IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 0995

FINDING INTO DEATH WITHOUT INQUEST

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

I, PETER WHITE, Coroner having investigated the death of BRUCE DESMOND ANDREWS

without holding an inquest:
find that the identity of the deceased was BRUCE DESMOND ANDREWS
born on 3 July 1952
and the death occurred some time between 7 March 2013 and 8 March 2013
at 2 Tamar Street, Bayswater, Victoria 3153
from:

1 (a) MEDICATION OVERDOSE

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

1. Bruce Andrews was 60 years old at the time of his death. He resided alone in Bayswater. Mr Andrews was a motor mechanic by trade. He volunteered at Animal Aid in Coldstream.

2. A brief was provided by Victoria Police to the Coroner, including statements obtained from Mr Andrew's step daughter Dalene Ridgewell, step granddaughter Renee Talbot, ex-partner Jenny Jones, treating clinician, attending paramedics, Ambulance Victoria (AV), the Emergency Services Telecommunications Authority (ESTA) and investigating officers. I have drawn on all of this material as to the factual matters in this finding.

3. Mr Andrews had previously been in a defacto relationship with Gloria Parker for approximately 40 years. Prior to this, Ms Parker was married with children. Mr Andrews developed a relationship with her children and grandchildren. He had a history of alcohol addiction and underwent rehabilitation in the 1980's and at other times during his life.

4. Since approximately June 2009, Mr Andrews started a relationship with Ms Jones, whom he met at Animal Aid. Prior to this, Mr Andrews had been seeing another colleague. Mrs Talbot reported that there was a visible strain on Mr Andrews during this time, Ms Parker had

developed early onset dementia requiring extra care, he started drinking again and his mental health deteriorated. His relationship with Ms Parker officially ended in April 2011.

5. Consultant Psychiatrist Dr Shashi Varma diagnosed Mr Andrews as suffering from major depression with anxiety disorder. It was reported throughout the coronial brief that Mr Andrews suffered from bi-polar and schizophrenia. Dr Varma noted at a consultation in May 2009 that Mr Andrews questioned whether he had bipolar. This was not a formal diagnosis. Dr Varma saw Mr Andrews regularly for a number of years. While under the care of Dr Varma, Mr Andrews was admitted to the Delmont Private Hospital on a number of occasions for psychiatric care, including admissions following attempts he made to take his own life. Mrs Talbot reported Mr Andrews took an overdose of his medication on at least three occasions.

6. Approximately two weeks prior to his death, Mr Andrews' relationship with Ms Jones ended. Mr Andrews had invested financially and emotionally in the relationship and it appears the break up came as a surprise and greatly affected him. Mrs Talbot and Ms Ridgewell, provided support to Mr Andrews. Mrs Talbot reported he had "an emotional breakdown" and struggled to come to terms with the end of the relationship.

7. At about lunchtime on 7 March 2013, Mr Andrews called Mrs Talbot. He was upset about the quality of workmanship on an installation made to his new vehicle. Mrs Talbot listened to his concerns. She reported that at the end of their conversation, he appeared to be back to his usual self. Mrs Talbot received a second call from Mr Andrews at about dinnertime later that day. It was obvious to Mrs Talbot he had been drinking, he sounded drunk; he discussed the break up with Ms Jones and sounded "miserable." Mr Andrews told Mrs Talbot that he had drunk six 'cans' of double strength vodka. They talked for a while and when they said goodbye, Mrs Talbot believed that while he was drunk and upset, he was "okay" and she was not too concerned.

8. Mr Andrews called Mrs Talbot again at about 9.30pm that evening. He told her that he had thrown himself head first off his porch thinking it would end his life. Mrs Talbot became upset, Mr Andrews told her he was not thinking and wanted the pain to go away. He reported having drunk another four 'cans'. He repeatedly said his head was sore. Mrs Talbot reported his speech was slightly slurred. Mr Andrews talked about his past relationships and told Mrs Talbot everyone would be better off if he was not here. They talked for approximately one hour. At the end of the call, Mr Andrews told Mrs Talbot that she should go to bed. She responded saying she would not go to bed unless she was sure he would answer the phone tomorrow. Mr Andrews told her he could not promise that. Mrs Talbot asked him if she

should drive to his house[1] that night, however he responded saying that was not necessary, he loved her and he had to go.

9. Concerned for Mr Andrews, Mrs Talbot called a friend for advice. She was told to call emergency services and ask for an ambulance. Mrs Talbot immediately called '000'. Mrs Talbot reported that she told the ESTA call taker that she needed someone to check on her Pop. He had a history of suicide, had been drinking and had thrown himself head first off his porch and had hit his head hard and that he told her his head was really hurting. The call taker asked if Mr Andrews had discussed ending his life and Mrs Talbot responded saying he had and that he usually takes tablets when he does however she was unsure whether he had taken any that night. When Mrs Talbot hung up, she called Mr Andrews, however he did not answer.

10. Ambulance paramedic, Sharon Cayzer reported that at approximately 12.12am on 8 March 2013, her ambulance (DA002) was dispatched to attend an incident described as Ambulance-Urgent within 25 minutes at 2 Tamar Street, Bayswater. The call had been received at 10.44pm. The information available to paramedics on the Mobile Data Terminal (MDT) stated they were responding to a 61 year old male who was conscious and breathing after he was involved in a fall that was less than two metres. They were also informed on the MDT that at 11.28pm on 7 March 2013, a Referral Service Paramedic[2] had telephoned the patient to conduct a welfare check. Ms Cayzer reported that before arriving at 2 Tamar Street, Bayswater they were diverted to a Code 3 in Cheltenham. At 3.07am, they were dispatched for a second time to 2 Tamar Street, Bayswater.

11. Ms Cayzer and Paramedic Mark Jozsa arrived at Mr Andrews home at approximately 3.23am. They knocked on the front door and nearby windows however there was no answer. They requested ESTA do a 'call back' to the residence. The dispatcher informed them there was no answer from the residence. Ms Cayzer contacted the Duty Manager of channel 101 for advice.

12. At approximately 3am, Mrs Talbot reported she received a phone call from the ambulance service asking for permission to break into Mr Andrews' home, which she gave. She asked the caller why it had taken so long for an ambulance to attend and was informed that it had been a busy night and the ambulance had been diverted twice.

13. The duty manager informed Ms Cayzer and Mr Jozsa they had permission to break into the house. They walked around the perimeter to find a suitable entryway. When they walked past

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[1] Mrs Talbot lived approximately two hours away.

[2] Also known as Refcomm

the kitchen window a second time, they saw Mr Andrews lying on the kitchen floor. Mr Jozsa believed Mr Andrews was deceased and they immediately requested a Mobile Intensive Care Ambulance (MICA) and broke a window to enter the house. On entering the kitchen, Ms Cayzer found Mr Andrews unresponsive; he was not breathing and had no palpable pulse. He was cold to touch and had a temperature of 31 degrees Celsius. Mr Andrews was declared deceased. Ms Cayzer noted she found no obvious injuries to Mr Andrews' head or body.

14. Victoria Police commenced an investigation into the circumstances of Mr Andrews' death. Police located a note in Mr Andrews' bedroom, evidencing his intention to take his own life. A small bag containing prescription medications was found on the living room table. The investigation did not identify any suspicious circumstances or evidence of third party involvement.

15. On 12 March 2013, Dr Michael Burke, Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM) performed a medical examination on the body of Mr Andrews. The post mortem computed tomography (CT) scan showed no evidence of drug residue within the stomach. There was no evidence of a facial or skull fracture. Dr Burke reported the external examination was unremarkable.

16. Post mortem toxicological analysis detected the presence of alcohol (0.12g/100mL), clonazepam (0.05mg/mL) and its metabolite 7-aminoclonazepam (0.08mg/mL), dothiepin (0.7mg/L) and zopiclone (0.3mg/L). Toxicologist Melynda Hargreaves commented that the combination of drugs may cause death in the absence of other contributing factors.

17. Dr Burke provided an opinion that the medical cause of Mr Andrews' death was medication overdose.

18. I determined to investigate the AV response time and requested statements from AV and ESTA. Benedict Piper, Communications Centre Manager, provided a statement on behalf of AV.

19. Mr Piper reported AV staff work alongside ESTA staff in the communications centre. All cases are managed using computer aided dispatching (CAD). CAD collects all case information case information from call start through to case completion. The details contained in CAD are visible to both ESTA and AV staff.

20. ESTA staff are responsible for call-taking and dispatch and AV staff are responsible for the operational, logistical and human resources aspects of service delivery. ESTA defers to AV for dispatch advice during periods where case demand outstrips supply of available ambulances. All 000 calls for ambulances are taken by ESTA call takers who primarily assess

the information using a program called Medical Priority Dispatch System (MPDS). The system categorises and prioritises case response based on answers to an algorithmic questioning hierarchy by the person making the call. The case is then dispatched to ambulances by ESTA. Cases are allocated a priority3 rating between zero and three, where zero has the highest priority. When demand outstrips supply, the highest prioritised cases will take priority for case dispatch and response. This may mean that an ambulance that is responding to a priority two or three case may be redirected from that case to respond to a priority zero or one case if it is the closest, or only, available ambulance at the time of dispatch.

21. After a call is received and triaged by an ESTA call taker, the case is forwarded to an ESTA dispatcher for dispatch. A function called Recommended Closest Unit (RCU) is undertaken by the dispatcher. The CAD assesses the seven closest ambulances within a 10 kilometre radius of the case location and recommends those units for dispatch to the case, ranking them in dispatch order from closest to furthest away from the case location. The dispatcher will then dispatch the closest available ambulance. When there are no nearby ambulances (within 10 kilometres), the dispatcher will either complete a "No Nearby Unit" workflow or discuss the case with an AV Duty Manager (DM) or Communication Support Paramedic (CSP) who will determine how the case should be resourced.

22. Mr Piper reported that in some instances it is necessary to hold low priority (priority two and three) cases until resources become available to dispatch. The DMs and CSPs determine which events can be held. When a case is held it is visible in CAD as pending and can be dispatched at any time by the ESTA dispatcher if an ambulance becomes available. However, a DM or CSP can instruct ESTA to hold the case for a particular ambulance.

23. To manage logistic support of the emergency ambulance fleet, DMs use 'dispatch warnings'. A dispatch warning has the effect of reducing the response capability of an ambulance. For example an ambulance may only be able to respond to certain priority cases and cannot respond to other priority cases. A consequence is that during particularly busy periods cases that are classified as code two and code three have increasing waiting times whilst the higher prioritised cases are attended to.

24. When there is no available unit to attend a case, the event is marked by the dispatcher with "area of resource need", who will then discuss the case with the DM or CSP. In some

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[3] Case priority is also linked to the term "code". The term "code" describes how AV resources respond to a prioritised event. Code 1 = Priority 0 and 1 requiring an emergency vehicle (lights and sirens) response. Code 2 and 3= Priority 2 and 3 are normal driving conditions response.

instances when this occurs, it is necessary for the DM to hold low priority cases until resources become available to dispatch. DMs and CSPs determine which events can be held.

25. Mr Piper reported that the AV Referral Service was implemented in metropolitan Melbourne in 2003. A Referral Service caller is a paramedic or registered nurse with at least four years of postgraduate experience. Their role is that of secondary triage. When case delays occur the Referral Service call taker contacts and assesses the patient, informs the patient of the delay and if necessary, reassess their medical condition for changes and case reprioritisation.

26. Ambulances may also be diverted to cases with a higher priority whilst on route to an event. This means the system has the flexibility to re-prioritise and deal with incoming cases that are more urgent. AV communications staff can also use a function in CAD called 'No Divert'. This warning means that an ESTA dispatcher cannot send that ambulance to a higher priority case without first discussing it with the person who placed the warning on that ambulance. This function is a way of stopping continual diversions of ambulances from lower to high priority cases during time of demand, as well as for clinical needs.

27. Mr Piper reported that upon reviewing AV data systems on the evening of 7 March 2013 and the early hours of 8 March 2013, there was a demand for ambulances that outstripped supply. This demand meant that between 10pm on 7 March 2013 and 2.15am on 8 March 2013, there were between 15 and 25 code two and three cases pending dispatch at any given time, as they were waiting for ambulances to become available to respond. Code zero and one cases were given priority and there were a number of pending code one cases. There were lengthy delays across metropolitan Melbourne and as a result the Referral Service was also extremely busy as they were required to conduct welfare checks via telephone for all waiting code two and three cases.

28. ESTA received Mrs Talbot's call at 10.44pm. The case was coded '17B1 (falls – possibly dangerous area)' according to MPDS Protocol 17 and assigned priority two and dispatch code two, meaning that an ambulance was required to be at the scene within 25 minutes. At 10.44pm the dispatcher utilised the CAD RCU, however dispatch did not occur because there were no available ambulances to dispatch. At 10.48pm, the call taker attempted to call Mr Andrews twice however the call went to voicemail. At 11.14pm, the CSP on duty noted there was no AV vehicle immediately available and made the decision to hold the case until an ambulance was available. The case was referred to the Referral Service.

29. Referral Service Paramedic Elizabeth Ray commenced work at 2pm on 7 March 2013. When she commenced her shift, the escalation policy was in place requiring Referral Service paramedics to conduct welfare checks to ascertain whether lower acuity cases still required

ambulance attendance. Ms Ray recalled it was extremely busy during her shift and it was particularly noisy in the room as a result of the increased volume of calls causing the background noise to increase making the room louder than usual. At 11.19pm, Ms Ray was prompted to call Mr Andrews. At this time, the ambulance response time of 25 minutes had already been exceeded by 12 minutes. Before calling Mr Andrews, Ms Ray reviewed the case details.

30. At approximately 11.20pm, Ms Ray telephoned Mr Andrews on his mobile phone.4 The first call went to voicemail, however on a second attempt, Mr Andrews answered. Ms Ray reported she had great difficulty hearing Mr Andrews. She recalled he was coughing a lot and his voice was croaky and unclear. She had to ask him multiple times to repeat his answers. Ms Ray reported she was having difficulty hearing because of the background noise and the quality of the telephone headset she was using, which did not block out background noise. Ms Ray asked Mr Andrews what he was coughing up to which he replied "probably a bit of overdose". She questioned what Mr Ray had overdosed on and she reported she could not hear his answer both times she asked this question. Ms Ray listened to the audio recording at a later date and reported it appears Mr Andrews replied to her question saying "Prothiaden". Ms Ray is confident she did not hear this during the phone call on 7 March 2013. Ms Ray was unable to say why she did not ask further questions about "a bit of overdose" but reported she did ask a number of times during the call what he had consumed. The call continued and Ms Ray asked questions about why his granddaughter made the call and whether he had hit his head. She asked whether he had drunk alcohol and he replied he had consumed 10 'cans' of vodka. He also indicated he had only eaten rice that evening for dinner. Ms Ray reported that Mr Andrews did not mention Prothiaden again during the call. Ms Ray asked questions to determine whether he was oriented to time and place, considering he had hit his head and had been drinking alcohol. She asked him if he was going to hurt himself and he replied "probably yeah". Ms Ray determined that Mr Andrews still required an ambulance. She informed Mr Andrews she was sending an ambulance because he told her he was going to hurt himself and advised him he was in a priority queue and the ambulance would not be much longer.

31. When Ms Ray ended the call, she determined the code two category was appropriate because it required an ambulance to attend within 25 minutes. Ms Ray made an entry into the CAD, "AV still required. PT is suicidal. No plan, GCS 15/15. Pt has had 10 cans of vodka tonight. Nil violence. Thanks. Refcom Liz." Ms Ray reported if she had heard Mr Andrews say he had taken an overdose of Prothiaden she would have used a different course of questioning,

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[4] Ms Ray reported at the time of her call to Mr Andrews there were two other Referral Service paramedics on duty.

including, when he took the drug, how many tablets he had taken so she could assess the potential effects of any additional substances. Ms Ray would then have calculated the approximate measure of overdose and referenced the Monthly Index of Medical Specialties (MIMS)5 to provide further information for attending paramedics. Ms Ray further reported the only explanation she can give as to why she missed the reference to Prothiaden is that it was an extremely busy shift and there were many welfare checks to be done and there was pressure to complete them as quickly as possible.

32. Mr Piper reported that in addition to the actions Ms Ray reported she would have taken if she heard Mr Andrews say he had taken an overdose of Prothiaden, the case would also have been upgraded from a code two to a code one, requiring urgent ambulance attendance within 15 minutes.

33. At 11.31pm, the CSP noted there was no available AV vehicle and decided to hold the case until an ambulance was available. At 12.12am on 8 March 2013, ambulance DA002 was dispatched, however it was immediately diverted by the DM to a code three case that was given priority as it had been waiting a number of hours. At 12.22am, ambulance MK168 was dispatched to Mr Andrews' case. At 12.30am, it was diverted to a code one case in Ferntree Gully. At 1.16am, the CSP noted there was no available ambulance and put a hold on the case until a vehicle was available. This CSP again noted no available vehicles at 1.56am, and decided to hold the case until ambulance KX111 was available. KX111 was dispatched at 2.33am and at 2.39am it was diverted to a code one case. At 2.45am, a hold was placed on the case by the CSP until ambulance RV013 was available. At 3.07am, ambulance DA002 became available and was dispatched to Mr Andrews' address, arriving at 3.23am.

34. Mr Piper reviewed the events of 7 and 8 March 2013. It is his view that the supply and demand issues that existed at the time contributed significantly to the delay in attending to Mr Andrews. He reported that AV has made a number of changes to the system since March 2013 including:

- Updated the Operational Work Instructions;
- Introduced a number of policy changes;
- Developed a new operating model; and
- Invested in new software.

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[5] Information service, which was at the time located in the referral communication triage room, that provides information about most drugs and medications including their brand names, side effects, the effects of any overdose and the treatment indicated for overdose.

35. The new operating model provides for; the presence of continual gateways to send an event back to a clinician for assessment and re-assessment, a 'dashboard report' that summarises an event and a 'cumulative clock' which shows total waiting time for an event. It also provides for an identifier that distinguishes between code two and three cases and when an 'area of resource need' is identified, an alert is triggered and the event is brought to the attention of the Referral Service and the CSP to be re-coded or re-triaged. Mr Piper reported long waiting cases are now identified earlier. Following re-assessment there are now a range of options being upgrade to a code one, provide a 'no divert' or continue to monitor. If the latter is chosen, further contact is made after 30 minutes.

36. A number of changes have been made to the Referral Service Communication Centre including provision of an electronic version of MIMS at each triage station, posters displaying information about tricyclic medications and the Poisons Information Line contact details are prominently displayed in the triage room. Referral Service paramedics have been provided with new headphones replacing those used on 7 and 8 March 2013 and Mr Piper reported that the Referral Service communications team was scheduled to moved into a purpose built building before August 2014, which has improved acoustics and noise dampening infrastructure.

37. Mr Piper reported these measures have been aimed at earlier intervention and reducing the number of cases requiring AV attendance. The improvements are in response to the events of 7 and 8 March 2013 and also part of an ongoing process of service improvement in accordance with AV's recognition that there has been a steady annual increase in cases requiring AV attendance and the growth in demand for services has impacted on ambulance response time.

38. Mr Piper further reported that if the same events of 7 and 8 March 2013, were to re-present the process from call intake to attendance would be handled differently according to the revised operating model as follows:

    a. There would be earlier contact by Referral Service paramedics;

    b. One hour after this contact, the DM would indentify the case via the cumulative clock;

    c. The DM would direct the matter to an AV clinician[6] to make telephone contact with the patient; and

    d. The AV clinician would re-assess the case and it would either;

[6] Trained MICA paramedic.

i. become a code one and given a priority service; or

ii. The AV clinician would confer with ESTA regarding whether or not the diversion was appropriate.

39. The Office of the Emergency Services Commissioner (OESC) conducted an investigation[7] into ESTA's management of the events on 7 and 8 March 2013. The OESC developed a number of recommendations that aim to reduce or eliminate the casual factors and root causes to assist in preventing a recurrence.

40. Mark Richards, Quality Improvement Manager for ESTA provided a statement to the Court and a response to the OESC report. Mr Richards reported the OESC's investigation report was based on ESTA's former audit technology which looked at technical compliance with ESTA's Standard Operating Procedures (SOPs) and adherence to the Medical Priority Dispatch System (MPDS) and the software, known as ProQA8 and its performance standards.

41. When ESTA's original audit was performed, it was determined that the mention of possible suicide behaviour should have seen the call processed according to Protocol 25 – Pyschiatric / Abnormal Behaviour / Suicide Attempt9 rather than Protocol 17 – Falls, Possible Dangerous Body Area. Therefore, the call failed the original audit because the auditor considered that the event was incorrectly coded.

42. In preparing his statement for the Court, Mr Richards reviewed the event and reflected on the call. It is now his view that the event was correctly coded on Protocol 17 – Falls, as there was no confirmation in the call that scene safety was in issue for the ambulance crew attending, or that Mr Andrews was immediately threatening to harm himself. Mr Richards formed this view based on Mrs Talbot's answers to the call-takers questions. He determined there was no indication from Mrs Talbot that she felt that her grandfather was in immediate risk of self-harm. Mr Richards explained that his change of view was a result of refinement of ESTA's auditing process. Previously, auditors would sometimes focus too heavily on the mention of any trigger word to code the event instead of focussing on the principle reason for the call. Mr

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[7] The OESC examines an event from the perspective of ESTA and is unable to examine AV's actions or performance.

[8] ProQA provides call-takers with key questions in respect of different event types to assist them to obtain relevant information from the caller and enter those details into ESTA's CAD system. These questions are scripted to: (a) identify the location for response; (b) identify what is happening and allow the call-taker to assign a chief complaint code (protocol) that most closely describes the foremost symptom or incident; (c) ask relevant key questions to determine the seriousness of the event, which CAD translates into a relevant event type for dispatch.

[9] Protocol 25 is priority/code 1 response requiring an ambulance to attend with lights and sirens. I note it was reported by Mr Piper that between 10pm on 7 March 2013 and 2.15am on 8 March 2013, there were a number of code 1 cases that were pending. There were lengthy delays across metropolitan Melbourne.

Richards reported that under the new methodology, the event would have received an audit score of 97%10 which would have passed the 95% threshold for audit compliance score.

43. Mr Richards explained that in his experience, it was not unusual in 2013, for ESTA dispatchers to receive verbal direction across the desk from an AV member and for the ESTA dispatcher to action the event in accordance with the direction and not record the action on CAD. Therefore, the fact that a direction was not recorded on CAD does not mean that AV and ESTA staff ignored an event or did not try to dispatch a resource to the event.

44. Mr Richards disagrees with a number of conclusions made in the OESC report. In summary:

    a. ESTA no longer considers that the event was initially coded incorrectly

    b. It is not correct to label the inability to dispatch an ambulance to attend upon Mr Andrews as a failure in service delivery. On 7 and 8 March 2013, the demand for ambulances exceeded available resources.

    c. Whilst it is correct to say that ESTA dispatchers and AV members have not followed procedure to the letter by recording every resourcing direction relating to the dispatch of resources in CAD, the fact that a direction is not recorded in CAD does not mean that events were not constantly being reviewed and resourcing decisions and directions not being made.

45. Mr Richards reported that notwithstanding the points of disagreement, the OESC report highlighted a number of improvements that could be made to operating systems and procedures. ESTA accepted each of the recommendations.

Finding

46. I am satisfied having considered all of the evidence before me that no further investigation is required. I am satisfied that there were no suspicious circumstances.

47. I note Mr Richards' assertion that the event was coded correctly. Regardless of whether the event was coded correctly, the ambulance did not attend within the required time frame of the code it was originally assigned.

48. I find that it is reasonable to suggest that if an ambulance had attended to Mr Andrews within the required 25-minute period of a code two response, medical intervention would have occurred. I find an opportunity for intervention was missed. I am unable to determine whether the intervention would have been successful.

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[10] In the initial audit the call did not reach the threshold score, receiving 94%.

49. I acknowledge that since March 2013, Ambulance Victoria has made a number of changes to their operational work instructions, policies, operating model and software, as outlined in paragraphs 34 – 38.

50. I also acknowledge the great pressure placed on Ambulance Victoria and the demand for services.

51. Accordingly I find the cause of Mr Andrews' death was medication overdose. I am satisfied that Mr Andrews intended to end his own life.

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

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

Mrs Renee Talbot, Senior Next of Kin

Ambulance Victoria

Emergency Services Telecommunications Authority

Office of the Emergency Services Commissioner

Senior Constable David Abass, Coroners Investigator

Leading Senior Constable King Taylor, Police Coronial Support Unit

Signature:

PETER WHITE
CORONER
Date: **8 October 2015**

Coroners Court of Victoria