicate with a friend.

25. NUM Ian Bennet stated that Mr Hamilton was initially cared for in the Intensive Care Area (ICA) and was assessed as being of high risk. After being transferred to the Low Dependency Unit (LDU) on 2 August 2014, he briefly returned to the ICA on 3 August 2014 after expressing suicidal ideation. On 4 August 2014, Mr Hamilton's Assessment Order was upheld and he was placed on a Temporary Treatment Order. At this time, Mr Hamilton was commenced on mirtazapine. NUM Bennet stated that Mr Hamilton's risk level was downgraded from medium to low on 6 August 2014, where it stayed for the remainder of his admission. From 10 August 2014, Mr Bennet was granted unescorted leave, which he subsequently used daily to visit the hospital chapel, without incident.

26. Dr Karunaratne described Mr Hamilton's engagement with the treating team as superficial, rather guarded and passive-aggressive throughout his admission. She noted that Mr Hamilton evinced cluster B personality disorder traits. NUM Bennet stated that it was difficult to establish a rapport with Mr Hamilton, who was dismissive of attempts to engage with him. He added that Mr Hamilton consistently expressed a belief that things were hopeless and he would take his own life on discharge, but not as an inpatient. Towards the end of his admission, Dr Karunaratne observed that Mr Hamilton showed some improvement in mood, but continued to have suicidal ideas without active intent or plans.

27. A social worker's progress notes on 7 August 2014, indicated that Mr Hamilton had no accommodation and no savings; he reportedly had no idea where he might live.

28. In a report on compulsory treatment produced for the Mental Health Tribunal, dated 19 August 2014, Mr Hamilton was described as *"still remains helpless with ideas to commit suicide on discharge (no plan currently). Feels that 'starting again would be too hard' given no accommodation to return to on discharge and no source of income."*

29. A clinical psychologist's notes on 22 August 2014, indicated that Mr Hamilton was dismissive of suggestions relating to accommodation and financial assistance services. In a

subsequent note dated 4 September 2014, Mr Hamilton was observed to maintain that he did not care where he went, because *"it doesn't matter"*, suggesting suicidal ideation.

30. In a nurse's progress note entered on Friday 5 September 2014, it was specified that Mr Hamilton *"continues to express on-going suicidal thoughts, he denies any current intent or plan. He is ambivalent about the pending discharge."* A clinical psychologist's note also entered on this date, indicated that Mr Hamilton reported increased suicidal ideation with no plan. Mr Hamilton reportedly indicated that he wanted to be discharged on Tuesday 9 September 2014, as he could then take his own life.

31. Dr Karunaratne stated that Mr Hamilton used one hour periods of unescorted leave over the weekend of 6 and 7 September 2014. Mr Hamilton was planned for discharge on 9 September 2014; he was to be referred to Latrobe Valley Mental Health Service for follow up care. Accommodation was arranged in Moe, and Dr Karunaratne stated that Mr Hamilton was supported with organising financial benefits through Centrelink.

32. NUM Bennet stated that Mr Hamilton was reluctant to engage with discharge planning; avoiding the assistance of clinical staff to organise his finances and consider accommodation options. NUM Bennet added that a Centrelink appointment was arranged for 8 September 2014; staff were going to escort Mr Hamilton to this appointment. Nearing discharge, NUM Bennet did not observe any obvious change in Mr Hamilton's presentation; he continued to be guarded and dismissive of attempts to engage him in conversation.

33. Following the incident, LSC Sally Rooks entered Mr Hamilton's room just after 9.30am on 8 September 2014. LSC Rooks stated that it was evident that Mr Hamilton had tied a knot at one end of a bed sheet and placed it over the top of the entrance door. He appeared to have then closed the door and made another knot, creating a hanging point.

34. NUM Bennet stated that the door is full length to ensure physical security of the room; provide visual and acoustic privacy; manage air flows for heating and cooling systems; prevent steam from bathrooms escaping into corridors; and to comply with fire regulations. NUM Bennet added that the door is fitted with a full length, piano type, dual swing hinge,

which allows the door to be either swung into the room or out into the corridor, and is designed to prevent a ligature from being attached between the hinges, the door and the frame. NUM Bennet stated that the door is fitted with anti-ligature door furniture and complies with the 'design brief' developed by the Capital Management Branch of the Department of Health and Human Services.

CORRESPONDENCE FROM MR HAMILTON'S FAMILY

35. On 18 July 2016, the Court received correspondence from Ms Janice Kitson, Mr Hamilton's mother. Ms Kitson advised that she had spent the last two years trying to find Mr Hamilton, and had only recently learned he was deceased. Ms Kitson wrote that the last she knew, her son was moving to Victoria to obtain his registration as a nurse and work in that capacity. Since then, she had been unable to contact him. Ms Kitson requested any information that would allow her to comprehend what had occurred. She added that Mr Hamilton was the youngest of her four children. Sadly, in April 2017, Mr Hamilton's sister, Karen Hamilton, advised the Court that Ms Kitson had passed away.

CORONERS PREVENTION UNIT REVIEW AND FURTHER INVESTIGATION

36. The Coroners Prevention Unit (**CPU**)[10] was requested to review the circumstances of Mr Hamilton's death on my behalf. Following the review, it was determined that further information was required to progress the investigation, including copies of guidelines, policies and procedures for risk assessments and nursing observations at the Northern Hospital Psychiatry Unit. Evidence was also sought relating to the layout of Mr Hamilton's room; the availability and monitoring of any Closed Circuit Television (CCTV) footage; the expected times at which Mr Hamilton was to be observed; and an executive summary of any internal review, including any related recommendations.

37. By way of letter dated 5 January 2017, Dr Kurt Wendelborn, Director of Clinical Services at Northern Area Mental Health Service, part of NorthWestern Mental Health, provided further

[10] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the Coroner. The unit assists the Coroner with research and formulation of prevention recommendations, as well as assisting in monitoring and evaluating the effectiveness of the recommendations.

information to the Court. Dr Wendelborn enclosed Clinical Risk Assessment and Management (CRAAM) guidelines that were and remained in place for the Northern Hospital Psychiatry Unit. Dr Wendelborn referred to an enclosed observation chart, and stated that observations for Mr Hamilton were carried out as per CRAAM guidelines for low level risk; sightings at meal/tea times during morning and afternoon shifts, and at midnight, 3.00am and 6.00am at night. Dr Wendelborn acknowledged that the chart indicated Mr Hamilton was also observed at 4.00am on 8 September 2014 (as this box was ticked). A plan of the Northern Hospital Psychiatry Unit Two wing was included; Dr Wendelborn stated that there was no direct line of sight from the staff station to Mr Hamilton's room.

38. Dr Wendelborn also included the conclusions and recommendations from the Root Cause Analysis following Mr Hamilton's death. The three recommendations were that a second opinion and/or case conference be conducted to review treatment goals, for patients presenting with prominent personality dysfunction and where admission has been longer than two weeks; provision of supervision, mentoring and peer support structures for those clinicians working with patients with complex disorders in acute settings should be maintained as an organisational priority; and access to expert opinion in care of said patients should be supported and encouraged routinely in such cases.

39. Dr Wendelborn observed that Mr Hamilton's care was diligent and well considered, but hampered by his reticence to disclose relevant information. Dr Hamilton stated that there were no causal factors identified in the Root Cause Analysis, but acknowledged that clients with complex disorders such as Mr Hamilton may benefit from an additional expert opinion, especially when they have been an inpatient for a longer than usual period.

DIRECTIONS HEARING ON 30 MARCH 2017

40. On 30 March 2017, a Directions Hearing was held in order to further the investigation into Mr Hamilton's death. In particular, I sought to understand the apparent disconnect between the statements provided to the Court and the observation charts (which indicated an observation took place at 4.00am); the decision to discharge Mr Hamilton to Moe, when he appeared to have a support base in Melbourne; and the planning regarding discharge,

including how ongoing risks were to be managed and addressed within the community.

41. At the Directions Hearing, I was assisted by Leading Senior Constable King Taylor, and Mrs Jan Moffatt appeared on behalf of NorthWestern Mental Health. Mrs Moffatt provided a number of statements, dated 29 March 2017. These included additional statements made by Dr Karunaratne and RPN Birrell, and a statement made by Director of Operations at NorthWestern Mental Health Peter Kelly.

42. In her further statement, RPN Birrell clarified that at 3.00am on 8 September 2014, she completed an observation round with RPN Poorun. However, RPN Birrell stated that she erroneously placed the ticks in the 4.00am column, and upon realising her mistake, altered the 3.00am column to reflect this. She stated that she unfortunately did not alter the ticks in the 4.00am column at this time.

43. Peter Kelly stated that visual observations at the Northern Hospital Psychiatry Unit Two are conducted at the minimal requirement, unless an issue or concern arises that will dictate an increased level of observations, including 'upgrading' a patient's risk assessment following a thorough assessment and consultation with the Associate Nurse Unit Manager or nurse in charge of the shift. Mr Kelly said that this was to ensure patients are minimally disturbed by staff throughout the night.

44. In her further statement, Dr Karunaratne advised that sourcing suitable accommodation for Mr Hamilton was a challenging task. Mr Hamilton had a friend in Canberra, who was happy to extend support. However, Dr Karunaratne said that Mr Hamilton's friend was about to travel overseas, so this option was not viable. No suitable accommodation was identified in the Northern Area Mental Health Service catchment area. Dr Karunaratne added that the treating team were concerned that discharging Mr Hamilton to a crisis accommodation / rooming house situation would be detrimental to his mental state. Dr Karunaratne stated that the accommodation from Moe was to involve a nice living arrangement, well supported by housing workers and with the option of a psychosocial rehabilitation oriented program. In light of these facts, it was decided that this accommodation was the better option for Mr Hamilton.

45. At the Directions Hearing, I expressed ongoing concern about the decision to discharge Mr Hamilton into accommodation and mental health services at Moe, where he lacked any familiar support system. Mrs Moffatt emphasised that the accommodation available in Moe would have apparently been superior to any crisis accommodation available in Melbourne.

46. At the conclusion of the Directions Hearing, I determined that I had sufficient evidence with which to conclude this matter by way of Summary Inquest. Mrs Moffatt undertook to advise the Court as to whether the recommendations following the Root Cause Analysis had been implemented.

ADDITIONAL INFORMATION

47. By way of letter dated 31 March 2017, John Dermanakis, Area Manager of the Northern Area Mental Health Service, part of NorthWestern Mental Health, provided further information relating to the Root Cause Analysis following Mr Hamilton's death. Mr Dermanakis advised that each of the three recommendations had been implemented. He added that NorthWestern Mental Health has learned valuable lessons from this case and deeply regrets the passing of Mr Hamilton in these circumstances.

FINDINGS

I find the identity of the deceased is Derek Hamilton born 13 June 1968 and that his death occurred on 9 September 2014 at the Northern Hospital.

The evidence indicates that Mr Hamilton suffered from largely unrelenting suicidal ideation throughout his admission to the Northern Hospital Psychiatry Unit Two. In particular, the investigation has identified that Mr Hamilton was ambivalent about discharge, and repeatedly informed staff that he would take his own life upon re-entering the community.

However, by 8 September 2014, Mr Hamilton had been an involuntary patient for 39 days and considered at low-risk for over one month, with uneventful periods of unescorted leave. In these circumstances, I find that the decision of NorthWestern Mental Health staff to discharge Mr Hamilton, albeit to a less than satisfactory geographic location, was understandable.

In light of Mr Hamilton's pre-existing suicidal ideation, I am unable to definitively find that Mr Hamilton's impending discharge to an unfamiliar, regional township, rather than long standing mental ill-health, was the precipitating factor which led him to adopt the course of action he ultimately chose. However, it is concerning that the most viable option for Mr Hamilton was to discharge him some 159 kilometres away, into a community where he had no foundation.

I accept and adopt the medical cause of death as ascribed by A/Prof David Ranson and I find that Derek Hamilton died from cerebral ischaemia, secondary to compression of the neck as a result of hanging, in circumstances that I find he intended to take his own life.

Pursuant to section 73(1) of the **Coroners Act 2008**, I order that this finding be published on the internet.

I direct that a copy of this finding be provided to the following:

- Mr Shane Tissera
- Ms Karen Hamilton
- Mrs Jan Moffatt, Grindal & Patrick Lawyers
- Mrs Pauline Chapman, Austin Health
- Ms Jackie Petrov, Medicolegal Assitant, The Northern Hospital
- Mr Peter Kelly, Director of Operations, Melbourne Health
- Office of the Chief Psychiatrist
- Senior Constable Bianca Scarfe

Signature:

AUDREY JAMIESON
CORONER
Date: **18 May 2017**