FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the Coroners Act 2008

Court reference: 1380/10

In the Coroners Court of Victoria at Melbourne

I, IAIN TRELOAR WEST, Deputy State Coroner

having investigated the death of:

Details of deceased:

Surname: DELANEY
First name: NIGEL
Address: 1/48 FORTH STREET, PARKDALE, VICTORIA 3194

AND having held an inquest in relation to this death on 15th April 2011
at Melbourne
find that the identity of the deceased was NIGEL ALEXANDER DELANEY
and death occurred on the 12th April, 2010

at Acute Management Bedroom 1 - Acute Psychiatry Inpatient Unit - Monash Medical Centre, Clayton, Victoria 3168

from
1a. UNASCERTAINED

in the following circumstances:

1. Nigel Delaney, aged 51 years, was a single parent at the time of his death and lived in private rental accommodation at 1/48 Forth Street, Parkdale. He had a long history of mental illness having been diagnosed as suffering Schizophrenia when he was in his early twenties and whilst studying at RMIT. The condition led to difficulties throughout his adult life, with it impacting on employment and culminating in multiple hospital admissions and reportedly, an attempted suicide by ingestion of caustic soda. Following a diagnosis of Schizo-affective Disorder in 1996, Mr Delaney became a client of Southern Health Mental Health Services and was case managed by the Service until January 2009, when it was considered that his mental state was stable enough for him to be transferred into the private sector. Mr Delaney then attended private Consultant Psychiatrist, Dr Jeanette Grey, seeing her on five occasions, with the last being 11th March, 2010.

2. On the 3rd April 2010, Mr Delaney was admitted to the Monash Medical Centre following relapse of his Schizo-affective Disorder. Family had visited Melbourne from Sydney and realizing he was unwell, they contacted Psychiatric Triage to report his argumentative and manic symptoms. This subsequently led to Crisis Assessment Team attendance at his home and the conveying of Mr Delaney to the hospital. Upon admission he was seen to be disheveled and

unkempt, with labile mood, guarded affect and poor insight. His mood was described as being elevated, grandiose and paranoid which led to his admission as an involuntary patient. Initially Mr Delaney was secluded having been deemed to be at high risk of aggression due to threats to staff. The next day he was transferred out of seclusion to the open ward, however several days later, he was placed in the high dependency area following uncooperative conduct and refusal of his regular medication, which comprised olanzapine, benztropine and diazepam. Following further episodes of refusal, medication was given intramuscularly and on the 10th April he was returned to the open ward following improvement in his mental state. On the 11th he again became threatening to staff and noncompliant with directions, resulting in him being returned to a seclusion room. On the 12th he was returned to the open ward with Mr Delaney stating that he was "feeling better than usual", however there followed further issues of refusing medication, although he subsequently agreed to commence sodium valproate which he had used in the past. Later he returned to the Acute Management Area after becoming uncooperative in his behaviour, with medication of zuclopenthixal and benztropine being given intramuscularly.

3. During the night of the 12th April, routine observations were undertaken by nursing staff with it being noted that Mr Delaney was sleeping at 10:00pm, having earlier refused to go to bed. Audible breathing and snoring was heard on subsequent checks. When checked at 11:15pm, Mr Delaney was found not to be breathing and pulseless, resulting in a medical emergency being called and the immediate implementation of resuscitation protocols. Despite these prompt measures, Mr Delaney could not be resuscitated.

4. On the 16th April 2010 a post mortem examination was performed by Forensic Pathologist, Dr Sarah Parsons, however, a cause of death was not able to be determined. Following ancillary tests that included toxicological examination of body fluids, Dr Parsons recorded the death as "unascertained".

COMMENTS:
Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comments connected with the death.

1. In statements provided to the Coroner, family members raised concerns that the amount of medication administered whilst in the care of the Monash Medical Centre, contributed to the death. Whilst anti-psychotic medication can adversely impact on the heart's electrical system, causing a prolonged QT interval, there is no evidence of this having occurred in this case. Dr Parsons specifically addresses the medication levels in her post mortem report, stating that they are "consistent with therapeutic use". Whilst it is clear that Mr Delaney felt he was being over medicated, this is common for patients with mental disorder who often lack insight into the severity of their condition and the most effective way for it to be managed. The evidence in this case satisfies me that the treatment and care Mr Delaney received at the Monash Medical Centre, was within the parameters of reasonable health care management.

Signature:

Iain West
Deputy State Coroner
20th April, 2011