CORONERS COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	**AN INQUEST INTO THE DEATH OF PETER ZOVAK**
Citation:	**[2015] ACTCD 1**
Hearing Date(s):	17 September 2014
Date of Findings:	15 June 2015
Before:	Chief Coroner Walker
Legislation Cited:	*Coroners Act 1997 (ACT)*
Cases Cited:	R v Doogan [2005] ACTSC 74 Onuma v The Coroner's Court Of South Australia [2011] SASC 218 WRB Transport v Chivell [1998] SASC 7002 Briginshaw v Briginshaw (1938) 60 CLR 336
Appearances and Representation:	Ms Sarah Macfarland of the Director of Public Prosecutions as Counsel Assisting the Chief Coroner. Mr Russell Bayliss for the Australian Capital Territory Government instructed by the ACT Government Solicitor. Mr Wayne Sharwood for the Deceased's family instructed by Snedden Hall & Gallop.
File Number(s):	CD 311 of 2013

CHIEF CORONER WALKER

1. In December 2013, Mr Peter Zovak took his own life. Whilst when, where and the manner of his death are clear on the available evidence, a hearing explored the treatment and care that he received from ACT Mental Health in the weeks and days prior to this tragic event, with a view to establishing whether there was any causal connection between the care, or lack of it, which contributed to Mr Zovak's death.

2. I will respectfully refer to Mr Zovak as Peter.

Background

1. Peter was born in January 1967 and turned 46 years old in 2013. He was a self-employed concreter. In 2013, he lived with his mother in a flat attached to her house.

2. Peter had used various drugs over the years including heroin, which left him hepatitis C positive, and, more recent to his death, marijuana and alcohol.

3. On 7 October 2013, he attended the Canberra Hospital (TCH) Emergency Department having suffered an injury to his hand in a fight. He was treated with prescriptions for Panadeine Forte for pain relief and Augmentin Duo Forte, an antibiotic. He attended each day to 10 October 2000 for treatment.

4. Peter next presented to TCH on Monday 25 November 2013. He was brought to the Emergency Department by his brother, Mr Nedan Zovak ('Nedan'), regarding concerns for his mental health. This was his first contact with mental health support services. He was not admitted to the hospital but was reviewed.

5. The primary diagnosis was possible first onset drug induced psychosis. It was noted that he felt there was no point in living but was not actively suicidal. He had lost about 10 kg in weight in the preceding three weeks. It was planned that the Crisis and Assessment Treatment Team (CAT Team) would follow him up at home on the following two days, namely 26 and 27 November 2013. Peter was not asked if he had any objection to ACT Mental Health speaking with his family about any issues he was experiencing, despite the fact that he was accompanied by his brother.

6. The next day, Tuesday 26 November, two members of the CAT Team, Mr Graham Ramsay, and Mr Gunasekera-Ranga, visited Peter. They spoke to him outside on the driveway of his home for 15 to 20 minutes. Mr Ramsay recollected that there was no evidence of delusional hallucinations during this visit and that Peter represented himself as quite safe, in the sense of not planning to harm himself. Mr Gunasekera-Ranga took notes and subsequently made entries into the computerised record-keeping system, MHAGIC, in which he recorded "nil acute risk issues". By mutual agreement with Peter, they changed the plan from one of a further follow-up the next day in person to telephone follow-up on the following Sunday morning.

7. On Wednesday 27 November, Ms Angie O'Neill, a psychologist and leader of the CAT Team that day, telephoned Peter. She could not recollect why she had called him that day rather than on Sunday, in accordance with the amended plan agreed with Peter the day before. I note that any contact on that day, albeit by telephone rather than in person, was consistent with the original arrangement put in place by Dr Blanch. She reviewed his notes before calling. She could not recall how long call the lasted. She said that Peter declined further follow-up. Her file note was as follows "*declined ongoing support from CATT and aware that he can contact 24/7 if required".* She had no reason to think that it would be required involuntarily; Peter did not report anything that indicated that there was a current risk and therefore she did not think it necessary to speak to others, such as family. She noted that a doctor had deemed it appropriate to discharge Peter from hospital and that there had been face-to-face follow-up by CATT staff who judged that there were no psychotic symptoms at that time. She then referred Peter's case for multidisciplinary team (MDT) review regarding closure.

8. On Tuesday 10 December 2013, there was an MDT review of Peter's file. The decision was made for "contact closure". There was no final follow-up with either Peter or his family before doing so.

9. Following the closure of Peter's case, on Thursday 12 December 2013, his brother Nedan called the CAT Team on the number from the card given to him when he had left the hospital with Peter on 25 November, having been told that Peter may relapse. Mr Gunasekera-Ranga took the call.

10. The call was significant and I will come back to it. In short, it elicited no assistance.

11. Nedan went to see his brother again the next day, being Friday 13 December. Peter was not interested in conversing at any length. Nedan told him that he was taking their mother for preoperative assessment for knee surgery on Monday and told him that he would get him some help. Peter's response was "thanks mate".

12. Nedan went over again to visit his brother on Sunday 15 December. He knocked on the door but it was not answered. He opened the door and Peter yelled out "leave me alone". Nedan asked if he was all right; his brother said that he was fine but just wanted to be left on his own.

13. On Monday 16 December, Nedan went to the house to pick up his mother. Peter spoke to him and said that he was feeling fine, had not smoked or drunk any alcohol and that Nedan should not worry about seeing anyone on his behalf. Nedan said he was happy to do that but Peter said not to bother as he did not wish to see anyone. That was the last time Nedan saw Peter alive.

14. On 18 December 2013, Peter's body was discovered hanging from a tree in the front yard of his home about 6 a.m. by a woman walking her dog. He was found on post-mortem examination to have multiple fresh cut wounds to both wrists and two stab wounds to his abdominal wall, all of which appeared to be self-inflicted. A knife likely to have caused the wounds was found on the ground near him. Toxicological analysis revealed tetrahydrocannibinol (a derivative of cannabis)

and ethyl alcohol in his blood. The medical cause of death was identified as asphyxia caused by hanging.

Peter's medical management

15. There are two real issues here.

16. The first is was Peter's case closed without adequate follow-up.

17. The second is did the service fail Peter in its response to his call for assistance through his brother Nedan in the telephone call of 12 December 2013.

18. Mr Bruno Aloisi, psychologist and Operational Director for ACT-Wide Mental Health Services, gave significant evidence on these issues.

19. He accepted that Peter's case had been handled inappropriately and that the CAT Team had failed Peter.

20. As to the case closure decision, whilst he described his opinion as "speculating", he concluded that *"with the benefit of hindsight, yes, one could argue, that there could have been, you know, perhaps more observation over a longer period".*

21. Although cautiously expressed, Mr Aloisi maintained in his evidence that he had identified "some concerns" about the service's contact with Peter; that *"I suppose, you know, taking into account the history that Mr Peter Zovak had with our service, I questioned the appropriateness of the response in terms of whether it was sufficient to meet his needs at that time".*

22. Specifically in respect to Nedan's phone call of 12 December, he said: "*I can only go on the basis of, you know, what I've read and my contact. But my sense was that perhaps it might have engaged a response from our service. So a contact; perhaps an assessment by our team"*

23. Mr Aloisi observed that Peter was new to the service so that there was no long established history to rely on, that there was evidence of residual psychotic symptoms after the case closure and that therefore a semi-urgent response from a specialist mental health unit within between 12 an 48 hours would have been a more appropriate than just telling Nedan to get Peter to see a GP.

24. Nedan and Mr van den Berg, who accompanied Nedan to a meeting with Mr Aloisi, referred to a comment made by the latter regarding listening to a recording of the call by Nedan to the CAT Team but Mr Aloisi gave unchallenged evidence that no audio recordings are made. I accept that no such recordings are made. Thus it appears that Nedan and Mr van den Berg came away with an erroneous impression of what they had been told, perhaps interpreting a reference to the file note of the call as a reference to the call itself. Mr Aloisi also categorically denied the statement recorded by both Nedan and Mr van den Berg to the effect that the CAT Team were sitting idle on 12 December when Nedan called.

25. In respect to his contact with Nedan after Peter's death. Mr Aloisi said: *"I can't remember my exact wording, but essentially that I thought that the response given probably deviated from what I would expect would be usual practice, and words to that effect, yes".*

26. I accept that Mr Aloisi gave a more muted critique of his service's performance in Court than in private discussion with Nedan but, again, in circumstances of extremely high emotion, it is possible that some of Mr Aloisi's statements to Nedan were misconstrued.

27. Ultimately, the significance of Mr Aloisi's evidence is that he concludes that his service's response on 12 December was inadequate. I consider the response to that inadequacy below.

28. As to the last contact on Peter's behalf with ACT Mental Health, being the telephone call by Nedan on 12 December 2013, the factual dispute is as to whether Nedan reported that the "current issues" mainly related to cannabis and alcohol use, thus in some way justifying referral to a GP rather than Cat Team involvement, and whether Nedan agreed to take Peter to a GP, which would have meant that Mr Gunasekera-Ranga had reasonably anticipated some professional involvement other than CAT Team support.

29. The entire file note made of the conversation by Mr Gunasekera-Ranga is as follows:

> *"12/12/2013 05:40 PM (sic): [File Note – PC from brother – NIL acute risk] (Completed 12/12/2013 05:58 PM (sic))*
>
> *PC from brother - Ned Zovac reporting;*
> - *Peter hasn't improved since he left hospital*
> - *Still sometimes talking to himself*
> - *NIL TOSH/TOHTO/SI*
>
> *Advised brother to take Peter to a GP and D/W GP the current issues. Brother reported current issues mainly related to A&OD abuse (continue to use THC & ETOH + other substances on non-regular basis)..*
> *NIL acute risk issues at the time. Brother is happy to take Peter to GP.*
>
> *Plan:*
> *As per previous RC"*

This file note certainly supports Mr Gunasekera-Ranga's recollection.

30. A subsequent statement and oral evidence extrapolated on this position and purported to include a significant number of exact quotes recollected by Mr Gunasekara-Ranga at least five months after the phone call. He also specifically denied some statements Nedan claimed to have made during the call.

31. Mr Gunasekera-Ranga denied that Nedan pleaded with him to go and see Peter, nor did Nedan say that Peter had not slept for a week; if he had, Mr Gunasekera-

Ranga would have recorded that in the notes and there would have been an immediate CATT response.

32. He denied that Nedan said that Peter wanted CATT to come as he felt comfortable with them nor “mate, please come. GPs are like a factory and are just next, next, next...”

33. He stated that Nedan was happy to take Peter to a GP

34. It should be noted that Mr Gunasekera-Ranga was aware that Peter had no GP and that the MHAGIC notes recorded that fact so that any attendance on a GP would have been “cold” in the sense that the selected GP would have no knowledge of Peter and may well have no particular mental health expertise, and very likely not to the level of a specialist mental health service.

35. Mr Gunasekera-Ranga said that he was influenced in his response to the call by the fact that Peter had refused ongoing mental health involvement on 26 November during the home visit and in the follow up phone call. I note that there is a difference between a refusal to engage at all and a statement that a person does not feel the need of a particular service at a point in time. Going back to Ms O‘Neill’s entry in the MHAGIC notes, she recorded *“declined ongoing support from CATT and aware that he can contact 24/7 if required”.* Of course, it was Nedan who made the contact on this occasion but he was doing so on behalf of Peter. Mr Gunasekera-Ranga said in evidence that he did not know if Peter was with Nedan when the telephone call was made and did not ask to speak to Peter. There was no effort to confirm with Peter that help either was or was not required, even though he was known to have recently suffered with psychosis and paranoid thoughts, a presentation which one can readily infer might make him less inclined to make the contact himself.

36. In his written statement, Mr Gunasekera-Ranga concluded *“on reflection, it appears that he (Peter) may have been suffering from psychosis when his brother called mental health triage on 12 December 2013. On reflection, of the events and in review of the mental health triage protocol, on the day that Mr Ned Zovak contacted Mental Health Triage I feel that I should have triaged Mr Peter Zovak’s case into a higher triage category, ‘D’ or ‘E’ rather than a triage category ’F’; which would potentially have resulted in a follow-up by CATT by a phone call or home visit the next day.”* And further in his oral evidence he conceded that looking back, it would have been appropriate to have Peter assessed face to face within a day or two after Nedan’s call.

37. It is necessary to review Nedan’s evidence in relation to this whole episode with Peter to put in context the telephone call of 12 December.

38. Nedan stated that his brother had smoked marijuana and drunk alcohol over the years but never before behaved in the way that he did in the weeks prior to his death

39. In interview with police, Nedan said that Peter did not have a regular GP and had in fact hardly seen a doctor in twenty years. He went on to say: *“I took him to the Phillip Medical centre on the day after we left the hospital* (which I took to be a

reference to Peter's earlier attendance in respect to his hand)...*He was in there for thirty seconds...The only thing he said to me when he got out of there, he goes, "Oh, someone's got to him"* which Nedan interpreted as evidence of paranoia.

40. Due to increasing concern about Peter's psychological health, and after he had smashed a window at his mother's home, Nedan called Lifeline but was unable to get through as the lines were busy. He then called the police and was given some support but ultimately was advised that if Peter was violent, then the police could attend and force him to go to hospital, a course Nedan was not prepared to pursue.

41. Peter was increasingly unwell until Nedan convinced him to attend the hospital on 25 November 2013. He confirmed that Peter's treatment at the Canberra Hospital was as recorded in the clinical notes. He was much improved by evening when he went home. He was not sure if his brother had been medicated at the hospital. He visited Peter the next day in the afternoon. Peter told him that the CAT Team had visited and that they were nice people. Peter said that would ring the service if he needed it and that he felt he was getting better.

42. Nedan thought that Peter's mood swings were not as severe in the days leading up to 12 December as they were before he went to hospital but was very concerned that he continued to be delusional, for example believing he had been told by a television personality that he had killed a little girl. Nedan suggested Peter go back to the hospital but he was frightened of being locked up there. Nedan visited Peter late afternoon on 12 December. Peter said that he needed help and was willing for the CAT Team to see him. Nedan agreed to call the CAT Team straightaway which he did from outside his mother's house.

43. On the day of Peter's death, Nedan was interviewed by the police and stated "*I rang the mental health unit at-the – the card they had given me, explained the situation that he had gone back to, um, hallucinating and imagining things that were not happening. So I, um, rang the person, spoke to them for about half an hour, explained the situation. Basically, he was very unhelpful, said to me, um, "get Peter to see a GP." I tried to get him to, um, bring the mental health unit vehicle over here again to see how he was doing. I pleaded with him to do that."*

44. In a written statement, Nedan stated that he called the CAT Team when Peter was still unwell because the doctor at the hospital had told him that Peter could have relapses and to call that number if it happened. In his oral evidence, Nedan revised his estimate of the length of this conversation, saying that he thought it lasted five to seven minutes, rather than the half hour referred to in interview. He stated that he told the person taking the call, Mr Gunasekera-Ranga, that his brother was having horrific nightmares, had not slept for a week and was losing weight. When he was told to take his brother to a GP, Nedan states that there was to and fro exchange about this issue and that in particular he said *"mate, their like a factory line; next, next, next"*. He claims that he begged for the CAT Team to send someone over because his brother trusted them. He did not realise the person he was talking to was one of the men who had seen Peter on 26 November. Nedan said that there was no discussion about Peter's drug and alcohol use. He stated that he absolutely did not agree to take Peter to a GP. He

stated that he was not told that if his brother would not go to a GP then he should call back.

45. Nedan said that he then, at 5:15 p.m. on Friday evening, went to speak to his brother and told him he could not get him any help that day. His brother did not respond. He said that *"the look of devastation will live with me forever"*.

46. The issue of credibility arose in this matter arising because of the discrepancy between the versions of the phone call between Nedan Zovak and Mr Gunasekera-Ranga on 12 December 2013. Both gave oral evidence consistent with their initial recording of those conversations, Mr Gunasekera-Ranga's in the MHAGIC notes and Nedan's in his recorded conversation with police on 18 December. Both provided significantly greater detail in their subsequent statements and particularly in their oral evidence. Having reviewed all of their evidence thoroughly, I am not satisfied that either of these witnesses consciously lied. I am satisfied that Mr Gunasekera-Ranga's evidence was given in a manner geared towards presenting his admittedly flawed decision not to have someone from the CAT Team attend on Peter in the best light. Nedan's evidence was, as one would entirely expect, overlaid with powerful emotion which makes his retelling of the event compelling. It is nonetheless possible to conclude that both men, influenced by their particular perspectives came away with a different understanding and recollection of that exchange.

47. I am satisfied that Mr Gunasekera-Ranga did tell Nedan to take his brother to see a GP, based on his perception of a lack of immediate risk of harm to anyone. I am satisfied that Nedan did not agree to do that, given that Peter did not have a GP, did not have a Medicare card and had had a negative experience in his most recent visit to a GP, as opposed to the positive comments he had made to Nedan about his experience with the CAT Team when they went to see him.

48. In short, Nedan's plea for help for his brother from the very team he had been advised to call in the event of an anticipated possible relapse was refused. He did so through his brother and help was denied him.

49. In the context of that recognition, Mr Aloisi responded by meeting with the family, by acknowledging that fact to the family, organising an internal review and implementing a series of changes documented in the Clinical Review Committee report and the Clinical Recommendations Action Plan.

50. The summary of the findings of the Clinical Review Committee is as follows:

> *"It was identified there were missed opportunities to clarify this patient's diagnosis and offer more assertive treatment. The clinical significance of the patient's deterioration following his first presentation with a possible psychosis was not properly judged and family concern was not acted on.*
>
> *There was no assessment of the patient during the last CATT triage call. The CATT member did not seek to speak with the patient. Following discussion with the brother the CATT member did not think a further CATT follow-up was necessary. The patient was not keen for a referral and this was not followed up by CATT.*

There was an error in clinical judgement in the advice given to the brother over the phone. Further follow-up by CATT should have been considered.

The MDT closed the case based on insufficient information as there was no collateral information from family on the patient's progress. The decision to close the case was based on the impression that the patient's symptoms were most likely related to alcohol and drug issues."

51. I note that the CRC identified collaboration with family as an issue arising from this situation. The report notes "*include engagement of primary family members in ongoing assessment and management planning".* It is apparent in this, as in so many cases involving the provision of mental health services, that there is a very real tension between respecting the confidentiality of the patient and liaison with the family in relation to identification of ongoing issues or in order to address the patient's support needs. It is unfortunate that at times there appears to be a resort to reliance on the need for confidentiality in situations where less than adequate regard has been paid to the input of family members.

52. I note that the Clinical Recommendations Action Plan provides for a number of remedial measures, many of which have already taken place including review of standard operating procedures, triage training, review and implementation of the reviewed training package, including refresher training, implementation of a "call surge" management procedure to allow triage workers to obtain assistance during times of peak demand, family/consumer feedback sessions, compassion fatigue training for all CATT staff, a review of triage response scales and identification of triage as a priority issue.

Scope of the inquiry

53. Counsel assisting properly identified the scope of inquiry available to the Coroner by reference to the decision of *R v Doogan* [2005] ACTSC 74 at paragraph 15 in which their Honours Higgins CJ, Crispin and Bennett JJ stated:

"The Act is generally concerned with the resolution of relatively straightforward questions such as "what was the cause of this death?" or "what caused this fire?". It does not provide a general mechanism for an open-ended enquiry into the merits of government policy, the performance of government agencies or private institutions, or the conduct of individuals, even if apparently related in some way to the circumstances in which the death or fire occurred. Specific provisions confer jurisdiction on coroners to enquire into stipulated questions, require them to make certain findings, and empowers them to make comments".

And at [29]:

"A line must be drawn at some point beyond which, even if relevant, factors which come to light will be considered too remote from the event to be regarded as causative."

54. I have referred previously to the decision of *Onuma v The Coroner's Court Of South Australia* [2011] SASC 218, a case in which the Court considered the scope of the Coroner's powers under the *Coroner's Act 2003* (SA).The Court applied *WRB Transport v Chivell [1998]. SASC 7002.* The relevant phrase under consideration was "cause and circumstances". In this jurisdiction, the relevant phrase is similar, namely "the manner and cause". In *Chivell* Lander J (with whom both Prior and Mullighan JJ agreed) said with regard to the meaning of the word "cause" at [9]:

> *"Clearly enough 'the cause and the circumstances' must be two different things. If it was otherwise there would be no reason for Parliament to have included both words.*
>
> *The cause of a person's death may be understood as the legal cause. In determining those events which may be said to give rise to the cause of the death, the Coroner is not limited by concepts such as 'direct cause', 'direct or natural cause', 'proximate cause' or the 'real or effective cause'. Nor is the Coroner limited to a cause which is reasonably foreseeable. The cause of a person's death in respect of the Coroner's jurisdiction is a question of fact which, like causation in the common law must be determined by applying common sense to the facts of each particular case: Mason CJ, March v E & M H Stramare Pty Ltd [1991] HCA 12; (1991) 171 CLR 506 at 515...That is a factual inquiry which only has, as its boundaries, common sense."*

55. I am also mindful that in making findings, I am to have regard to the principle espoused in *Briginshaw v Briginshaw (1938) 60 CLR 336* as stated by Dixon J at 361-2:

> *"The truth is that, when the law requires the proof of any fact, the tribunal must feel an actual persuasion of its occurrence or existence before it can be found. ...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 issue has been proved to the reasonable satisfaction of the tribunal."*

56. I also note that whilst scope for the Coroner to make comment is limited by a finding "arising in connection with" the inquest (s52 of the Coroners Act 1997 ACT), "recommendations" can be made only if they relate to findings about the cause of death (s57(3)(c) of the Coroners Act 1997 ACT).

57. These are important considerations noting the broad ranging recommendations sought by Peter's family.

Conclusions

58. Peter Zovak did not receive an adequate level of mental health care.

59. Whilst the multidisciplinary team decision to close Peter's case on 10 December 2013 may have been a little premature, it was not unreasonable on the evidence

then available. There had been some post-discharge follow-up through which Peter appeared unaffected by those symptoms which had lead to him attending hospital in the first place. He indicated that he did not want follow-up but that he knew how to seek it if he did and he had family support as evidenced by Nedan taking him to hospital in the first instance.

60. However, the service's failure to respond to Peter's need for assistance on 12 December 2013 was not reasonable. Although the provisional diagnosis for Peter on discharge from hospital was drug induced psychosis/delirium, it was further recorded as possible first episode psychosis with no organic features found to explain it. In the context of a first engagement with mental health that must have been far from definitive.

61. The information provided to Mr Gunasekera-Ranga on 12 December 2013 was strongly indicative of significant ongoing mental health symptoms. It was, or should have been, known to him that Peter did not have a relationship with a general practitioner at all, never mind one with a modicum of expertise in mental health. Mr Gunasekera-Ranga made a serious error of judgment when he declined the call for help directly from Peter's brother and indirectly from Peter himself.

62. However, as the submissions of all parties to these proceedings recognise, it is speculative to infer that this failure contributed to Peter's death. It no doubt represents a lost opportunity to influence the outcome of Peter's illness but it is entirely speculative what, if any, difference a more proactive response by Mr Gunasekera-Ranga following Nedan's call on 12 December 2013 would have produced.

63. Consequently, I make no finding of contribution to Peter's death from the failures of ACT Mental Health.

64. I am, however, able to make comment based on issues of public safety arising in connection with the inquest. They are more limited than the recommendations sought by Peter's family in light of the considerations as to the scope an inquest detailed above.

Comment

65. That ACT Health should implement and continue to monitor those measures detailed in the "Clinical Recommendations Action Plan – Review Mental Health Triage May 2014".

66. It would be useful for ACT Mental Health to review the Crisis and Assessment Treatment Team role having regard to the emphasis placed on immediate risk of harm as opposed to the broader requirement for an community outreach mental health system and consider whether the Team as it is presently structred is best equipped to meet community need.

67. ACT Mental Health should consider making it a mandatory requirement in dealings with patients that they be positively requested to indicate whether they

consent to the service communicating with one or more nominated family members or carers in respect to the patient's mental health with a concomitant requirement to record that consent in the service's electronic data system.

Formal findings:

(a) The deceased was Peter Zovak.
(b) He died on 18 December 2013 at Streeton Drive, Rivett in the Australian Capital Territory.
(c) The manner and cause of death was asphyxia by hanging – suicide.

68. In conclusion, I convey my deepest sympathy to Peter's family and all those affected by Peter's loss, including the staff of ACT Mental Health. The untimely loss of any family member is a great tragedy. The community must continue to be vigilant to the often hidden social affliction of suicide, its causes and its aftermath.

I certify that the preceding 68 numbered paragraphs are a true copy of the Findings of her Honour Chief Coroner Walker .....

Associate:

Date:15 June 2015