FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the ***Coroners Act 2008***

Court reference: 3728/07

Inquest into the Death of PATRICK TOLAN

Delivered On:	19th October, 2010
Delivered At:	Hearing Room, Coroners Court of Victoria, Level 1, 436 Lonsdale Street, Melbourne 3000
Hearing Dates:	10 September, 2 October and 3 October, 2008
Findings of:	PETER WHITE
Representation:	Mr John Snowdon on behalf of Southern Health
Place of death:	Southland Shopping Centre, Nepean Highway, Cheltenham, Victoria 3192

Counsel Assisting the Coroner: Mr John Dickie

FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the ***Coroners Act 2008***

Court reference: 3728/07

In the Coroners Court of Victoria at Melbourne

I, PETER WHITE, Coroner

having investigated the death of:

Details of deceased:

Surname:	TOLAN
First name:	PATRICK
Address:	Room 11, Sunnyhurst Gardens Special Accommodation Home, 29-31 Union Street, Brighton East, 3187

AND having held an inquest in relation to this death on 10 September, 2 October and 3 October, 2008
at Southbank
find that the identity of the deceased was PATRICK TOLAN
and death occurred on 21st September, 2007

at Southland Shopping Centre, Nepean Highway, Cheltenham, Victoria 3192

from
1a. MULTIPLE INJURIES SUSTAINED IN A FALL.

in the following circumstances:

1. Mr Tolan was a 55-year-old man with a history of significant depression over many years, as well as alcohol dependence and compulsive gambling. As will be detailed below, he had numerous incidences of suicidal behaviour, however, would generally endeavour to give an impression, particularly to staff in the Crisis Team and the various hospitals he attended, that he was coping well.

2. In early 1998, Mr Tolan became depressed and took an overdose of paracetamol. He was diagnosed with depression and was further identified as being suicidal. He was receiving psychiatric treatment at Monash Medical Centre and from private providers. His estranged wife Liza and family remained very supportive.

3. In 2005, Mr Tolan again made an attempt at suicide by threatening to jump from the Bolte Bridge, but was talked down by a passing motorist. This incident brought to light Mr Tolan's gambling habit, as well as his ongoing problems with alcohol. As a result of this event, psychiatric help was sought and he initially appeared to stop drinking and started taking prescription medicine. Mr Tolan then spent time in the Alfred Psychiatric Ward. After two months, he again took an overdose of sleeping tablets mixed with vodka.

4. By late 2006, Mr Tolan's behaviour was noticed to be more erratic, with drinking binges, suicide threats, aggressive behaviour and regular refusals to take his controlling medication. In mid December of that year, he was involved in a police chase and a collision with a police vehicle and was involuntarily hospitalised at St Vincent's Hospital, then transferred from Monash Emergency to Monash Psychiatric. Mr Tolan left Monash without authorisation on Christmas Eve or the next morning and was eventually located in St Kilda several days later.

5. Around Christmas, Mr Tolan also spent time at the Melbourne Clinic for approximately two weeks in an attempt to overcome his depression issues. During his stay, he sustained, at his own hand, superficial lacerations to his neck.

6. While at Monash, he left without permission after breaking a window to escape. The reviewing Doctor, Dr Plakotis, noted that his earlier assessment that Mr Tolan's not be accepted for involuntary admission, may need to be re-assessed. Some eight hours later Mr Tolan returned of his own accord. Shortly after this, he was released, later taking up residence at Mentone Hub.[1]

7. A few days later, (on 4 January 2007), Mr Tolan was found threatening to jump from the parapet at Southland. After approximately six hours, he was successfully negotiated to a point where he attempted to remove himself from his position to a place of safety. However, due to his level of intoxication and its subsequent effect on motor control, he lost his balance and fell some four stories to street level, sustaining serious injuries to both legs. Mr Tolan was then admitted in a critical condition to The Alfred Intensive Care. As a result of those injuries, Mr Tolan subsequently spent the first three months of 2007 in Intensive Care, followed by a further three months in the ward at The Alfred, followed by rehabilitation at Caulfield General Hospital. He was later discharged and placed in the Sunnyhurst Gardens Special Accommodation Home in East Brighton on the 4th of September 2007.

8. On Friday 21 September 2007, Mr Tolan left his lodgings at Sunnyhurst Gardens after lunch, advising he was going to Southland to get a haircut and then planned to watch an evening football match at a friend's place. He seemed in normal spirits.

[1] See Dr Martins evidence from transcript page 144

9. The next reported sighting of Mr Tolan on that day was at approximately 2.00pm, when he was seen to be precariously balanced on the support structure of a metal sign which protrudes from the front of (Southland) Westfield Shopping Centre, Cheltenham. Mr Tolan was approached by a member of Police, however, this initial attempt to open dialogue was unsuccessful. Police Communications were provided with a further situation report and the services of a Critical Incident Response Team with a negotiator were requested. Police Anti-Crime and Emergency Response (PACER) Unit, Police, Ambulance, Crisis Assessment and Treatment (CAT) Services and Emergency Response were also notified and requested to attend. The PACER team made attempts to communicate with Mr Tolan for some time. At approximately 2.40pm, the Critical Incident Response Team (CIRT) arrived and monitored the negotiation efforts of the PACER team.

10. Observations made of Mr Tolan suggested that he appeared to be suffering from cramping in his legs, as he was adjusting his seated position and displaying signs of discomfort. It should be noted that Mr Tolan was still dependent on crutches for walking, in light of his previous leg injuries. At this time, Mr Tolan's continuing injuries from his previous fall also included partial blindness, which constituted legal blindness. He was observed to rock forward at times appearing to adjust his balance from his seated position. These movements became more frequent, until he was swaying almost continually and showing more obvious signs of discomfort and fatigue. Mr Tolan also seemed to be affected by the cold wind and had put on his jacket, from which it might be inferred that he was expecting to be in his current location for some time and was not intending to act on his suicidal ideation immediately.

11. The PACER team also contacted Southern Community Mental Health Service (CMHS) and acquired a list of Mr Tolan's medications, which included Mirtazepine 45mgs, Oxycontin 30mg, antibiotics and Temazepam 10-20mgs nocte. It was advised that Mr Tolan's medication would increase the effects of alcohol on his central nervous system.

12. The Melbourne Metropolitan Fire Brigade (MFB) also attended at 1.20pm, including two members of a high-level rescue team, in order to attempt rescue of Mr Tolan at height, should such action be required.

13. At approximately 4.20pm, Mr Tolan threw the empty bottle of vodka from which he had been drinking into the upper level car park. At this time, his swaying had become even more pronounced and he then appeared to move sideways along the sign framework edge towards the car park wall, where the negotiators were standing. As he moved sideways, he was holding on to a white plastic conduit attached to the sign framework. This conduit was flexible and did not appear to be fastened well enough to be able to bear weight. The negotiators and High Angle Rescue Team noticed this and motioned to Mr Tolan to take care. Several minutes later, at 4.24pm, Mr Tolan appeared to overbalance and fall backwards through the space between the outside framework of the sign and the roof top car park exterior wall. One of the MFB rescue

members went onto the billboard structure and managed to reach Mr Tolan as his left foot gave way and he swung suspended by his grip. In the intervening few seconds, despite attempts to secure Mr Tolan, he slipped, leaving the MFB member holding him by only his jacket. He eventually fell from this unsustainable grip, receiving blows from multiple impacts on the structure and car park façade, before falling 20 feet to the carriageway of the Nepean Highway car park exit, immediately below the metal sign. Mr Tolan was found to be deceased by attending medical personnel and he was formally identified by his brother, Mr Christopher Tolan, having also been present shortly after being notified by police at approximately 2.00pm of his brother's situation.

Request of Mr Tolan's brother to be involved in negotiations

14. A question arose in the inquest as to whether Police acted inappropriately at the scene by failing to allow Mr Tolan's brother, Mr Christopher Tolan, to go up to speak with him. Mr Tolan had been contacted by a Southland employee and informed of the situation and so was present and available to speak with his brother. However, Police decided this was not the best way of proceeding.

15. Having considered the evidence of Senior Sergeant Watson, I accept that this was an appropriate decision in the circumstances. The reasons for this approach are fully set out from page 3 of submissions made on behalf of the Chief Commissioner and I accept these reasons.

Notice of discharge given to Southern CMHS

16. As noted above, Mr Tolan was released from Caulfield Hospital as part of his rehabilitation programme at The Alfred. However, no warning was given to Southern CMHS, who were responsible for finding him suitable (available) accommodation after his hospital stay, until one to two days prior to his discharge. This short period did not permit Southern CMHS to make suitable arrangements, which resulted in Mr Tolan being located to accommodation situated near a large liquor store. It was also the case that the short notice meant that no post release plan could be devised and put in place prior to his departure from Caulfield. This omission was particularly significant in the case of Mr Tolan, given the stated opinion of Dr Le Bas (discussed below) from paragraph 21.

17. Given his circumstances, which included a history of alcohol dependence, combined with severe depression and suicidal tendencies, I find that this arrangement was poor.

18. I am also satisfied that this absence of a release plan as well as the (accommodation) result could have been avoided had Caulfield Hospital provided sufficient notice of their intention to discharge Mr Tolan to Southern CMHS.

The release by Caulfield Hospital.

19. In terms of his psychiatric care, Mr Tolan's brother, Christopher, stated at transcript page 16,

> *'I would have been quite happy for him to be sectioned and for somebody who has tried to throw themselves off tall buildings or bridges, or whatever on multiple occasions; something is wrong.*
> *Now how can he be released from a mental facility with no advice from anyone except yourself-when you manage to tell them your right you're free to go? To me that just defied logic. If there was ever a person screaming out for help that was Patrick. And not just that he didn't receive help-whenever he was an inconvenience, he was just handballed out of the place as ... quickly as possible.'*

20. I note Dr Sahhar's view that Mr Tolan was not suitable for an involuntary treatment order. I consider however that this assessment did not sufficiently include a consideration of the depressive behaviour indicated by his earlier conduct, referred to above.

21. Rather, it appears from the evidence of Dr Sahhar, that Mr Tolan's release from Caulfield Hospital was driven by the views of his post trauma clinicians over those responsible for his psychiatric care and I find that in this regard, even at the point of discharge, Mr Tolan remained seriously unwell. [2]

22. It is relevant that in response to Mr Tolan's case manager inquiring of Dr James Le Bas, Psychiatrist, (who had previously seen Mr Tolan on nine occasions), whether he would see Mr Tolan privately after the first jump from Southland, Dr Le Bas indicated that he,

> *"thought that Mr Tolan was too sick for solo psychiatric follow-up and needed a team approach, with direct access to hospital and crisis care."*

23. It is also relevant that the evidence reveals that the psychiatric staff appear not to have been fully appraised of Mr Tolan's psychiatric history, including the number of and regularity of his previous admissions and suicide attempts or threats, as set out above. See the evidence of Dr Sahhar,[3] where emphasis is given to his alcoholism rather than to his related history of depressive conduct.

24. Given that emphasis, it was felt that Mr Tolan's needs would best be met by counselling concerning his orthopaedic surgery and in respect of his failed marriage and ongoing family issues.

---

[2] See transcript from page 114
[3] Dr Sahhar transcript page 107-115, and at 142

25. In such circumstances, I consider that the arrangements made to discharge Mr Tolan from psychiatric care at Caulfield Hospital, were pre-mature and made without full consideration being given to his history of depressive conduct. While that conduct was viewed as being connected to his alcoholism, I consider that its repetition suggested the need for a more comprehensive management than was offered in this instance.

26. I further find that this fact was not altered by Mr Tolan's request for discharge and that the decision was also sub-optimal because his post release plan, which at the very least, should have attempted to accommodate the stated views of Dr Le Bas, was not in place.

27. As earlier noted, immediately prior to his earlier fall in January 2007, Dr Plakotis (at the Monash Medical Centre), had contemplated making an order that Mr Tolan be dealt with as an involuntary patient.[4] I consider that by September such a finding may also have been open to the Doctors at Caulfield (i.e. a referral under the *Mental Health Act*), and that Mr Tolan's situation was such that a consideration of this possibility, involving a full review of his medical history and treating consultants opinions, was warranted.

Finding

On all of the evidence I am satisfied that Mr Tolan died from injuries sustained in an accidental fall. This occurred soon after his premature release from the Caulfield Hospital.

RECOMMENDATIONS:

1. Putting to one side the question of whether Mr Tolan might properly have been referred under the Act, I recommend that Caulfield Hospital undertake a review of its procedures for assessing the suitability for discharge of patients with multi-faceted presentations. Such review should be undertaken with a view to ensuring that those patients suffering from mental illness receive a full medical appraisal of that condition, based upon a complete medical history and a consideration of treating specialist's reports.

2. Should a review indicate that release (rather than referral to a psychiatric unit) is appropriate, there remain two further issues for consideration:

   a) the need to provide the receiving Community Mental Health Service with sufficient time to meet with a patient and evaluate and devise an appropriate post release management plan;

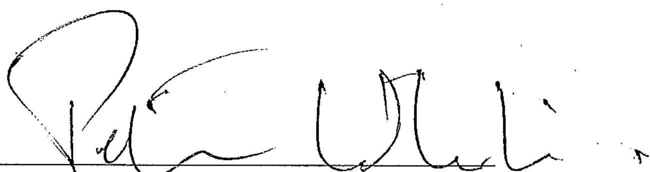
[4] See the discussion of this matter in the evidence of Dr Martin and Exhibit 6

b) the need to provide the receiving Community Mental Health Service with sufficient time to arrange appropriate accommodation, either within family provided accommodation, or in some other appropriate situation.

3. In this regard, I recommend that a lengthier period of notice be given to the relevant Community Mental Health Service, and should always include a similar notification to family members.

4. I consider that any notice of less than two weeks in duration, might reasonably be viewed as inadequate.

Signature:



Peter White
Coroner
Date: 19th October, 2010

Distribution:
The Family of Patrick Tolan.
Caulfield Hospital.
The Southern Community Mental Health Service.
Sunnyhurst Gardens Special Accommodation Home, East Brighton.
The Alfred Hospital.
The Attorney-General for the State of Victoria.
Dr Le Bas.
Dr Sahhar.