IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 3498

FINDING INTO DEATH WITH INQUEST

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

Deceased:	**Samer Rony DAMOUNI**
Delivered on:	7 June 2017
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing dates:	28 March 2017
Findings of:	**IAIN TRELOAR WEST DEPUTY STATE CORONER**
Coroner's Assistant:	Ms Sonja Mileska
Representation	Mr Raph Ajzensztat appeared on behalf of the Damouni family Mr Paul Halley appeared on behalf of Monash Health
Catchwords	Mental Health, Hospital Security, Absconding

I, IAIN TRELOAR WEST, Deputy State Coroner having investigated the death of Samer Rony DAMOUNI

AND having held an inquest in relation to this death on 28 March 2017

at MELBOURNE

find that the identity of the deceased was Samer Rony Damouni

born on 16 May 1994

and the death occurred on or about 14 July 2015

at the paddock between Lochard Terrace and Centre Road Narre Warren, 3805 Victoria

from:

1 (a) COMPRESSION OF THE NECK CONSEQUENT UPON HANGING

in the following circumstances:

1. Samer Damouni was a 31-year-old man who resided in Endeavour Hills with his parents, John and Denise Damouni. He was also the brother to Larissa Damouni.
2. Mr Damouni had a history of psychological illness interspersed with drug use. He commenced experimenting with illicit drugs namely cannabis before injecting amphetamines by the age of 16. This resulted in a marked change in his behaviour which included aggression towards family members and he also began to fight with persons in public places, attracting the attention of police.
3. In 2005, Mr Damouni suffered a severe psychotic episode and exhibited paranoid behaviour, believing that persons were going to come to his house and attack him. He armed himself with various weapons and placed them throughout the family home. His mother sought intervention from mental health providers and he was subsequently transported to the Casey Hospital for treatment. He was diagnosed with schizoaffective disorder, substance dependence and anti-social personality disorder.
4. Between 2008-2013, Mr Damouni had several interactions with mental health practitioners, both as an inpatient and outpatient, resulting in antipsychotic treatments being administered. On numerous occasions, he would reach crisis point and receive intervening treatment until stabilised and then disengage. His continued use of illicit substances also exacerbated his illness.
5. In February 2015, Mr Damouni's psychiatric health deteriorated markedly as a result of significant amphetamine use and he began to suffer hallucinations and expressed delusions of grandeur. He remained in contact with mental health practitioners and was receiving therapeutic drugs to treat his illness.
6. In March 2015, Mr Damouni suffered a severe psychotic episode whilst other family members were away. His father returned home later in the evening and was confronted in the front yard of the family home by Mr Damouni who had armed himself with knives. He was eventually calmed and was admitted to the Casey Hospital for treatment.
7. On 17 April 2015, Mr Damouni again suffered a psychotic episodes, believing that he had been fighting in the Iraq conflict and that he was wounded. He was admitted to the Casey Hospital as an involuntary patient but by this stage had learned to modify his behaviour

whilst being treated, convincing mental health practitioners that he was again stable. He was subsequently discharged on 20 April 2015.

8. Between 5 May to 17 June 2015, Mr Damouni spent a significant period of time at Casey Hospital as an involuntary patient under a Treatment Order pursuant to the *Mental Health Act 2014* (Vic). He was regularly managed by mental health practitioners and it was established he had been suffering specific delusions and hallucinations. On 29 May 2015, Mr Damouni sought legal advice and presented a case to the Mental Health Tribunal to have his involuntary treatment order rescinded, facilitating his release from the hospital. His family arranged for him to stay with his sister but he absconded from her home shortly after his release.

9. On 31 May 2015, Mr Damouni was again conveyed back to Casey Hospital on an involuntary basis. On 9 June 2015, he absconded from the hospital before being located and returned on 15 June 2015. His mental state was unchanged and he was not overtly psychotic. On 17 June 2015, Mr Damouni was again released into the community after discussions with his treating practitioners and family members.

10. On 6 July 2015, Mr Damouni was again conveyed to Casey Hospital for treatment on an involuntary basis due to suffering a psychotic episode and was placed on an Assessment Order. He refused oral medications. At 9.40am that morning he went to the bathroom and was then unable to be located. He later returned to the emergency department at 11.30am and was reviewed by a psychiatric registrar. He reported that he had injected the drug "ICE" the previous day. He denied auditory hallucinations and delusions. That afternoon at 2.45pm, Mr Damouni was noted to have absconded and police were notified.[1]

11. On 8 July 2015, Mr Damouni was returned to the hospital by paramedics with a deteriorating mental state and a plan for admission as a compulsory patient. On 9 July 2015 at 9.30am, he absconded from the hospital whilst in the bathroom. He was returned on the same day but again absconded at 3pm.[2]

12. On 12 July 2015 at 2am, Mr Damouni's mother heard noises and voices outside the family home. She saw her son outside in the street and called on him to return home however he ran away along the street. At 6.30am that same morning, he returned home and Mrs Damouni had a brief conversation with him before contacting police.

13. At 7.40am, police arrived and transported Mr Damouni to the Casey Hospital pursuant to his Temporary Treatment Order. His demeanour became highly agitated and police located a used syringe in his pocket. Upon arrival at the Emergency Department (ED) he was placed into an assessment cubicle and police remained with him to ensure his security. At 8.45am, he was assessed by Social Worker Claire Jones from the Enhanced Crisis and Assessment treatment Team (ECATT). She deemed Mr Damouni to be '*loud, aggressive and hostile...and appeared to be in acute state of withdrawal from methamphetamines.*'[3] He was deemed to be a high risk of absconding, and a medium risk of harm to others given his aggressive and threatening demeanour.[4] Ms Jones assessed him as requiring a psychiatric inpatient admission but as there were no immediately available psychiatric inpatient beds, it was necessary he remain in the ED until a bed became available.

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[1] Statement of Dr Tennent Nirushan Tampiyappa p 23 IB
[2] Statement of Nurse Unit Manager Suzanne Coles p 25-26 IB
[3] Statement of Clare Jones p 28 IB
[4] Exhibit 6 Emergency Adult Mental Health Assessment by Clare Jones p 195

14. At 9.35am, Mrs Damouni contacted hospital staff and warned them to be careful as she feared her son may try and escape as he had done so previously.[5] She also stated that he had been talking about death earlier that morning. Hospital staff assured her that he was being properly secured and in the process of being admitted to the psychiatric ward.

15. Police liaised with medical staff and remained in attendance for 2 hrs to monitor Mr Damouni. Constable Fergus Stewart stated that 'a *member of security attended but indicated they had been and were still busy dealing with other patients and I did not see him again.*'[6] At 10.40am, Senior Registrar Dr Riaz Khan spoke to the police members and stated according to Constable Stewart '*he is ok here, he is being admitted to the psych ward. You guys can go.*'[7] Police subsequently left and a Constant Patient Observer (CPO), Ms Debra Curtain, was assigned to Mr Damouni at 10.30am. Later that morning, Mr Damouni asked her for some sandwiches and she remained outside his cubicle whilst a Registered Nurse brought some to him. Ms Curtain stated that at 12.20pm, Mr Damouni was '*half way through two lots of sandwiches when he stood up and faced the wall, stretched and placed his hands behind his head. The he turned around and bolted out of the cubicle through the resuscitation area.*'[8] Ms Curtain contacted security but Mr Damouni activated the ambulance bay doors button and ran out onto Kangan drive.

16. At some stage between 12-14 July 2015, Mr Damouni attended the parkland adjacent to Menindee Terrace in Narre Warren. He passed a length of rope in a tree and fastened it to a lower branch. He then looped and tied the opposite end of the rope around his neck and hanged himself.

17. On 14 July 2015 at 9.30am, a passer-by was walking along Menindee Terrace when he observed Mr Damouni hanging from a tree and contacted emergency services. Police arrived at 9.45am and located Mr Damouni's resting with his knees on the ground. Rigor mortis had set in indicating he had been deceased for several hours, if not overnight. Several pieces of packaging of nylon rope were located approximately 50 metres from the location of his body. No suspicious circumstances were identified and no suicide note was located.

18. Forensic Pathologist Dr Sarah Parsons from the Victorian Institute of Forensic Medicine performed an external examination of Mr Damouni and provided a written report of her findings. She identified a ligature abrasion around the neck, consistent with hanging. The post mortem CT scan did not detect any abnormality. Toxicological analysis revealed the presence of 0.02mg/L of olanzapine, 0.1mg/L of methylamphetamine and 0.04mg/L of amphetamine.

Purposes of the Coronial Investigation and Standard of Proof:

19. The primary purpose of the coronial investigation of a reportable death[9]is to ascertain, if possible, the identity of the deceased person, the cause of death (interpreted as the medical cause of death) and the circumstances in which the death occurred.[10]The investigation is conducted pursuant to the *Coroners Act 2008* (Vic).

20. Coronial findings must be made on the basis of proof of relevant facts on the balance of probabilities. Assistance in determining the level of satisfaction required is found in the

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[5] Statement of Denise Damouni p 9 IB
[6] P 41 IB
[7] P 41 IB
[8] Statement of Debra Curtain P 31 IB
[9] Section 4 of the Coroners Act requires certain deaths to be reported to the coroner for investigation.
[10] Section 67 of the Act.

High Court decision of *Briginshaw* v *Briginshaw*.[11] The Court stated: "*The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters 'reasonable satisfaction' should not be produced by inexact proofs, indefinite testimony, or indirect inferences...*" [12]

21. This finding is based on the entirety of the investigation material comprising the coronial brief of evidence, including material obtained after the provision of the brief, the statements and testimony of those witnesses who gave evidence at the inquest and any documents tendered through them, other than documents tendered through Counsel (including Counsel Assisting), and written submissions of Counsel following the conclusion of the inquest. All this material, together with the inquest transcript, will remain on the coronial file and comprises my investigation into the death of Mr Damouni. I do not propose to summarise all the material/evidence in this finding, but will refer to it only in such detail as is warranted by its forensic significance and where otherwise appropriate.

Uncontentious Matters:

22. The identity[13] of the deceased is not in dispute. His name was Samer Rony Damouni. His date of birth was 16 May 1994.

23. The medical cause[14] of Mr Damouni's death is not in dispute with the cause being compression of the neck consequent upon hanging.

Investigation:

24. The investigation into the death of Mr Damouni was undertaken on my behalf by Detective Sergeant Duane McDonald, who also prepared the Inquest Brief (IB). In addition, I was assisted by a report prepared by Professor Erwin Loh, Chief Medical Officer, and Executive Director Innovation, Patient Safety and Experience, Monash Health.

The Inquest:

25. The circumstances in which the death occurred[15]became the focus of the inquest with the following issues examined:
    a. The Damouni family's concerns in relation to Mr Damouni's absconding from Casey Hospital and matters contained within Professor Loh's report;
    b. A consideration of the preventative measures outlined in Professor Loh's report which have been implemented/are being considered for implementation, by Monash Health.

26. In the absence of Professor Loh being available to attend the inquest, the following witnesses were called to speak to his report and did so by giving concurrent evidence:
    a. Dr Neil Goldie, Director of Emergency Medicine at Monash Health
    b. Professor David Clarke, Program Medical Director of the Mental Health Program at Monash Health.

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[11] (1938) 60 CLR 336
[12] Ibid at p 362
[13] Section 67(1)(a)
[14] Section 67(1)(b)
[15] Section 67(1)(c)

Evidence:

Mr Damouni's absconding from Casey Hospital:

27. Submissions on behalf of the Damouni family state that there was sufficient information available to Casey Hospital staff on 12 July 2015 to place them on notice that Mr Damouni would probably attempt to abscond and that he may attempt to self-harm.

28. In relation to the former, it is clear in the evidence that Mr Damouni had an extensive history of absconding from Casey Hospital or being absent without leave (AWOL) prior to 12 July 2015. This included absconding on 9 June, being AWOL on 6 July and absconding twice on 9 July 2015 from the ED.

29. At the inquest, the evidence of Dr Goldie was that there were normally two security staff members present for the whole of Casey Hospital with none being assigned to the ED specifically.[16] Despite Mrs Damouni and the police members having notified hospital staff that morning of Mr Damouni's need for security to monitor him, security staff were not provided. Security had initially approached the police members who were monitoring Mr Damouni but had indicated that they had been '*busy and were still dealing with other patients.*'[17]

30. Ms Jones' notes also assessed Mr Damouni as being a high risk of absconding but there is no evidence in the written witness statements that staff from Casey Hospital actually conducted an assessment of the need for security staff to be stationed at Mr Damouni's cubicle. Dr Khan's statement is silent as to his interactions with Constables Stewart and Croaker or whether he considered the need for security to remain present.

31. In relation to the aspect of self-harming, Mrs Damouni contacted the hospital at 8am on 12 July and informed staff that Mr Damouni ought to be placed in seclusion as he had been '*talking about death*'[18] that morning. Mr Damouni however denied feeling depressed or suicidal when assessed by Ms Jones[19] and she concluded that he remained at a medium risk to himself.[20] It is not clear in the notes that Ms Jones was aware of this phone call from Mrs Damouni and Professor Clarke acknowledged that it would have been beneficial for Ms Jones to have had this information for her assessment.[21]

32. Submissions on behalf of the Damouni family also state that no consideration was given by hospital staff as to whether or not Mr Damouni's condition required chemical or physical restraint. Despite Ms Jones noting that he had noncompliance with all treatment since 17 June 2015, his aggressive and hostile behaviour and high risk of absconding, there is no documentary evidence indicating that restraint of any kind was considered. In relation to this aspect, at inquest, Dr Goldie indicated that there are procedures relating to physical, mechanical and chemical restraint, with chemical restraint being the preferred option.[22] However, it is based on an assessment of the patient's current state and does not include their absconding risk per se.[23] Professor Clarke also stated that '*sedation is helpful for an agitated patient but if a person wants to abscond...sedation doesn't change their will to*

[16] Transcript (TS) p 6
[17] Statement of Constable Shayne Croaker p 45 IB
[18] P 9 IB
[19] P 194 of Exhibit 6
[20] P 195 of Exhibit 6
[21] TS 27
[22] TS 9
[23] TS 10

leave...Sedation does have dangers and it's not a treatment for absconding.'[24] Neither Dr Goldie nor Professor Clarke were critical of Dr Khan not prescribing any sedative medication,[25] particularly given the model of care at the time which was not one of consistent coordinated care between the mental health practitioners and emergency department practitioners.

33. Dr Goldie further stated that mechanical constraint would be considered appropriate if '*the patient was at risk of immediate self-harm or harm to others.*'[26] This was not the case according to his assessment by Ms Jones. Dr Goldie also explained that despite Mr Damouni's cubicle having the capacity to be locked, there were no circumstances under which he would anticipate that door being locked to restrain a patient.[27] Professor Clarke clarified that this was due to the fact pursuant to the *Mental Health Act 2014* (Vic) there are clear principles about restraining patients in seclusion rooms and Mr Damouni's cubicle was not a seclusion room and therefore not used as one. The only available seclusion rooms are located on the psychiatric wards.[28]

34. Given Mr Damouni's high risk of absconding, he was assigned a CPO whose role Dr Goldie explained was to '*ensure the patient's clinical safety which has a flow-on effect to - in terms of their security. They don't necessarily have a role in providing that physical security presence.*'[29] When Mr Damouni absconded, a Code Grey was called which Dr Goldie explained is a '*team response of five or six individuals, all of whom have a component in the physical restraint of a patient...so the risk to the patient and the risk to the individual is much minimised or much more minimised.*'[30] Professor Clarke further noted that even if a security officer had been present at Mr Damouni's cubicle, whilst they may have provided more of a "physical presence" it does not follow that the security officer may have been able to stop Mr Damouni from absconding given that a judgment would need to be made about their own safety.[31] If restraints were required to be applied, it is always done through a Code Grey team response procedure.

35. When questioned about the appropriateness of holding involuntary patients like Mr Damouni in the emergency department until a suitable bed can be found in the psych ward, Dr Goldie stated that the ED is currently considered the most appropriate area as there is no provision elsewhere within the hospital to provide the same level of care.[32] He further went on to state that he did not personally believe it was the most appropriate area but that there are currently no '*alternative within the system and the system is Victoria wide.*'[33]

Professor Loh's Report and Preventative Measures:

36. Exhibit 1 at the inquest was the report prepared on 9 December 2016 by Professor Erwin Loh, Chief Medical Officer and Executive Director of Innovation, Patient Safety & Experience. The report acknowledged that '*better steps could have been taken to ensure Mr Damouni did not abscond, particularly as he had done so twice from its ED three days*

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[24] TS 10
[25] TS 38
[26] TS 10-11
[27] TS 15
[28] Ibid
[29] TS 7-8
[30] TS 11-12
[31] TS 13
[32] TS 14
[33] Ibid

earlier.'[34] At inquest, Dr Goldie elaborated that the following matters could have been improved;

a. The medical assessment that Mr Damouni underwent whilst in the ED[35] in so far as his preference would be for a '*combined assessment from the mental health team and the emergency team.*'[36] At the time, they were more separate assessments with Dr Goldie hoping that changes can be made to make it a '*combined parallel processing of the patient to ensure that all of the needs of a patient are met at the time, not a separate short assessment.*'[37]

b. The lack of beds in the psychiatric ward meaning Mr Damouni had to be held in the cubicle in the ED for a lengthy period of time. Dr Goldie stated that although the '*assessment area for mental health patients within the ED is lacking,*'[38] it is still currently considered the most appropriate area for holding involuntary patients given that there is no provision elsewhere within the hospital to provide the same level of care.[39] He further went on to state that he did not personally believe it was the most appropriate area but that there are currently no '*alternative within the system and the system is Victoria wide.*'[40]

c. The absence of a Behavioural Assessment Room (BAR) for the assessment of patients presenting with acute behavioural disturbances and exhibiting signs of agitation or clinical aggression. Dr Goldie explained that a BAR is '*the initial room where the assessment occurs and it's designed for a brief interaction with the patient of the order of 30 to 40 minutes to assess the safety of both the patient and staff and to provide an environment that is slightly removed from the Emergency Department.*'[41] It would involve the most senior doctors, ECAT and the most senior nurse along with the Code Grey Team.[42] He further stated that the presence of a BAR at the time of Mr Damouni's admission '*would have provided for an initial assessment. There may have been a higher likelihood that we would have used a chemical restraint at that time. The expectation is that Mr Damouni would have only been in that room for 30 minutes or so and then he would have been moved to within the department and most likely again to cubicle 17 and would have ongoing assessments and ongoing CPO.*'[43] This may have prevented Mr Damouni from absconding '*due to the potential higher likelihood of him of being administered a chemical restraint, a sedative.*'[44]

37. The report further noted the following preventative measures which have been implemented or are in the process of being implemented;

a. Monash Health has reviewed its security procedures in regards to patients presenting with mental health concerns, particularly its CPO program and was now providing CPO's with training in regards to de-escalation and managing clinical aggression and

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[34] Exhibit 1 p 1
[35] TS 21
[36] Ibid
[37] Ibid
[38] TS 16
[39] TS 14
[40] Ibid
[41] TS 17-18
[42] TS 39
[43] TS 18
[44] TS 19

suicide intervention. At the time of Mr Damouni's absconding, Ms Curtain had not received this training. At inquest, Dr Goldie stated that he believed this training would provide a more proactive response where the CPO and patient would develop a 'therapeutic bond' and thereby possibly reduce the will of a patient to abscond.[45] The role of the CPO continues to be reviewed and is in the process of being progressively transitioned into a more comprehensive Health Assistant in Nursing role.

b. Submissions have been made to the Department of Health and Human Services for a BAR to be built as well as a Behavioural Health Precinct (BHP) which would include cubicles, secure behaviours of concerns room and a short stay unit. The Monash Health submissions note that a BHP may provide a safer and more secure environment within the ED, which would allow mental health assessment and treatment to be located further away from the exits of the ED and to be staffed by both mental health clinicians and emergency clinicians.[46] Such a BHP would have had a 'higher likelihood' of preventing Mr Damouni absconding[47] and would be Dr Goldie's preferred environment for looking after a patient such as Mr Damouni whilst awaiting admission to a ward.[48]

c. The ED and Mental Health Program have reviewed their existing systems in place for managing patients presenting to the ED with mental health diagnoses. A number of formal written protocols including the *Mental Health Missing Persons Abscond and Absent without Leave Procedure, Mental Health Unplanned Departure Emergency Departments Procedure and Capacity Management and Escalation Mental Health Procedure* have been developed and have been communicated to staff via emails and team meetings.

d. The Mental Health Program has also reviewed and restructured its staffing to introduce site based management and support services; increase clinician staffing, introduced new forums and regular meetings to enhance communication between Mental Health and the ED, and reinforced with all staff and consultants the importance of escalation to the on-call psychiatrist.

Conclusions:

1. Security provisions at Casey Hospital were suboptimal on 12 July 2015 when Mr Damouni absconded for the third time in a matter of days.
2. In accordance with the evidence of Dr Goldie, the assessment area for mental health patients within the ED was lacking.

[45] TS 38
[46] Monash Health Submissions p 5
[47] TS 42
[48] TS 44

COMMENTS:

Pursuant to section 67(3) of the *Coroners Act 2008* (Vic), I make the following comments in relation to the death;

The inquest highlighted the difficulties in keeping involuntary patients secured within the ED whilst awaiting placement in the psychiatric ward. The submissions from Monash Health contained the following information from Professor Clarke which was not referred to at inquest;[49]

The last National Mental Health Report (2013) stated that in Victoria the average number of acute mental health inpatient beds was 20.6 per 100,000 population;

a) In 2015, the Casey-Cardinia area had an adult population of 201,911;

b) Applying a ratio of acute mental health inpatient beds of 20.6 per 100,000 population, Casey Hospital requires 41 acute mental health inpatient beds;

c) Casey Hospital has 25 acute mental health inpatient beds (a shortfall of 16 beds); and

d) Casey Hospital's population is growing rapidly and projections to 2025 would indicate that applying a ratio of acute mental health inpatient beds of 20.6 per 100,000, it will require a minimum of 50 acute mental health inpatient beds (a shortfall of 25 beds).

The provision of an increased number of acute mental health inpatient beds would undoubtedly improve the flow of mental health patients through the ED leading to speedier access to a much more appropriate treatment environment and reducing the risk of absconding.

The Monash Health submissions also noted that a BHP within an ED may provide a safer and more secure environment to allow for mental health assessment and treatment. Although it could not be stated that a BHP would eliminate absconding, such an area will reduce the risk of absconding given its physical location, layout and the fact that it would be staffed by both mental health clinicians and ED clinicians, which in itself will facilitate better and more efficient coordination of care.

The Monash Health BHP proposal includes:

a) co-location of mental health clinicians and emergency clinicians working within a coordinated model of care;
b) a dedicated internal waiting area;
c) interview rooms;
d) approximately five flexi cubicles (which can be used by general ED patients when not being used by behavioural health patients);
e) a secure room with visibility (a Behavioural Assessment Room); and
f) four short-stay mental health beds aimed at:
    i. ensuring that appropriate behavioural health patients (those not needing a admission to an acute inpatient bed and not well enough to be immediately discharged into the community) receive timely access to short-term inpatient care and treatment where required;
    ii. facilitating the timely discharge and the provision of quality behavioural health care in the community; and
    iii. improving patient flow through the ED.

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[49] Monash Health Submissions p 7

RECOMMENDATIONS:

Pursuant to section 72(2) of the *Coroners Act 2008* (Vic), I am able to make recommendations in relation to the death. I am aided by both Counsel for Monash Health and Counsel for the Damouni family in respect of these matters.

1. That Monash Health implement a Behavioural Assessment Room at Casey Hospital and, if appropriate, across the network of Monash Health Hospitals.
2. That Monash Health, in conjunction with Better Care Victoria, implement a Behavioural Health Precinct at Casey Hospital and, if appropriate, across the network of Monash Health Hospitals.
3. That Monash Health, in conjunction with Better Care Victoria, increase the acute mental health inpatient bed capacity at Casey Hospital and, if appropriate, across the network of Monash Health Hospitals.
4. That Monash Health review the manner in which clinical histories are obtained by staff when performing mental health assessments for patients presenting at the emergency department.
5. That Monash Health review its policies or procedures (if any), for incorporating information received from third parties about patients who present to the emergency department, particularly with psychiatric conditions.

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

Family of Mr Damouni

Detective Sergeant Duane McDonald, Cardia CIU

Mr Raph Ajzenstat, Victoria Bar

Mr Paul Halley, Victorian Bar

Ms Barbara deBrouwer, Minter Ellison

Mr Bruce Jerrett, Maurice Blackburn

Professor Erwin Loh, Chief Medical Officer, Monash Health

Dr Neil Goldie, Director of Emergency Medicine, Monash Health

Professor David Clarke, Program Medical Director of the Mental Health Program, Monash Health

Ms Rebecca McTernan, Director at Better Care Victoria

Signature:

IAIN WEST
DEPUTY STATE CORONER
Date: **7 June 2017**