IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2013 / 4262

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of: Peter James Nolan

Delivered On:	29 June 2017
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street, Southbank, VIC 3006
Hearing Dates:	22 and 23 February 2016
Findings of:	PETER WHITE
Representation:	Ms Fiona Ellis of Counsel for North Western Mental Health.
Police Coronial Support Unit	Leading Senior Constable Tracey Ramsey assisting the Coroner.

I, Peter White, Coroner, having investigated the death of PETER NOLAN

and having held an inquest in relation to this death on 22 and 23 February 2016

at Melbourne find that the identity of the deceased was PETER NOLAN

born on 11 May 1938

and the death occurred on 23 September 2013 at Broadmeadows Aged Psychiatric Mental Health Unit situated at 35 Johnstone Street Broadmeadows.

CASE NOTE

Suicide by an elderly male in an Aged Psychiatric Mental Health Unit. Management of a patient assessed as being between a medium and high risk of suicide requiring 15 minute observations, and management of such risk.

Purpose of a coronial investigation

1. The Coroners Court of Victoria is an inquisitorial jurisdiction[1]. The purpose of a coronial investigation is to independently investigate a reportable death to ascertain if possible the identity of the deceased person, the cause of death and with some exceptions, the surrounding circumstances. Surrounding circumstances are limited to events which sufficiently proximate and casually related to death.

2. The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death.

3. For coronial purposes the circumstances in which death occurred, refers to the context or background and surrounding circumstances to the death, but is confined to those circumstances sufficiently proximate and casually relevant to the death and not merely all circumstances that which might form part of a narrative culminating in death. The law is clear that Coroners establish facts, they do not determine criminal or civil liability[2].

4. The broader purpose of a coronial investigation is to contribute to a reduction in the number of preventable deaths, the promotion of public health and safety, and the administration of justice. The Coroners role is to seek to establish the facts and surrounding circumstances.

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[1] Section 89(4) *Coroners Act 2008* (Vic).

[2] *Harmsworth v The State Coroner* [1989] VR 989, *Clancy v West* (unreported 17/08/1994, Supreme Court of Victoria, Harper J).

5. Additionally a Coroner may comment on any matter connected with the death, may report to any Minister, public statutory authority or any person connected with the death, including recommendations relating to public health and safety and the administration of justice3.

6. This finding draws on the totality of the material produced as part of the coronial investigation into Peter Nolan's death, including the inquest brief, statements, reports and testimony of witnesses who gave evidence at the inquest and any exhibits tendered through them. In writing this finding I do not purport to summarise all of the evidence but refer to it only in such detail as appears warranted by its forensic significance. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

BACKGROUND

7. Peter James Nolan (Mr Nolan) was born on 11 May 1938. He resided at 540 Street Brunswick with his wife, Maree Nolan and an adult son who suffered from Fragile X Syndrome.4 Mr Nolan was a retiree and up until his last two years he had enjoyed relatively good health and a pain free lifestyle.

8. Mr and Mrs Nolan had a daughter and five sons. One of their sons had passed away in 2012 at the age of 52, which caused them both a great sense of loss. Mr Nolan was also very concerned about a daughter who herself had six children and who had broken up with her partner.5 Mr Nolan additionally suffered from chronic pain due to arthritis and constant shaking. Despite appropriate therapy and analgesic medication he was not able to successfully manage these conditions and began to increase his intake of alcohol telling Doctors that he would consume between 4-6 light beers per day.

9. Mr Nolan was treated by General Practitioner D A Hore from 2203 and was last seen by him on 7 September 2013. Dr Hore prescribed Kalma and Zyprexa for his anxiety but also became aware that he was attending another clinic, West Brunswick Medical Centre (Dr Michael Christie) and obtaining additional medication. Both Doctors became similarly aware and

[3] [3] Section 72(1) and (2) *Coroners Act 2008* (Vic).
[4] See family tree and relevant family medical history set out at exhibit 7 page 421.
[5] See Dr Tipirneni's report at ibid page 21.

advised him to be managed at one clinic only, however this practise continued. Dr Christie informed that after Mr Nolan was diagnosed with arthritis and could not control the pain or improve his shaking, that he became depressed.

10. Dr Hore referred Mr Nolan to Consultant Psychiatrist Dr Sura Tipirneni, in relation to managing his anxiety and depression. In August 2012 Dr Tipirneni found worsening depression over the previous 18 months against a background of increasing alcohol abuse and significant psychosocial stressors in the family.6 HE was treated for these conditions and also for Osteoarthritis, Lumbar and Cervical spine generation and Ischaemic Heart Disease.

11. Dr Tipirneni last reviewed Mt Nolan on 30 August 2013 and advised him to slowly withdraw off his then current medication, Olanzapine. As an alternative he prescribed Zoloft 50mg for four days and to gradually increase it to 100mg. He was also advised to return in two to three weeks and was referred back to Dr Hore for ongoing treatment.

12. Dr Tipirneni was later made aware of Mr Nolan's suicide attempts by his family and offered to share his information with hospital staff following his admission. He suggested he be admitted for inpatient care with intensive monitoring.

13. Approximately three months before his death Mr Nolan told his wife that he, could not go on, and would repeat this to her, every few weeks.7 On 16 September 2013 he was admitted to St Vincent's Psychiatric unit following an attempted suicide by overdosing on Metropolol, which drug had been prescribed to him for his heart condition and anxiety. He was released the following day and he returned home with his wife. The Critical Assessment Team, (CAT) was due to attend to see him on Thursday 19 September 2013 at his home for assessment. After the CAT team left, Mr Nolan again attempted suicide by grabbing a scarf and tightening it around his neck. He was found by his wife in the bathroom. She and her son Michael then restrained him until VICPOL attended. Mr Nolan was later to the Royal Melbourne Hospital by ambulance.

14. It is also relevant that approximately two weeks before, Mr Nolan attempted to take his own life by carbon monoxide poisoning from his car exhaust, at home. His wife stated that this also appeared to be a suicidal gesture. No one was notified of this incident.

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[6] [6] Ibid page 20.
[7] See Mrs Nolan's statement at exhibit 1 page 1.

15. Mr Nolan was admitted to the Royal Melbourne Hospital (RMH) under the Mental Health Act 1984 on 20 September, after being recommended as an involuntary patient. He was assessed by Marilyn Konrad a registered psychiatric nurse and found to be agitated, restless, with a poor appetite and symptoms consistent with depression. His level of depression was found to be 12 out of 15 and his risk of self-harm was found to be high.8 While at RMH he was also assessed by Dr Spykerman.

16. He was later transferred to the aged care psychiatric unit at Broadmeadows Aged Psychiatric Mental Health Service (BAPMHS) located in Johnson Street Broadmeadows, arriving there early on the morning of Saturday 21 September 2013. He was seen by Dr Arron Wiggins (see below from paragraph 31) and assessed as being between a medium and high risk and placed on 15 minute close observations under the management of Dr Terrence Chong, a Consultant Psychiatrist. See also the clinical risk management assessment conducted at 10.20am, by nursing staff where his risk of suicide was again put at between high and medium, with 15 Minute observations to continue.

17. On both Saturday 21 September and Sunday September, Mr Nolan's wife and family visited him. On the Sunday evening his wife felt he was in a deep depressive state. He told her that, he wasn't feeling right.9

18. At 6.45am on Monday 23 September 2013 it is suggested that Mr Nolan was checked by the nightshift Unit Manager, RN Debra Pickitt. At this time he was in his room and said to be sleeping in his bed. Ten minutes later RN Pickitt was in the garden area outside his room (seeking to return another patient) and by chance observed through his window that Mr Nolan appeared to have left his bed and was in vertical position with the back of his head up against the window.10

19. On return to his room RN Pickitt Jordan found Mr Nolan hanging at the neck by a blue plastic slip sheet, which was being used as temporary curtain. Later with the help of colleague Rona Ramos, she was able to cut Mr Nolan down. The blue slip sheet was removed from his neck and he was laid down on his back on the floor of the room. The code blue team arrived at 7 am and commenced CPR.

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[8] [8] Exhibit 7 page 228-9. See also the clinical risk management assessment conducted by nursing staff at 10 20 am on Saturday 21 September at BAPMHS, where his risk of suicide was assessed as between high and medium with 15 minute observations to remain in place.
[9] [9] Transcript
[10] See evidence of this matter discussed below at paragraphs

20. Broadmeadows Fire Brigade members along with Paramedics and a MICA unit attended. The paramedics pronounced Mr Nolan deceased at 7.17 am and together with Fire Brigade and MICA staff, left the scene before the arrival of VICPOL. Police later attended Mrs Nolan's home and advised her of her husband's death. He was 75 years of age at the time of his death.

Investigation

21. Mr Nolan's death was reported to the Court on 23 September 2013 by DSC K Eykman and an investigation was commenced. While Mr Nolan had died whilst a voluntary patient at BAPMHS, having considered the issues raised by the investigation into his death I determined that an inquest should be held.11

22. Later at a directions hearing held on 7 September 2015 certain further directions were given to the parties and a date for the Inquest was determined.

23. The inquest commenced on 22 February 2016 and focussed on,

    a) How and in what circumstances a blue slip sheet came to be used to attempt to provide a curtain effect, leading to greater privacy and a reduction in light coming into the Broadmeadows Aged Care Facility room, occupied by Mr Nolan.

    b) How and to what extent did the use of the said slip sheet in this manner, cause or contribute to the death of Mr Nolan.

-Mrs Maree Nolan

24. Maree Nolan, and Mr Nolan had been married for a period of 53 years at the time of his death. She testified about their life together and his deteriorating physical state and her opinion as to the effect this was having upon his mental state. She referred to their last three years and to the death of their severely retarded son who they had looked after for 17 years, and of the effect this had on her husband.

25. *(He)… was getting very run down and he fell down a step and damaged his knee… But the Doctor's wouldn't operate, we weren't covered by private cover and so he kept going, kept struggling he kept trying to do his work, he was a cleaner all his life. We raised our seven children… he never wanted to give up working, he was a goer, he was a very determined person… very. So then in the last twelve months with the pain of his knee and the Doctors*

[11] See evidence as to his change of status from involuntary to voluntary by Dr Wiggins discussed below at paragraph 38 and at exhibit 3(d).

giving him medication... his mental state, he was getting blurred. I would say his deterioration was for the last three years, but the last twelve months he went down, It was just when he was in such pain he had to stop in the last six months.[12]

26. Q. *And so in relation to his pain that he was suffering was that coming from his knee...* A. *Um he had his heart. He had a heart condition. They wouldn't do anything, they said it's not bad enough. He was trying to deal with his body, you know. So mentally, that's what bought him down.*[13]

27. Mrs Nolan further testified as to her husband's anxiety about his medication. He would stress about his low blood pressure and irregular heartbeat. And as to how he had kept his first two suicide attempts from her, with her son only informing her following the second such attempt. Mrs Nolan also testified of his transfer from St Vincent's Hospital back home on 19 September 2013 after spending one night there and then afterwards of his transfer form home to RMH and then later to the Broadmeadows Psychiatric Aged Care, this on the early morning of Saturday 21 September 2013.[14]

-Nurse Marek Turski-Szendzialarz (Nurse Marek) [15]

28. Mr Nolan was comprehensively assessed in his home by Nurse Marek on 20 September 2013. He was assessed as being a high risk of suicide and the following matters were noted.

    a) Suicidal ideation comes on suddenly;

    b) Recent past history of overdose and attempted hose/exhaust in car;

    c) Family report that since discharge from SVH, suicidal thoughts have been constant.

    d) Wife found him with scarf around his neck.

29. At the time of this assessment there were no inpatient beds available and Mr Nolan was taken by ambulance to the RMH until a bed could be located. (Mr Nolan had been sent to the RMH after concerns about suicide had been raised by Nurse Marek). Whilst a patient at the RMH, Mr Nolan was also reviewed by a Dr Spykerman who recommended him as an involuntary

[12] Transcript 7-8. From Mrs Nolan, Mr Nolan continued to work as a contract cleaner over the whole of this period.
[13] Transcript 7-9.
[14] Following his return home from ST Vincent's Hospital, the RMH Aged Psychiatric Assessment and Treatment Team (APAT) were called and advised Mrs Nolan to call an ambulance. Later, while she and Mr Nolan waited for the arrival of the ambulance with their son, Mr Nolan further threatened suicide and on one occasion went to a drawer and took out a knife, which was recovered. Shortly before the arrival of the ambulance Mr Nolan took out a scarf, which Mrs Nolan also took from him. Each of these incidents occurred without any display of hostility towards either Mrs Nolan or their son.
[15] See statement exhibit 2 and assessment at exhibit 2(a)

patient under the Mental Health Act 1984. He was subsequently transferred to the BAPMHS arriving at 1.40 hrs on Saturday 21 September 2013.

Saturday 21 September 2013

-Dr Aaron Wiggins [16]

30. At 2am on Saturday 21 September 2013 at BAPMHS Dr Wiggins completed, as required under the Mental Health Act 1984, a risk assessment and the involuntary treatment order commenced earlier at RMH.

31. On admission Mr Nolan reported a 4 week history of worsening depressive symptoms, *on a background of alcohol dependence... He had attempted suicide twice in the preceding week, which had led to a two day admission to St Vincent's Hospital.* Dr Wiggins found that Mr Nolan presented having features of a depressive disorder.

32. *He was co-operative... and did not present as agitated and denied any current suicidal ideation. He was placed on a recommended 15 minute visual observations, and to be reviewed later that day by the on call Consultant Psychiatrist.*[17] Dr Wiggins further referred to his oversight in respect of his review of two of the earlier attempts, this to do with his practice of not having the form with him when he conducted the risk assessment.[18]

33. Dr Wiggins assessed his suicide risk on the border of between high and medium. Q … *why have you ticked between high and medium?* A. *Oh, just considering his previous attempts that out him in high risk... he was currently contained in the inpatient unit, he was no longer suicidal he wasn't agitated or distressed... but my practise usually is to do a bit more of a descriptive risk assessment now.*[19]

-Dr Terence Chong

34. Dr Terence Ching, a Consultant Psychiatrist, conducted a statutory review of Mr Nolan at approximately 8.20 hrs on 21 September. Dr Chong found that,

[16] Dr Wiggins was working as the on call psychiatric registrar at BAPMHS at this time. See his clinical notes at exhibit 7, pages 374-387. See also exhibit 4(a) – (d).
[17] Exhibit 4, page 1.
[18] Transcript 186 and 188.
[19] Exhibit 4(b). Transcript 188.

He was clearly a man who could not be discharged home, he needed to be in the hospital and he needed treatment in hospital.[20]

35. He also noted that Mr Nolan had multiple stressors including osteoarthritic pain, the health of his son, the earlier death of a son, his alcohol abuse and withdrawal and his own recent suicide attempts. [21] Dr Chong recorded that Mr Nolan's attempts at suicide were, *impulsive rather than planned and that his devout Christian faith was a protective feature.*[22]

36. Dr Chong further testified that a concerning aspect of suicide attempts is when they are planned because in that scenario it is, very difficult to keep them safe because they are actively wanting, pursuing means to do something to harm themselves. *The impulsive nature usually gives us more of a chance to try and help to... protect their lives...* [23]

37. As Mr Nolan's attempts had been impulsive the aim, according to Dr Chong, was to try and treat the underlying illness, in this case depression and anxiety, while maintaining frequent visual observations and trying to develop a therapeutic relationship and in this way engage Mr Nolan in a safety plan.[24]

38. Following Dr Chong's assessment, Mr Nolan's involuntary treatment order was not upheld as he was agreeable to treatment and was considered able to consent to treatment.[25] Despite this change in status Mr Nolan's treatment environment did not become less restrictive.[26] Rather he continued to present as impulsive while being a serious risk to himself and he was therefore maintained on 15 minute visual observations.

[20] Transcript 143.
[21] Exhibit 3(a) page 392.*
[22] Ibid. See also transcript at page 152.*
[23] Transcript 129 – 130.
[24] Transcript 131.
[25] Transcript 142.
[26] Transcript 144.

-Mrs Maree Nolan

39. In her testimony Mrs Nolan spoke of her visit to BAPMHS on Saturday 21 September 2013, where she remained for, *at least a couple of hours.*[27] While in his room Mrs Nolan noticed, *this material hanging from the window beside the curtains... like been put there to block out extra light... I just thought, Oh that's strange, and I didn't say anything unfortunately to anybody.*

40. Q. *Do you recall how it was attached to the window frame or the window?* A. *It was thrown over. You know you've got your curtain rod and it had a knot in it, like... that it wouldn't fall off... it was thrown over the rod.*[28]

41. And later, *All I can say is I saw it on the window when I arrived there and my daughter and grandson also witnessed it on the Sunday.*[29]

-BAPMHS Clinical Notes

42. The progress notes for 21 September record that Mr Nolan's low mood continued, and that over the course of the day his interaction with co-patients improved and he was observed to be enjoying the football on television.

Sunday 22 September – Monday 23 September 2013

-Mrs Maree Nolan

43. On 22 September Mrs Nolan visited Mr Nolan, with her daughter(s) and grandchildren arriving early after lunch, and remained until around 6pm when she had to leave because it was becoming dark and she had to drive home (her younger family members had departed during the course of the afternoon). During this period she went into his room and was there for approximately a half hour, during which time she recovered a razor she had brought in at his request.[30] The rest of the time was spent in the dining room or in the garden.

44. She didn't have a conversation with staff and had no recollection of staff coming to see her husband during her stay. This may have happened but she could not recall.

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[27] Transcript 22. She further testified that she went into his room for only a brief period when she first noticed the curtains, but that they spent most of this time together in the dining room.
[28] Transcript 19-20. It is common ground that the blue material seen by Mrs Nolan was a blue slide sheet commonly used in a hospital setting to help slide patients on and off a horizontal surface. I further note here that Mr Nolan's room was on the ground floor facing a garden to which patients and hospital staff had access.
[29] Transcript 21.
[30] Transcript 33-4.

45. She stated that he had become very upset when she left that evening. She remembered asking him if he felt suicidal.

46. *Well the children, my daughters came with their children... and when they left I stayed with him and he started to get very emotional so he went up to a (female) staff and he just said to her, "I don't feel good," and she said, "look I can't give you your medication yet, but I'll give you..." I think she said his sleeping tablet or something and he obviously settled down that night because it wasn't until the morning that he passed away.*[31]

47. *That night when I returned home I rang Peter at about 8pm and he was hardly talking to me. I said to him "I love you." I knew that his mind was not there when he replied with, "Thank you." He was an affectionate man and would usually say I love you, but I could tell that his mind was just not there...*

48. *I can't say that I am surprised that this was the outcome. Peter had suffered depression for a while and he had attempted suicide on two previous occasions. I could not do anything more to help him and neither could the Doctors.*[32]

49. *In* further elaboration. Mrs Nolan testified that his mood on Sunday was fluctuating. *Apparently he watched football on the Saturday, but on the Sunday he said "No, I have seen enough football now all my life, I've seen enough," and you know so that was a mood swing...*

50. *He wasn't getting involved... You know if like the family came he'd pep up a little bit for a little while... and then when no one was around... he went down.*[33]

51. *And, you say in your statement that you recall him saying they won't let me out? A. He said to me once... and he realised, you know, how it can drag on you know. And he just said to me if I ever go in they won't let me out... so he knew that it would have been an ongoing problem that he had because he was so down.*[34]

-RN Pickett [35]

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[31] Transcript 24.
[32] Exhibit 1, page 3.
[33] Transcript 30.
[34] Transcript 26.
[35] Nurse Pickett is a registered psychiatric nurse with 34 years' experience as at the date of her testimony.

52. RN Pickett was rostered to work over the night shift commencing at 9.30pm on 22 September and as per normal practice received a handover of all patients including Mr Nolan, whom she had not met before.

53. Her additional evidence was that she considered Mr Nolan to be of high risk because of his previous suicide attempts and that greater focus was given to him than the other patients. She was also aware that Mr Nolan was on 15 minute observations, but felt that he had been settled since his admission. RN Pickett further informed that she and her colleague were responsible for a total of 19 patients over the night in question and that, not unusually, the unit was full.

54. RN Pickett gave further evidence of introducing herself to Mr Nolan at approximately 10.10pm on 22 September 2013, when he was sitting in the lounge room. She also stated that at that time Mr Nolan said he was just tired and that he just wanted to go to bed because he hadn't had much sleep over the last few nights.[36]

55. RN Pickett stated at the time of handover at 9.30pm she was present and later at 10.30pm witnessed Mr Nolan take Zopicline 15mg, PRN, to assist with sleep.[37] The room light was on and she entered with her colleague, Nurse Rona Ramos, but she did not notice a blue slip being used at this time and would have removed it if she had done so.

56. RN Pickett also testified that at around 4am Mr Nolan approached the nursing staff at their office and stated that he was feeling a bit anxious and didn't know why. He was offered a cup of tea and asked if he wanted to come and sit with them in the office. Mr Nolan declined both offers but was offered and accepted further calming medication for agitation being Oxazepam 7.5mg, PRN, at 4.15am, which evidence I note appears to be supported in the medication record fond at exhibit 4(c). From that time she stated that Mr Nolan *appeared to be asleep... according to Rona.*[38]

57. RN Pickett further testified that Rona began doing the ECT observations (observations of people booked for ECT that morning) from 6.30am and that she took over the general overnight visual observations commencing from around that time. RN Pickett also testified that, she in fact did not conduct observation every 15 minutes and that, *The way that we did*

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[36] Transcript 198.
[37] Transcript 206 and the medication record at exhibit 4(c)
[38] Transcript 214.
See paragraphs below. From a consideration of the rest of evidence and the Observation Chart, exhibit 5(a) and the Medication Chart, exhibit 4(c), it is not established that RN Pickett was able to make regular observations or indeed any observations following the delivery of the Oxazepam PRN medication at 4.15am.

the work was... I had a lot of paperwork and medications to give out so normally the Division 2 nurse that's on duty does the observations. If she's bust I take over the observations but there is always someone doing those observations.[39]

58. *We were both responsible... But me being the nurse in charge, the way we worked it back then was Rona would do most of the rounds, unless she was caught up with somebody then I would do the rounds because a lot of the time I have to do tablets for someone else or.. if someone is.. I have to go and talk to them*[40]*... sorry your honour, I wasn't doing strict 15 minute observations, sometimes I was in there to see him more often... and like I was up and down that corridor so I mean sometimes it was 10 minutes that I'd look in on him... that time of the morning's so busy, I mean all of the times are approximate.*[41] Her further testimony was that, *I can't recall looking in on him at a certain time but... Every time I was down that corridor I'd just look in.* Q. *He certainly didn't come out after that time?* A. *No...* Q. *And things started to get a bit noisy at what time?* A. *Usually around 6 you start getting people waking up and you are doing... you are doing 2,000,000 things at once. You are doing nursing notes, you are doing rounds, you are doing medications that need to be given at 6... if you have anyone that's aggressive you are trying to calm down, give them medications. You had the ECT obs.*[42]\

59. She also testified that one of her patients, *became agitated because the doors were locked so, he used to go out at about 5.30am every morning and he'd walk around for 10 minutes and then I'd bring him inside... that's who I was actually going to get when I saw Mr Nolan.*

60. Under further examination, RN Pickett stated that he didn't go out at a specific time... *I'd just let him go out, and go out and get him when I had a spare few minutes to go and get him.*[43] RN Pickett was then questioned about her statement made on 23 September 2013 (the date of Mr Nolan's death) to the effect that she had found Mr Nolan at 6.53am, she stated that *she couldn't be 100% sure and I doubted whether it was much earlier because the day staff were arriving, which takes place, usually fairly close to 7am.*[44] *She also testified that she didn't hand over her observation duties to anybody while she attended to this task because it was in*

[39] Transcript 196.
[40] Transcript 199.
[41] Transcript 200.
[42] Transcript 214.
[43] Transcript 215-216.
[44] Transcript 216.

between the time when we were meant to check.[45] Her further testimony was that observations every 15 minutes was probably not an accurate representation of what occurs.[46]

61. RN Pickett also agreed that now the Unit's slip sheets were kept in a secure area and agreed the sheets were strong and designed for use to move body weight.

-Autopsy examination

62. On 27 September an autopsy was conducted at the Coronial Services Centre Southbank by Senior Forensic Pathologist Dr Noel Woodford, who confirmed the cause of death without other cause or contribution.

-Peter Kelly

63. Peter Kelly is the Director of Operations at North Western Mental Health, which is part of Melbourne Health and was at the relevant time (and remains) responsible for the Aged Persons Mental Health Unit at the Broadmeadows Health Service, 35 Johnstone Street, Broadmeadows. Mr Kelly provided evidence concerning the circumstances in which the patient slide came to be used in Mr Nolan's room on the morning of his death.

64. In an email to the Investigating Officer dated 25 September 2013, Mr Kelly observed that, *it has become apparent that the Patient Slide sheet had been attached to the curtain rail by an as yet unidentified member of staff, pending the usual curtain being re-installed.*[47]

65. In a second statement Mr Kelly offered that, despite our best efforts we are not able to categorically state that a staff member did or did not attach the patient slide to the curtain track... *Unfortunately, despite the passage of time the circumstances of how it came to be attached to the curtain rail remain unclear.*[48] Mr Kelly further advised that all maintenance requirements such as those that might have included the replacement or repair of a fallen or broken curtain, would go to the office of the Nurse Unit Manager, and that there was no record of such a report having been made in respect of this particular curtain.[49]

66. Mr Kelly was also questioned about the frequency with which patient bedrooms were searched for hazards and in respect of Occupational Health and Safety (OH&S) issues. He

[45] Ibid.
[46] Transcript 214.
[47] Exhibit 6(a)
[48] Exhibit 6(c), page 1.
[49] Exhibit 6(c)

responded that the unit conducts regular OH&S audits as required at an organisational level, and that, there does not appear to be evidence supporting a robust OH&S hazard reporting system in the past however...[50] Mr Kelly then went on to describe certain initiatives taken at a total of five NWMH facilities during 2013 and 2014, which involved the removal of ligature risks with ensuite bathrooms at these facilities. More relevantly (Mr Nolan's death occurred in the bedroom), Mr Kelly also explained that recently NWMH has introduced a Ligature Audit Programme, which is based on evidence from the UK, and now includes the involvement of a mixture of staff (carrying out the audit) including at least one person from outside the service that is being audited as a means of identifying risk that are "*hidden in plain sight*".[51]

67. Mr Kelly also informed that following the death of Mr Nolan and in accord with Melbourne Health policy, a root cause analysis was carried out which made five recommendations. These were,

1) The development of a systematic schedule of auditing, documenting, reporting and actioning recommendations to identify and address ligature points, to include development of local education and training sessions and the review of current design and investigative alternative options;

2) An important programme (such as the 'productive ward programme') – to ensure that decisions taken under 1) above are fully implemented and kept up to date;

3) That a local procedure be developed and implemented to ensure that all staff and executive team are aware of their responsibilities when responding to emergency codes;

4) That local education and training schedules incorporate simulated code blue sessions for staff to increase confidence when dealing with such matters, and

5) To ensure that ligature cutters are available to staff and that staff are trained in their use.[52]

68. I note Mr Kelly's evidence that these recommendations have all been successfully implemented.[53]

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[50] Ibid page 2.
[51] Ibid page 3. Earlier recommendations of this Court following Inquests into the deaths of Esther Ng Kit Ching, 4823 of 2012 and Majong Ngor, 2761 of 2013 similarly refer.
[52] Ibid page 4 and 5.
[53] Ibid page 5 and transcript.

FINDING

69. I find that Peter James Nolan died on 23 September 2013, at the Aged Persons Mental Health Unit, at 35 Johnstone Street, Broadmeadows, from

1(a) HANGING,

In the following circumstances:

70. I note here that the observation record for Mr Nolan over the 21, 22 and 23 September 2013, Exhibit 5(a), contradicts RN Pickett's evidence that observations were not necessarily conducted every 15 minutes. Rather the observation record purports to establish that observations were conducted at 15 minute intervals over the whole of this period.

71. It is also the case that the events occurred during a period on the morning of 23 September when the unit was filled to at or near capacity, and was supervised by two staff who were both extremely busy with waking patients, which included one who appears to have left the unit for a ten minute walk in the grounds, and who had not returned.[54]

72. According to RN Pickett at approximately 6.53am she was outside Mr Nolan's ground floor window trying to locate this particular patient. At this time she observed Mr Nolan through his window. She returned inside and saw the blue slip sheet around his neck and realised what had happened.[55] The amount of time RN Pickett spent outside before seeing Mr Nolan in this position and the time taken to get back to Mr Nolan's room is not known.

73. The record also suggests that observations between 10pm on 22 September and 6.30am on 23 September were conducted by the same nurse, RN Rona Ramos, and that no further observations were recorded after that time that is after 6.30am, (which includes 6.45am), until the code blue was called at 7am that morning.[56]

74. It follows from all of the above that there is no cogent evidence as to whether observations were made of Mr Nolan by RN Pickett after she gave him his last PRN (Oxazpam) medication at 4.15am on 23 September, or by Nurse Ramos from the time of her reported last visual observation at 6.30am. RN Pickett's evidence in regard to the frequency of observations during this period was also contradictory and inconsistent with the written record

[54] Transcript 215.
[55] Transcript 217-218.
[56] Transcript 204.

and I find that it has not been established that Nurse Ramos or indeed anyone else, conducted an observation of Mr Nolan after 6.30am.[57]

Origin of the blue slip sheet

75. In regard to the submission made by NWMH that there was no consistent evidence that the slide sheet had been knotted in that position prior to Mr Nolan employing it as a ligature, I note that RN Pickett testified that she was told by Nurse Ramos that the slide sheet had been put up the night before because a curtain had fallen down and Mr Nolan had complained about the curtain falling down and the light from the car park shining in. Further, RN Pickett's (also hearsay) evidence was that Nurse Ramos had told her that Mr Nolan had complained in this manner to a Nurse Kim Benis during their shift and as a result that the blue slip sheet had been put up at this time.[58]

I also record here that it was conceded by NWMH that the slide sheet had been put into a position against the window although not necessarily knotted, as found in photograph exhibit 1(a) by a member of BAPMHS staff, before Mr Nolan's death.

76. In regard to the issue of when the sheet was so positioned, I note Mrs Nolan's testimony that she noticed the placement of the blue slip sheet in a curtain position in her husband's room during her first visit to see him on Saturday 21 September following his admission to BAPMHS earlier that morning, and the additional hearsay evidence that other family member's noticed it when they entered the room again on Sunday 22 September.[59]

77. Having reviewed all of the evidence and submissions I draw the inference that the slip sheet was as Mrs Nolan testified in place prior to her arrival on the Saturday morning and that it remained in this position until its tragic use by Mr Nolan approximately 2 days later. I also find that the slide sheet had initially been provided and attached to the curtain rail by a BAPMHS member of staff in an attempt to reduce light coming into the room and that it was in these circumstances that it later became available to Mr Nolan.

78. There is no direct evidence to establish how it was knotted when first so placed, but clearly it was fastened by the time Mr Nolan came to use it, that is by himself or another. It is further the case that there is no evidence to suggest that any risk analysis was undertaken in respect of

[57] See PRN medication record at exhibit 4(c) and visual observation record at exhibit 5(a).
[58] Transcript 209.
[59] Transcript 19-21 and 33.

the use of such a sheet as a curtain in the room of Mr Nolan, (who had been admitted because he was at risk of suicide and maintained on 15 minute observations), and I find that same did not occur either when it was positioned during the early am on September 21, or at any time thereafter.

79. I further find that no steps were taken within this period to have the curtain replaced or to notify appropriate staff of the need to undertake such a replacement.

- Mr Nolan's Mental State

80. It is clear that Mr Nolan's mental state had deteriorated over the last 12 months and most particularly over the last three months of his life.[60] His physical health also deteriorated significantly and this together with the earlier loss of a son and growing anxiety over his own physical condition and his reliance on alcohol together with concerns about his children, all contributed to his changing metal state.

81. I further find that this much loved man who had lived a life of service to his family, had lost his will to live, and by the time of his admission to BAPMHS was at a high risk of suicide. It was in similar circumstances that prior to his death Mr Nolan had attempted suicide on a number of occasions with each instance involving an impulsive rather than a planned and executed course of conduct. However, death in this manner and in this facility was avoidable and the difficulty presented by Mr Nolan on admission and thereafter, not properly addressed with the need for planning and the administration of his care of paramount importance.

82. I find then that this confluence of circumstances all combined to contribute to Mr Nolan's death. I also find that error arose from a lack of appreciation as to the extent of the risk posed by his presentation and history, coupled with an insufficient level of consideration given as to how his supervision should be managed.

83. The competing duties that the two nursing staff were tasked to perform from around 6am was an additional and predictable factor and I further find that the unsatisfactory nature of the condition of his room, (that is the risk presented by the use of the slip sheet as a curtain), additionally and unwittingly increased the possibility of such an outcome.

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[60] See evidence of Dr Wiggins from transcript 172 and that of Mrs Nolan as set out above.

84. In conclusion I find that Mr Nolan was a brave and loving man who despite numerous obstacles had, with his wife, devoted his life to supporting the needs of a large and growing family.

85. I thank the parties for their assistance and extend the Courts sincere condolences to Mrs Nolan and her family.

Pursuant to section 64(3) of the Coroners Court Rules 2009, I order that the Finding be published on the internet:

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

The Family of Peter Nolan

The CEO of North Western Mental Health

Mr Peter Kelly, Director of Operations, at North Western Mental Health

The Chief Psychiatrist in the State of Victorian Department of Justice

The Chief Executive of the Department of Health and Ageing in the State of Victoria

Dr A Wiggins

Dr T Chong

RN Pickett

RN Ramos

Signature:

PETER WHITE
CORONER

Date: 29 June 2017.