IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 5064

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the Coroners Act 2008

Findings of:	**JUDGE JOHN CAIN, STATE CORONER**
Deceased:	**MR HAROLD GEORGE NOLAN**
Date of birth:	24 January 1943
Date of death:	24 October 2016
Cause of death:	I(a) Stab wound to the neck
Place of death:	7/478-480 Mitcham Road, Mitcham, VIC 3132
Catchwords:	Homicide; family violence; intimate partner; death resulted directly from injury; unexpected, violent; not from natural causes, stabbing with knife.

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HIS HONOUR:

BACKGROUND

1. Harold George Nolan (**Mr Nolan**) was born in Rockhampton, Queensland, on 24 January 1943. He was 73 years old at the time of his death.

2. Mr Nolan met his ex-wife, Ms Renee Nolan (**Ms Nolan**), in 1966 and they were married in Hobart on 11 April 1968.[1] Mr and Ms Nolan had two children together, Brett Nolan (**Brett**) and Derek Nolan (**Derek**).

3. Mr Nolan started his working career as a clerk for the Queensland Public Service before moving into Office Manager and Payroll Officer roles throughout Queensland, Tasmania and Victoria before he ceased employment in May 2012.[2]

4. In 1994, Ms Nolan moved to Western Australia but returned to live in Victoria intermittently until May 1996 when Mr and Ms Nolan formally separated. They continued to live together when Ms Nolan was in Victoria.[3] Mr and Ms Nolan were divorced on 12 May 2012.[4]

5. On 31 January 2013, Mr Nolan had a stroke and was hospitalised at Box Hill Hospital for approximately two weeks.[5] Following the stroke, Mr Nolan required ongoing care, so Ms Nolan returned to live in Victoria to care for him full time. Their son, Derek, also lived in the house. Ms Nolan remained Mr Nolan's full-time carer until the date of the fatal incident. [6]

6. In late July 2016, Ms Nolan began to exhibit stress in relation to her financial situation. Ms Nolan told her sons and respite support workers that she owed money to Centrelink and the Australian Tax Office (**ATO**).[7] Evidence in the coronial brief suggests that Ms Nolan did not actually owe any money to the ATO. Her sons formed the belief that she had been targeted by scammers who were calling her and falsely claiming to be from the ATO.[8]

7. In the months leading up to the fatal incident Ms Nolan was engaged with several services, including a psychologist, her General Practitioner, and aged care respite services. She also

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[1] *Coronial Brief*, Certificate of Marriage dated 11 April 1968, 252
[2] *Coronial Brief*, Statement of Brett Nolan dated 16 November 2016, 82; Appendix N, 287-292
[3] *Coronial Brief*, Appendix T, 320
[4] *Coronial Brief*, Appendix I, 258
[5] *Coronial Brief*, Appendix CC, 691-692
[6] Ibid; Statement of Derek Nolan dated 24 October 2016, 139
[7] *Coronial Brief*, Statement of Brett Nolan dated 16 November 2016, 86-87; Statement of Richard Anderson dated 4 November 2016, 93
[8] *Coronial Brief*, Statement of Brett Nolan dated 16 November 2016, 87

had regular contact with a pastor from St Luke's Anglican Church in Vermont, Pastor Richard Anderson. Mr Nolan was also placed in respite care on several occasions for the purposes of giving Ms Nolan a break from her duties as his carer.[9]

8. Evidence in the coronial brief suggests that Ms Nolan's emotional well-being deteriorated in the lead up to the fatal incident. Ms Nolan disclosed feeling significant stress about her financial difficulties and overwhelmed with caring for Mr Nolan to her General Practitioner (**GP**), respite workers and Pastor Anderson.[10] She also disclosed suicidal ideation to Pastor Anderson.[11]

9. As a result of the stress that Ms Nolan was experiencing, both family and respite workers noted that she appeared to have lost weight and appeared frailer.[12] Pastor Anderson described Ms Nolan as being exhausted and significantly stressed from her financial concerns in the months leading up to the fatal incident.[13]

10. On 22 August 2016, Ms Nolan attended with her GP and was referred to a private psychologist under a mental health care plan. In the three months prior to the fatal incident, Ms Nolan attended four sessions with a private psychologist.[14]

11. During a session with her private psychologist on 6 September 2016, Ms Nolan disclosed that she was experiencing anxiety, stress and low energy and was having difficulty eating and sleeping.[15] Ms Nolan also reportedly expressed concern that she would go to jail for using Mr Nolan's superannuation money to pay off her credit card.[16]

12. At a follow up session with her private psychologist on 14 September 2016, Ms Nolan reportedly exhibited paranoid thinking in relation to her financial issues. For example, she stated that staff at her local train station were watching her on behalf of the ATO.[17] Ms Nolan's psychologist attempted to engage additional services for Ms Nolan and advised her General Practitioner and her son Brett of her deteriorating condition.[18]

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[9] Ibid, 85
[10] Coronial Brief, Appendix BB, 640; Appendix EEE, 1774; Statement of Cathy Honan dated 18 November 2016, 112
[11] Coronial Brief, Statement of Richard Anderson dated 4 November 2016, 95
[12] Ibid; Statement of Brett Nolan dated 16 November 2016, 87; Statement of Cathy Honan dated 18 November 2016, 112
[13] *Coronial Brief*, Statement of Richard Anderson dated 4 November 2016, 96-98
[14] *Coronial Brief*, 116
[15] *Coronial Brief*, Appendix OO, 1081
[16] *Coronial Brief*, 116
[17] Ibid, 117
[18] Ibid

13. On 23 September 2016 Ms Nolan cancelled a period of respite care that had been planned for Mr Nolan, citing financial reasons to the care provider.[19]

14. On 7 October 2016, Derek assisted Ms Nolan to call the ATO as she said she had received two calls purportedly from them, telling her that the police were going to arrest her for not paying her tax.[20] The ATO confirmed that Ms Nolan did not owe them any money and that the calls had not been from them. Brett and Derek came to the conclusion that the calls must have been a scam.[21]

THE PURPOSE OF A CORONIAL INVESTIGATION

15. Mr Nolan's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria[22] and was violent, unexpected and not from natural causes[23].

16. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[24] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[25]

17. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[26] It is also not the coroner's role to determine criminal or civil liability arising from the death under investigation,[27] or to determine disciplinary matters.

18. The expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

19. For coronial purposes, the phrase "*circumstances in which death occurred*,"[28] refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the

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[19] *Coronial Brief*, Statement of Catherine Young dated 16 December 2016, 108; Statement of Cathy Honan dated 18 November 2016, 110
[20] *Coronial Brief*, Statement of Brett Nolan dated 16 November 2016, 87
[21] Ibid
[22] Section 4 *Coroners Act 2008*
[23] Section 4(2)(a) *Coroners Act 2008*
[24] Section 89(4) *Coroners Act 2008*
[25] See Preamble and s 67, *Coroners Act 2008*
[26] *Keown v Khan* (1999) 1 VR 69
[27] Section 69 (1)
[28] Section 67(1)(c)

death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

20. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the Court's "*prevention*" role.

21. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;[29]

    (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice;[30] and

    (c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[31] These powers are the vehicles by which the prevention role may be advanced.

22. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[32] In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[33] 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.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the Deceased pursuant to section 67(1)(a) of the Act

23. On 31 October 2016, Dr Richard Bassed, a Senior Forensic Odontologist practising at the Victorian Institute of Forensic Medicine, conducted a dental examination upon the deceased's body. Dr Bassed provided a written report, dated 7 November 2016, confirming positive identification of the deceased to be Harold Nolan, born 24 January 1943, after a comparison of ante-mortem dental records and post-mortem CT imaging of the deceased's teeth.

24. Identity is not in dispute in this matter and requires no further investigation.

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[29] Section 72(1)
[30] Section 67(3)
[31] Section 72(2)
[32] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152
[33] (1938) 60 CLR 336

Medical cause of death pursuant to section 67(1)(b) of the Act

25. On 25 October 2016, Dr Matthew Lynch, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon the deceased's body. Dr Lynch provided a written report, dated 10 January 2017, which concluded that Mr Nolan died from a stab wound to the neck.

26. Dr Lynch commented on the following in his written report:

    (a) The autopsy revealed evidence of a single stab wound to the front of Mr Nolan's neck. The wound was of a depth of approximately 13 centimetres and resulted in damage to major blood vessels in neck (right external carotid artery) and chest (brachiocephalic trunk) with 2200 ml of blood found in the right chest cavity. There were no defensive injuries identified.

    (b) Significant natural disease was noted in the form of an old left middle cerebral artery cerebrovascular accident (stroke) and coronary artery atherosclerosis.

27. Toxicological analysis of postmortem specimens taken from the deceased identified the presence of fentanyl, pregabalin and paracetamol at levels consistent with therapeutic use.[34]

28. I accept the cause of death proposed by Dr Lynch.

Circumstances in which the death occurred pursuant to section 67(1)(c) of the Act

29. On 23 October 2016, Brett visited Mr and Ms Nolan for approximately one hour. During this visit Brett noted that Ms Nolan seemed "*a little bit down again*" but "*definitely didn't seem depressed.*"[35] Ms Nolan told Brett that "*they*" might still be after her and suggested that someone had called her again and she was waiting on another call. Brett took this to mean the ATO or Centrelink.[36]

30. Ms Nolan also told Brett that Centrelink had cancelled her pension. Brett asked Ms Nolan if she had any paperwork confirming this, and she was unable to produce any, so Brett assumed

[34] Fentanyl was detected at a concentration of 2 ng/mL, Pregabalin was detected at a concentration of 1.6 mg/L and Paracetamol was detected at a concentration of 13 mg/L
[35] *Coronial Brief*, Statement of Brett Nolan dated 16 November 2016, 88
[36] Ibid

it was another scam. Brett did not otherwise notice anything unusual in his mother's behaviour during this visit.[37]

31. The following morning, on 24 October 2016, Ms Nolan went into Mr Nolan's bedroom at approximately 11.00am. She used a kitchen knife to inflict a single stab wound to the front of his neck, whilst he was asleep.[38]

32. Ms Nolan noticed that her son, Derek, was still sleeping in his bedroom and she got changed before informing him of what she had done.[39] Ms Nolan then called the police and emergency services arrived at approximately 12.15pm and Mr Nolan was pronounced deceased by paramedics on scene.[40] Ms Nolan was subsequently arrested by police officers and charged with murder.[41]

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

Family Violence

33. For the purposes of the *Family Violence Protection Act 2008* (Vic) (the Act), the relationship between Mr and Ms Nolan clearly fell within the definition of "*family member*"[42] under that Act. Moreover, in causing the stab wound to Mr Nolan's neck and causing his death, Ms Nolan's actions constitute "*family violence.*"[43]

34. Considering Mr Nolan's death occurred in circumstances of family violence, I requested that the Coroners' Prevention Unit (CPU)[44] examine the circumstances of Mr Nolan's death as part of the Victorian Systemic Review of Family Violence Deaths (VSRFVD) and to review Ms Nolan's mental health treatment.[45]

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[37] Ibid
[38] *Coronial Brief*, Appendix EEE, 1737-1738
[39] *Coronial Brief*, Appendix EEE, 1739
[40] *Coronial Brief*, Statement of Keith Frewen dated 24 October 2016, 154
[41] *Coronial Brief*, Statement of Senior Constable Paul Willoughby dated 27 October 2016, 159-164
[42] Family Violence Protection Act 2008, section 9(1)(b)
[43] Family Violence Protection Act 2008, section 5(1)(a)(i)
[44] The Coroners Prevention Unit is a specialist service for Coroners established to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety
[45] The VSRFVD provides assistance to Victorian Coroners to examine the circumstances in which family violence deaths occur. In addition, the VSRFVD collects and analyses information on family violence-related deaths. Together this information assists with the identification of systemic prevention-focused recommendations aimed at reducing the incidence of family violence in the Victorian Community

35. The available evidence indicates that there was no discernible history of family violence between Mr and Ms Nolan. Ms Nolan's actions appear to have been driven by her mental health deterioration and situational stressors in her role as Mr Nolan's carer.

Ms Nolan's mental health treatment

36. The available evidence suggests that Ms Nolan's mental state deterioration was due to a situational stressor given her role as a carer which made it difficult to treat. Mental health practitioners were not able to address the cause of Ms Nolan's mental deterioration (her caring role) and were attempting to address the symptoms through prescribing antidepressant medication and psychological counselling. Unfortunately, these interventions were insufficient to address Renee's symptoms.

37. The evidence further suggests that the extent of Ms Nolan's depression and associated psychosis inhibited her ability to engage in treatment. In the proximate period leading up to the fatal incident, Ms Nolan felt hopeless about the future, paranoid and guilty about finances which prevented her from purchasing antidepressant medication, and too exhausted and overwhelmed by her caring responsibilities to attend appointments.

38. Whilst it is not a legal requirement to follow-up with a patient after initiating a course of antidepressants, it is best practice to monitor the therapeutic benefits and side effects in follow up appointments to ensure that an appropriate therapeutic dose had been achieved. According the Royal Australian and New Zealand College of Psychiatrists (RANZCP) Clinical Practice Guidelines for Mood Disorders, "*as a rule of thumb, only one third of patients will remit with initial antidepressant treatment. Treatment non-response is therefore a significant issue in managing depression.*"[46]

Carer fatigue and mental health support

39. The stressors experienced by Ms Nolan in her caring role are not unique. The Royal Commission into Aged Care Quality and Safety **(Royal Commission)** identified that caring responsibilities can affect the physical, mental, social and financial wellbeing of carers:

[46] *Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for mood disorders*, available online at https://www.ranzcp.org/files/resources/college_statements/clinician/cpg/mood-disorders-cpg.aspx, 50

"Up to half of all carers surveyed in New South Wales in 2012 believed that their mental health has been negatively affected by caring, and 40% reported a need for mental health support"[47]

40. I note that caring responsibilities can limit a carer's time to engage in social activities and interact with friends or the community. Carers often reduce their work hours and earn less income in addition to the significant financial burden of providing care to someone with high needs (medication, transport, equipment). Carers also report ignoring their own physical and mental health.[48]

41. Evidence available indicates that although respite care was offered and provided for Mr Nolan, this was only a temporary solution and Ms Nolan had to resume her caring role at the end of each respite period. Furthermore, even when Mr Nolan was in respite care, Ms Nolan remained actively involved in his treatment. She visited most days to ensure he was settled and to give information on his care or to bring in additional items.[49]

42. In September 2015, Mr Nolan was recommended for a Level 3 and 4 Home Care Package in addition to residential respite.[50] Information provided to the Royal Commission indicates that individuals can wait for extensive periods of time after being assessed as eligible.

It is particularly challenging when an older person is deemed eligible for a Home Care Package, because they must first wait in the national prioritisation queue before a package of services is 'assigned', and they must find a service provider to deliver their care. That can take a very long time, especially for those who have higher care and support needs. Once someone is assessed as needing the highest level of care, a Level 4 Home Care Package, they can wait for a year and often longer for the Package to become a reality.[51]

43. The Royal Commission has described this system as "*cruel, unfair, unsafe and neglectful*", and further identified that it can lead to carer burnout. The Royal Commission further identified that the provision of more Home Care Packages to reduce waiting times for higher level care at home should be a priority consideration for the Australian Government.[52]

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[47] Royal Commission into Aged Care Quality and Safety, *Carers of Older Australians Background Paper*, 26 July 2019, 5
[48] Ibid, 4
[49] *Coronial Brief*, Statement of Cathy Honan dated 18 November 2016, 110-111
[50] *Coronial Brief*, Appendix W, 338-339
[51] The Royal Commission into Aged Care Quality and Safety Interim Report, *Aged Care in Australia: A Shocking Tale of Neglect* (31 October 2019), 3
[52] The Royal Commission into Aged Care Quality and Safety Interim Report, *Aged Care in Australia: A Shocking Tale of Neglect* (31 October 2019), 10

44. I confirm that the Royal Commission is due to publish its final report in November 2020. I also confirm that in response to the Royal Commission's interim report, the Australian Government has pledged a $537 million funding package, part of which includes increasing the number of Home Care Packages.[53]

45. Ms Nolan was charged with the murder of Mr Nolan and on 8 November 2017 in the Supreme Court of Victoria, she was found not guilty by reason of mental impairment. Ms Nolan was found liable to a 25-year custodial supervision order in the custody of the Victorian Institute of Forensic Health.[54]

46. I am satisfied, having considered all the available evidence, that no further investigation is required.

FINDINGS AND CONCLUSION

47. Having investigated Mr Nolan's death, I make the following findings, pursuant to section 67(1) of the Act:

    (a) that the identity of the deceased was Harold George Nolan, born 24 January 1943;

    (b) that Mr Nolan died on 24 October 2016, at 7/478-480 Mitcham Road, Mitcham, Victoria, from a stab wound to the neck; and

    (c) that the death occurred in the circumstances set out above.

48. I convey my sincerest sympathy to Mr Nolan's family.

49. Pursuant to section 73(1) of the Act, I order that this Finding be published on the internet.

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

    (a) Mr Brett Nolan, Senior Next of Kin;

    (b) Detective Senior Constable Matthew Lewis, Coroner's Investigator, Victoria Police; and

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[53] Prime Minister of Australia, *Media Release: Response to the Aged Care Royal Commission's Interim Report*, dated 25 November 2019

[54] *The Queen v Renee Nolan* SCR 2017 0063

(c) Commissioner Lynelle Briggs AO, Commissioners, Royal Commission into Aged Care Quality and Safety.

Signature:

JUDGE JOHN CAIN

STATE CORONER

Date: 20 March 2020