IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 003862

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	Simon McGregor, Coroner
Deceased:	Thi Ha Do
Date of birth:	1 September 1973
Date of death:	On or about 18 August 2016
Cause of death:	Incised injury to the neck
Place of death:	Camberwell

I, SIMON McGREGOR, Coroner,

having investigated the death of THI HA DO

without holding an inquest:

find that the identity of the deceased was THI HA DO

born on 1 September 1973

and that the death occurred on or about 18 August 2016

at Epworth Health Care, 888 Toorak Road, Camberwell, Victoria 3124

from:

I (a) INCISED INJURY TO THE NECK

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Ms Do was a 42-year old married mother of two children. She lived in Cheltenham with her second husband, Ian Johnson, and their four year old son, and her teenage daughter from a previous marriage. Ms Do had travelled to Australia from Vietnam in 2011 to commence a doctoral program at Victoria University but deferred those studies when she became pregnant with her son.[1]

2. According to Mr Johnson, about six months after the birth of their son, his wife's behaviour changed. She became periodically sad, and at other times quite moody and angry. On one occasion Mr Johnson was so concerned by her inconsolable sobbing that he called for an ambulance, with paramedic attendance leading to his wife's transportation to Dandenong Hospital for psychiatric assessment. Ms Do discharged herself from the hospital shortly thereafter.[2]

3. Ms Do's behaviour continued to be erratic in 2013 and 2014 with what Mr Johnson described as 'lengthy temper tantrums' and other bizarre conduct such as spitting at walls and purposely flooding the laundry.[3] Despite being referred by her general practitioner [GP] for psychological counselling, Ms Do's engagement was short-lived, attending only two sessions before refusing to return. However, there were also periods when Ms Do appeared 'okay'.[4]

4. By 2015, Mr Johnson felt that his wife was becoming 'emotionally detached' from him and the children. Ms Do was once again persuaded to attend her GP and was this time referred to psychiatrist Dr Alan Blandthorn for management. Ms Do's presentation was overwhelmingly anxious, reporting poor sleep and appetite, feeling overly fatigued, stressed and overwhelmed. She admitted some thoughts of suicide commencing in late 2014 without any specific plan or

[1] Coronial brief of evidence, Statement of Ian Johnson.
[2] Ibid.
[3] Ibid.
[4] Ibid.

intent. Dr Blandthorn diagnosed her with depression and commenced her on the antidepressant mirtazapine. Throughout 2015, the psychiatrist reviewed Ms Do every three months and she attended a mental health nurse monthly for mental state examination and risk assessment. Ms Do's mental state was considered to have stabilised by the end of the year.[5]

5. However, in around July 2016, Ms Do's mental health deteriorated sharply. She presented to Dr Blandthorn on 5 July 2016 with a three-week history of poor sleep, low energy, irritability, low motivation and thoughts that she did not want to live. She had been prescribed the sedatives zopiclone and temazepam by her GP to assist with sleep but these had little effect on her insomnia. The psychiatrist increased her dose of mirtazapine but when little improvement in her mood was observed by the following week, the antipsychotic olanzapine was added in part to help initiate sleep. When reviewed on 22 July 2016, Ms Do's sleep had improved and this, in turn, had had a positive effect on her mood.

6. At review with Dr Blandthorn on 5 August 2016, Ms Do reported that she was not coping, lacked energy, interest and motivation and it would be 'easier to be dead', though the latter remark was not accompanied by specific thoughts of suicide.[6] The antidepressant venlafaxine was added to her medication regime. When Ms Do's low mood persisted on review, an inpatient admission to the Epworth Clinic [Epworth] was arranged by Dr Blandthorn for further treatment of her depressive symptoms and anxiety.[7]

Ms Do's psychiatric admission to the Epworth

7. On the evening of 10 August 2016, Ms Do was admitted to the psychiatric inpatient unit of the Epworth for voluntary treatment. She was accommodated in a large single room with an *en suite* bathroom on level two of the hospital in the 34-bed Unit A.[8]

8. On admission, Ms Do was examined by psychiatrist Dr Ashu Rajan Gandhi who also reviewed Dr Blandthorn's referral. Ms Do presented as agitated and restless but was polite and cooperative. She appeared flat, with restricted range and reactivity but without evidence of thought or perceptual abnormalities. She reported depressive symptoms since late 2014 and intermittent suicidal ideation, with no intent or plan. Ms Do's insight into her illness was fair and she was help-seeking.[9]

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[5] Coronial brief of evidence, correspondence between Anh Nguyen (mental health nurse) and Dr Hilal (GP) dated 17 February 2016 and statement of Dr Blandthorn.
[6] Coronial brief of evidence, statement of Dr Blandthorn.
[7] Ibid.
[8] Coronial brief of evidence, statement of Paul Sweeney.
[9] Coronial brief of evidence, statement of Dr Gandhi.

9. Dr Gandhi concurred with Dr Blandthorn's diagnosis of major depressive disorder. He considered that underlying complex psychosocial issues including cultural dissonance, adjusting to a different culture as a migrant, marital conflict and possibly lack of close psychosocial supports were likely contributing to her presentation, in addition to complicating her response to treatment.[10]

10. Dr Gandhi performed a risk assessment. On the basis that Ms Do denied any past history of suicide attempts and reported intermittent suicidal thoughts without any specific plan or intent, her acute risks of self-harm and suicide were assessed as low. However, as she was a new patient presenting with depressive symptoms, Ms Do was placed on 30-minute observations[11] and was dissuaded from seeking leave from the unit until she had settled in and Dr Gandhi had a clearer picture of her history and mental state.[12]

11. Dr Gandhi discussed the inpatient program with Ms Do, including her expectations about treatment. He recommended the group psychotherapy programs, noted that the unit was staffed day and night with nurses and that her regular medications would continue to be administered and others prescribed as needed. Ms Do's medication regime consisted of a reducing dose of mirtazapine given her lack of response to it, an increased dose of venlafaxine and the introduction of temazepam and quetiapine to assist with sleep, and clonazepam to address symptoms of anxiety.[13]

12. Over the subsequent days, Ms Do was reviewed on a near-daily basis by Dr Gandhi. Her presentation altered little: she remained of low mood, intermittently agitated and denying suicidal ideation, her sleep showed some improvement but she ate nothing because she disliked the food provided. Although Ms Do appeared engaged in her treatment, participating in discussions about the rationale for continued titration of her various medications and the like, she declined to attend group therapy sessions said she was 'bored' in the hospital.[14]

13. When Ms Do remained 'flat, lost and vague'[15] on 14 August 2016, Dr Gandhi suggested transcranial magnetic stimulation and electroconvulsive therapy [ECT] as possible treatment modalities given the intractability of her symptoms. ECT was discussed further at a family meeting attended (with Ms Do's consent) by Mr Johnson. Dr Gandhi obtained a corroborative history from Ms Do's husband in which the prevalent themes were his wife's sadness and

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[10] Coronial brief of evidence, statement of Dr Gandhi.
[11] The Epworth's Mental Health Services Risk assessment and Observation Protocol (2013) outlines the risk assessment procedure and establishes four categories of risk from low risk (category 1) to very high risk (category 4). Ms Do was subject to category 2 or medium risk observations, requiring visual sighting every 30 minutes day and night.
[12] Coronial brief of evidence, statement of Dr Gandhi.
[13] Ibid.
[14] Ibid.
[15] Ibid.

waning resilience, her frustration at her inability to obtain employment commensurate with her skills, ongoing marital issues, and his perception that Ms Do seemed happier with her Vietnamese friends than with him, and that she seemed unlikely to continue in the marriage and in Australia.[16]

14. On 15 August 2016, Ms Do was visited by some of her Vietnamese friends.

15. On 16 August 2016, Ms Do's contact nurse contacted Dr Gandhi due to concern that Ms Do was not eating, despite the attempts made to negotiate with her. The psychiatrist suggested further engagement and negotiation and perhaps contacting Mr Johnson to see whether he could visit and assist. In the evening, Dr Gandhi received an update of progress: Mr Johnson had visited and his wife had eaten some food and continued to engage with the nurse. Given ongoing concerns about Ms Do's inadequate diet and ongoing psychiatric symptoms, Dr Gandhi considered the possibilities of requiring Ms Do to receive involuntary treatment under the *Mental Health Act* 2014 and commencing ECT without delay, particularly if she continued to refuse food. He arranged for a second psychiatric opinion to be provided by a colleague on 18 August 2016 with a view to commencing ECT by the end of the week.[17]

Circumstances proximate to death

16. On 17 August 2016, Ms Do texted her brother, Phong Do who lives in Victoria, asking him to bring a knife with him when he visited that evening. He replied that he could bring one but would not leave it with her. She later texted him again telling him not to worry about the knife.[18]

17. Ms Do called her husband and her daughter during the day.[19] In the course of each call, she gave them instructions about how to take care of her son.

18. That evening, Ms Do telephoned her friend, Vo Trang, who had visited her a number of times during her admission. She reported that another friend had brought her some fruit but had no knife with which to cut it and asked that Ms Trang bring one with her when she visited a short time later.[20]

19. Ms Trang arrived at the Epworth at around 7.45pm and brought with her a green-coloured knife in a scabbard.[21]

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[16] Coronial brief of evidence, statement of Dr Gandhi.
[17] Ibid.
[18] Coronial brief of evidence, statement of Phong Do.
[19] It is not entirely clear from the available evidence whether these telephone calls occurred on 16 or 17 August 2016. I note that in his statement, Mr Johnson refers to the calls occurring on 'the day before [Ms Do] passed away'.
[20] Coronial brief of evidence, statement of Vo Trang.
[21] Ibid.

20. Before reviewing Ms Do that evening, Dr Gandhi discussed her presentation that day with her contact nurse. The nurse reported that Ms Do had engaged with him well and extensively during the shift and had even laughed; he had no concerns about her food intake. When Dr Gandhi went to collect Ms Do from her room for review, she had a visitor with her and was reluctant to leave her. However, the visitor encouraged her friend to attend the review and Ms Do agreed to follow Dr Gandhi over to a consulting room. According to Dr Ghandi, when Ms Do entered the consulting room she 'appeared quite relaxed' and was eating a segment of orange.[22]

21. Ms Do reported to Dr Gandhi that she was feeling much better and more active. She had enjoyed the company of a number of visitors throughout the day and had been able to eat lunch and dinner. Ms Do said she was keen to go home the next day but, when the psychiatrist relayed the arrangements for a colleague to provide a second opinion about commencing ECT, she agreed to remain. She asked some questions about ECT and whether the improvement in her mood that day was attributable to ongoing changes to her medications. Dr Gandhi assessed Ms Do's mental state and insight into her condition as improving, noting that her mood had lifted and that her range of emotion and reactivity had improved. She explicitly denied any ongoing suicidal thoughts, intent or plan.[23]

22. Around 8.30pm, Ms Do's brother arrived at the Epworth with their father and his own son. Mr Do saw that Ms Trang was visiting his sister and that she left a short time after his arrival. Mr Do left the unit around 9pm.[24]

23. At 9.30pm, Registered Nurse [RN] Ferdinand Pajarillo and Associate Nurse Unit Manager [ANUM] Paul Sweeney commenced the nightshift in Unit A with a verbal and visual handover of each of the 28 patients on the ward and a medication count with the nurses finishing their shift.[25] Ms Do, in Room 22, was among those patients assigned to RN Pajarillo's care for the shift, though both he and ANUM Sweeney shared the conduct of the 30-minutely observations depending on what other responsibilities arose for each overnight.[26]

24. When RN Pajarillo started his shift and completed the 'patient walk around', Ms Do was already in bed with the room lights off and apparently asleep though some movement was

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[22] Coronial brief of evidence, statement of Dr Gandhi.
[23] Ibid.
[24] Coronial brief of evidence, statement of Phong Do.
[25] Coronial brief of evidence, statement of ANUM Sweeney.
[26] Coronial brief of evidence, statements of ANUM Sweeney and RN Pajarillo.

visible in the bed.[27] For each subsequent observation there was always the appearance of someone in the bed.[28]

25. At about 5am on 18 August 2016, RN Pajarillo performed the visual observation of Ms Do. He shone his torch on her bed and it appeared occupied. Despite this, he decided to check the *en suite* bathroom and, upon opening its door, saw Ms Do kneeling in front of the toilet with her head over the bowl, with what appeared to be a lot of blood around the base of the toilet and a green-coloured knife to its left. RN Pajarillo alerted the ANUM and both returned to Ms Do's room.[29]

26. ANUM Sweeney checked Ms Do for a pulse and respirations but found neither[30] and pressed the emergency button, which activated a Code Blue emergency response comprised of other staff on duty. Although she appeared to have died some time earlier, Ms Do was placed on the floor of the bathroom and cardio-pulmonary resuscitation was attempted.[31] An ambulance was called and the attending paramedics confirmed that Ms Do had died.[32]

Coronial Investigation

27. Victoria Police members attended the scene and a coronial investigation was commenced. During a search of Ms Do's room, the green knife located near her body was seized but no 'suicide note' was found.[33] One of the attending police members, Detective Sergeant Eric Young of Boroondara Crime Investigation Unit later compiled the brief of evidence on which this finding is largely based.[34]

28. This matter was initially investigated by Coroner Peter White. Following his retirement, I took carriage of the matter.

29. Senior forensic pathologist, Dr Michael Burke of the Victorian Institute of Forensic Medicine, reviewed the circumstances of the death as reported by police to the coroner, post-mortem computer assisted tomography [PMCT] scans of the whole body and performed an external examination. Among Dr Burke's anatomical findings were an incised injury to the left-side of the neck measuring 11 centimetres [cm] by 4cm, a deep 3.5cm transverse incised injury to the

[27] Coronial brief of evidence, statement RN Pajarillo.
[28] Coronial brief of evidence, statements of ANUM Sweeney and RN Pajarillo.
[29] Coronial brief of evidence, statement of RN Pajarillo.
[30] Coronial brief of evidence, statement of ANUM Sweeney.
[31] Ibid.
[32] Ibid.
[33] Coronial brief of evidence, statement of Constable Lai Sang.
[34] Coronial brief of evidence, statement of DS Young.

anterior aspect of the left wrist and a superficial 2.5cm transverse incised injury about 2.5cm proximal to the other injury to the anterior left wrist, and signs of medical intervention.[35]

30. Routine post-mortem toxicology detected venlafaxine and its metabolite, mirtazapine, quetiapine and 7-aminoclonazepam at levels consistent with their therapeutic use.[36]

31. Dr Burke advised that it was reasonable to attribute Ms Do's death to an incised injury to the neck, without the need for a full autopsy.[37]

32. In correspondence with the Court dated 1 September and 8 November 2016,[38] Mr Johnson raised a number of concerns about his wife's management at the Epworth that centred on environmental safety – Ms Do's access to a knife – and the adequacy of overnight visual observations. Accordingly, at Coroner White's request the Mental Health Investigators of the Coroners Prevention Unit [CPU][39] reviewed Ms Do's Epworth medical records, the coronial brief and other available materials and provided some advice about the adequacy of the care she received during her inpatient admission. The CPU advised:

    a. The quality of care provided to Ms Do was reasonable in regards to assessment of presentation, physical health, care planning, family engagement and type, dose and frequency of medications. However, there was a lack of focus on safety in the environment, nursing staff completion of shift risk assessments, rigor of the clinical handover visual round and the system for completing visual observations which did not appear to be linked to a current and reasonable risk assessment.

    b. The initial assessment of risk was completed appropriately and Dr Ghandi recorded his assessment of risk at each of his face-to-face contacts with Ms Do. However, further clarification of the risk assessment process, especially by nursing staff, should be sought from the Epworth.

    c. It is not clear whether clinical handover occurred, notwithstanding the statements of Nurses Sweeney and Pajarillo, given the latter's comment that nothing significant was handed over from the previous shift. In the context of the remarkable

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[35] Coronial brief of evidence, Report of Dr Michael Burke.
[36] Coronial brief of evidence, VIFM Toxicology Report authorised by Kerryn Crump.
[37] Coronial brief of evidence, Report of Dr Burke.
[38] Mr Johnson first raised concerns when he was contacted by the staff of Coronial Admissions and Inquiries on 20 August 2016.
[39] The Mental Health Investigators [MHI] are part of the Coroners Prevention Unit [CPU] established in 2008 to strengthen the prevention role of the Coroner. CPU assists the Coroner to formulate prevention recommendations and comments, and monitors and evaluates their effectiveness once published. The CPU's two clinical branches – MHI and the Health and Medical Investigation Team - are staffed by practising physicians and nurses who are independent of the health professionals or institutions involved. They assist the Coroner's investigation of deaths occurring in a healthcare setting by evaluating the clinical management and care provided and identifying areas of improvement so that similar deaths may be avoided in the future.

improvement in Ms Do's mental state on that day, as documented by Dr Ghandi and nursing staff, it is surprising that this information was not handed over. Moreover, photographs taken of Ms Do's room after her death suggest inadequate engagement with her during the evening and night shifts.[40]

d. A letter dated 3 May 2017 provided by Dr Graham Wong, Director of Psychiatry and ECT, outlines the outcomes of the Epworth's internal review following Ms Do's death. The implementation of improvements recommended by the review focusses on risk assessment and observations by nursing staff and environmental safety. However, further information should be obtained to clarify the measured adopted.

33. At Coroner White's request, and on the recommendation of the CPU, further information was obtained from the Epworth. The CPU reviewed the clarifying information provided by Director of Clinical Services, Suzie Hooper dated 28 September 2017[41] and provided additional advice. Ms Hooper provided a further update on what changes had been made on 15 May 2019:

a. The consolidated risk assessment [CRAM] – the risk recording sticker placed in a patient's progress notes – was in place at the time of Ms Do's death but was not then used by nursing staff. In 2016, the minimum expectation was that the CRAM was completed daily and at times when clinical presentation changed. However, there were no CRAM in Ms Do's progress notes.

b. The Epworth has revised a number of protocols and actions to provide greater emphasis on risk assessment and reassessment, engagement with patients during rounding and establishing patient and environmental safety: Mental Health Inpatient Leave Protocol, Search of Patient's Room Protocol, Mental Health Unit Suicide Management Protocol, Epworth Prevention of Suicide Identification and Management Guidelines and Risk Assessment and Management Protocol.

c. Of particular relevance are the changes made to the Risk Assessment and Management Protocol was updated to require that patient safety be established at each handover and on 60-minutely rounding. The requirements for establishing safety includes engagement and/or establishing to the clinician's satisfaction the health and safety of any patient who is asleep.

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[40] The Mental Health Investigator referred specifically to the presence of the meal tray, with uncovered food and a metal hospital knife, from the evening before her death [Photograph 65].

[41] The Mental Health Investigator also had telephone contact with Ms Hooper on 14 November 2017.

d. The changes to protocols were introduced on 15 October 2017 following dedicated training sessions for staff provided by the nurse educator and nurse unit managers.

e. The Epworth Clinic Patient Information Booklet (also accessible to family and visitors) has been revised to include information about dangerous items including knives, and that they should not be brought into the unit. It also indicates that staff may search belonging's and/or a patient's room if concerned about safety issues.

f. The Epworth Clinic Code of Conduct was revised to require patients to acknowledge that staff can and will search a patient's room if they perceive increased risk and a patient's agreement to volunteer any dangerous or inappropriate items.

g. New signage asking that visitors refrain from bringing dangerous items into the unit, including knives, at the entrance of both mental health wards.

h. As of 15 May 2019, the Epworth has introduced a more rigorous pre-admission assessment which includes a greater focus on acuity of the patient through a designated Mental Health Intake Unit.[42]

i. The Epworth has also revised and enhanced the Mental Health Inpatient Clinical Risk Assessment and Management Form. The form now includes comprehensive screening for suicide risk as part of the overall risk assessment process. The form is required to be completed on admission and is reviewed each shift by the mental health nursing team.

j. The Epworth has delivered comprehensive face-to-face and online Suicide Prevention Training for all current mental health staff incorporating acute mental health risk assessment and management. The training program has been developed through:

    i. conducting a literature review of best practice regarding suicide risk assessment and management; and

    ii. a training needs analysis to ascertain the staff's level of knowledge about managing the risk of suicide, allowing training to be tailored to address knowledge gaps.

An internationally accredited training with expertise in suicide risk management has developed the content and the training program is delivered on a quarterly basis.

[42] This Unit was open and providing services at the time of Ms Do's admission, but was subsequently relocated to a dedicated space on the ground floor of Epworth Clinic. This was done to better facilitate privacy and uninterrupted, face to face review of each patient and their current level of risk, prior to entering the Epworth Clinic as an inpatient.

k. The Epworth has reinforced their structured escalation process for managing patient deterioration and suicidality by the availability of a quick reference visual aid which is displayed in staff-only areas.

l. The Epworth has commenced a one-day Orientation Workshop for all newly employed mental health nurses to introduce them to the method and frequency of risk assessment and the Epworth's management strategies for suicide prevention.

m. The revised protocols add more rigour to the comprehensiveness, documentation and frequency of nursing staff's assessment of risks and links this to rounding and nursing observations practices. The additional training should assist in ensuring that all staff effectively implement protocols.

n. Nursing staff are now expected to confirm that a patient who appears to be asleep is safe. This change has clear relevance to Ms Do's death as incomplete documented overnight observations placed her in bed and assumed that she was asleep and safe when at some stage during the period of these observations she was in the bathroom harming herself.

o. Awareness raising at the Epworth, and inclusion of information about dangerous items that are prohibited on the unit is positive and focuses on patients and visitors, and decreases access to means of self-harm. The information for patients is useful, but in Ms Do's case it was the visitor who needed to be aware of potential dangers of certain items.

p. Ms Do appears to have specifically requested the knife from her friend with intent to use it to self-harm. In these circumstances, she is unlikely to have volunteered the knife to staff as expected in the Code of Conduct and Information Booklet. Reliance has to be in signage that is clear to visitors who are entering and/or inside the unit. The placement of signage provides opportunities to visitors that would encourage them to not bring dangerous items into the unit or speak with staff for advice.

34. The CPU concluded that the combination of improvements to active nursing staff engagement and monitoring of a patient's mental state and risks, increased staff skills and training, and awareness raising that dangerous items are not appropriate on the unit, should reduce the risk that the circumstances of Ms Do's death will arise again at the Epworth.

35. I find that Ms Do, late of Robross Street, Cheltenham, died on or about 18 August 2016 at the Epworth, 888 Toorak Road, Camberwell, and that the cause of her death was an incised injury

to the neck. I am satisfied by the available evidence by the available evidence that Ms Do intended to take her own life.

36. I find that suboptimal environmental safety and overnight visual observation of Ms Do at the Epworth contributed to her death.

37. That said, I endorse the various improvements implemented by the Epworth following Ms Do's death, particularly in relation to the posted prohibition of dangerous items on the ward, the rigour of nursing observations overnight and risk assessments, and am reassured that together these should minimise the likelihood of similar deaths occurring in future.

Previous coronial recommendations and Safer Care Victoria

38. On 14 April 2018, Coroner White delivered his findings into the death of Gerard Helliar, a man who took his own life while he was an involuntary patient using a belt which he had brought into the ward.

39. Coroner White made several recommendations addressing issues including the presence of dangerous items in inpatient mental health settings. Coroner White recommended:

'*That the Office of the Chief Psychiatrist reviews its approach to the bringing into psychiatric hospital units of any personal items of a potentially dangerous nature. Belts, cords and the like are clearly such items.*'

40. Following the publication of Coroner White's recommendation, Professor Euan Wallace of Safer Care Victoria responded in a letter dated 21 May 2018. Professor Wallace stated that Safer Care Victoria would support the implementation of the above recommendation in the following way:

'*We are in the process of establishing a Safer Care Victoria Mental Health Clinical Network to work closely with the Office of the Chief Psychiatrist and the Department of Health and Human Service Mental Health Branch. I will ensure that the network receive a copy of the coronial findings.*'

41. I commend this effort by Safer Care Victoria, and I will make a recommendation that they take into account Ms Do's death and the Epworth's subsequent improvements in their work.

RECOMMENDATION

1. Pursuant to section 72(2) of the *Coroners Act 2008*, I recommend that Safer Care Victoria and the Safer Care Victoria Mental Health Clinical Network work to identify inadequate approaches to excluding dangerous items from psychiatric hospital units and to implement improvements, such as the Epworth's, across the Victorian health system.

Pursuant to section 73(1A) 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:

Ian Johnson

Professor Euan Wallace, Safer Care Victoria

Melissa Kavanagh, Epworth Healthcare

Andrew Mariadason, Avant Insurance

DS Eric Young, Boroondara CIU

Signature:

SIMON McGREGOR
CORONER
Date: 17 May 2019