IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 20210993

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

Section 67 of the Coroners Act 2008

Deceased:	Edward Timothy Peterson
Delivered on:	19 May 2026
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing dates:	Inquest: 29-30 November 2023, 8 August 2024 Final Submissions: 8 August 2024
Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Counsel Assisting the Coroner:	Leading Senior Constable Clinton Smith, Police Coronial Support Unit, instructed by Mr James Whyman, Coroner's Solicitor, CCOV
Representation:	Mr Abhi Mukherjee of Counsel appeared on behalf of the Peterson family, instructed by Shine Lawyers Mr Paul Halley of Counsel appeared on behalf of Eastern Health, instructed by MinterEllison

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INTRODUCTION

1. Edward Timothy Peterson, referred to as Ned in this finding at the family's request, was born on 19 September 1995 at Dandenong Valley Hospital. For most of Ned's life, the household comprised his mother Joanne Peterson, older sister Brittany and younger brother Liam. Tragically, Ned's father died in a motor vehicle collision when he was four years old.

2. Growing up Ned played football, enjoyed long distance running and belonged to a local athletics club. He was described by his family as quite a social boy who enjoyed going out and being with his friends.

3. When he was in Grade 4, Ned started displaying anger management issues towards his mother and siblings. He attended Dr Richard Young's clinic in Wheeler's Hill for six months between 17 December 2004 and 14 June 2005 and was treated with cognitive behavioural psychotherapy, psychoeducation, motivational interviewing and grief counselling related to the death of his father. At the end of this course of therapy, Ned reported feeling well and spoke of being more settled at school and at home.

4. In 2014, Ned began a plumbing apprenticeship which he never completed. This was followed in 2016 by a massage course and a graphic design course, neither of which were completed. He returned to plumbing for a short time.

5. Some years earlier, when he was 15, Ned had begun experimenting with recreational drugs. This led to drug use for the next ten years which negatively impacted his mental state and functioning. Ned became more introverted, developed social anxieties and his mental health issues became more evident. The main triggers for Ned's behaviours were any perceived opposition from his mother or siblings which would cause him to retreat to his room and use drugs, mainly cannabis.

NED'S DETERIORATION BETWEEN 2018 - 2021[1]

6. By 2018, Ned was socially isolated, spending most of his time in his room drawing and listening to music. That year, Ned had a psychotic episode at home. Police were called and Ned was detained under section 315 of the *Mental Health Act 2014* (**MHA**) and admitted to

[1] This is a brief overview of Ned's circumstances and the psychiatric treatment provided to him between 2018 and 2021, prior to the February 2021 admission immediately before his death. The overview is uncontentious but in the event of any inconsistency the later sections of the finding with references to the evidence are to be preferred.

the psychiatric unit at Maroondah Hospital, Ringwood, for four weeks where he was treated with medication and counselling.

7. During the 2018 admission, Ned presented with disorganised thoughts and behaviours and was diagnosed with first episode psychosis. He was discharged on daily Risperdal 4mg and Olanzapine 15mg and on a treatment plan for follow-up with the early psychosis team. Following a period of engagement with the early psychosis/community treatment team, in 2020, Ned was discharged to his GP for ongoing care.

8. Ned's mental health and functioning deteriorated further in 2019. He quit his plumbing job and stopped attending family functions, further isolating himself. The COVID-19 lockdown regime was particularly difficult for him. He continually broke restrictions and curfew by wandering the streets for hours and would travel to the central business district to draw. While in the community, Ned's behaviour was problematic. He started getting into trouble and coming to the attention of police for committing public nuisance offences with regular outbursts and the use of profanities resulting in police being called.

9. One such occasion was on 8 February 2021, when Ned incurred three fines at Dandenong Railway Station for spitting in, on or at public transport vehicles, behaving in a riotous manner and using profane, indecent or obscene language.

10. On 9 February 2021, Ned had a heated argument with his mother, smashing a photo frame and making threats directed at her. Police were called and responded. They obtained an Intervention Order protecting Joanne Peterson and Ned was detained under section 351 of the MHA and taken to Monash Medical Centre for assessment.

ADMISSION TO MAROONDAH HOSPITAL

11. On 11 February 2021, Ned was transferred to the psychiatric unit of Maroondah Hospital as an involuntary psychiatric patient. He was placed in Inpatient Unit 1 (**IPU1 or unit 1**), a Low Dependency Unit. The clinical management and care provided to Ned during this admission and the way he absconded from the unit were the <u>main focus of the coronial investigation and inquest</u> into his death and will be discussed in some detail below. Suffice for present purposes to say that Ned remained in the unit until the morning of 22 February 2021 when he absconded by scaling the external wall of the courtyard adjoining the unit.

12. Shortly after, Maroondah Hospital staff reported Ned as a missing person to Ringwood Police and a formal missing person report was compiled. Police communications were notified and

a "keep a lookout for" Ned was broadcast. Police tried to contact Joanne Peterson by phone and left a message to inform her of recent developments regarding Ned. Local police members attended Joanne's home in case Ned had made his way there.

13. Subsequent investigation failed to clarify Ned's movements after he absconded from Maroondah Hospital or how and why he made his way to the Frankston area.

14. Ned was next sighted at 5.55pm on 22 February 2021 when he was seen jumping a fence in Cricklewood Avenue, Frankston, before running across the train tracks and putting himself in the path of an approaching train. The train driver was unable to stop the train in time to avoid impact. Ned suffered fatal traumatic injuries and died on impact.

INVESTIGATION AND SOURCES OF EVIDENCE

15. This finding is based on the totality of the material the product of the coronial investigation of and inquest into Ned's death which includes relevant witness statements, photographs, the forensic pathologist's report and medical records.[2] This finding is also based on the evidence of those witnesses who were required to testify at inquest and any documents tendered through them; and the final submissions of Counsel for each of the parties.

16. All this material, together with the inquest transcript, will remain on the coronial file.[3] In writing this finding, I do not purport to summarise all the material and evidence but will only refer to it in such detail as is warranted by its forensic significance and the interests of narrative clarity.

PURPOSE OF A CORONIAL INVESTIGATION

17. The purpose of a coronial investigation of a *reportable death*[4] is to ascertain, if possible, the <u>identity</u> of the deceased person, the <u>cause of death</u> and the <u>circumstances</u> in which the death occurred.[5]

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[2] The compilation of material sometimes referred to as an inquest brief (designated Exhibit A at inquest) will be referred to as the "brief" in the rest of this finding.

[3] From the commencement of the *Coroners Act 2008* (**the Act**), that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act. Unless otherwise stipulated, all references to legislation that follow are to provisions of the Act.

[4] The term is exhaustively defined in section 4 of the Act. Apart from a jurisdictional nexus with the State of Victoria a reportable death includes deaths that appear to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury. Some deaths fall within the definition irrespective of the section 4(2)(a) characterisation of the 'type of death' and turn solely on the status of the deceased immediately before they died – section 4(2)(c) to (f) inclusive.

[5] Section 67(1).

18. Ned's death clearly falls within the definition of "reportable death" in section 4 of the *Coroners Act 2008* (**the Act**), satisfying both the jurisdictional nexus with the State of Victoria required by section 4(1) of the Act, and section 4(2) which includes (relevantly) –

> *(a) a death that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury;*
>
> *(c) the death of a person who immediately before death was a person placed in custody or care.*

19. The concept of a person placed in custody or care is defined in section 3 of the Act and relevantly includes a person detained in a designated mental health service within the meaning of the MHA. It is uncontroversial that this clause refers to patients who are involuntary or compulsory inpatients in a public hospital psychiatric unit immediately before their death and that Ned satisfies this aspect of the definition of reportable death.[6]

20. The formulation *'cause of death'* incorporates where possible the *mode* or *mechanism* of death. For coronial purposes, the *circumstances* in which death occurred refers to the context or background and surrounding circumstances but is confined to those circumstances *sufficiently* proximate and causally relevant to the death, and not all those circumstances which might form part of a narrative culminating in death.[7]

21. The broader purpose of any coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the *prevention* role.[8]

22. Coroners are empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public

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[6] This was mentioned in the opening – transcript page 11.

[7] This is the effect of the authorities – see for example *Harmsworth* v *The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.). Note that coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence. However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69 (2) and 49(1) of the Act.

[8] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, compared with the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

health or safety or the administration of justice.[9] These are effectively the vehicles by which the coroner's prevention role can be advanced.[10]

IDENTITY

23. When his body was discovered, Ned had no identification papers or items on his person that might help to identify him. The following day, a missing persons circular that included a photo of Ned was circulated by police. Given the apparent partial likeness, police obtained DNA samples from the Peterson family and DNA comparison evidence was sought from experts within Human Identification Services at the Victorian Institute of Forensic Medicine (**VIFM**).

24. On 1 March 2021, a formal determination of identity was made by Coroner Darren Bracken identifying Ned as Edward Timothy Peterson, born on 19 December 1995 based on expert evidence of DNA comparison analysis.[11]

25. As identity was not in issue, no further investigation was required.

CAUSE OF DEATH

26. Ned's body was brought to the Coronial Services Centre in Southbank (**CSC**). Forensic pathologist Dr Yeliena Baber, from VIFM, reviewed the Police Report of Death to the Coroner (VP Form 83), photographs taken by police at the scene and post-mortem CT scanning of the whole body undertaken at VIFM (**PMCT**), before performing an external examination of Ned's body in the mortuary.

27. Having done so, Dr Baber provided a written report that is included in the inquest brief.[12] Her findings include multiple traumatic injuries particularly to the head, cervical spine, facial skeleton and upper body.

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[9] See sections 72(1), 67(3) and 72(2) regarding reports, comments and recommendations respectively.

[10] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

[11] The relevant report of scientific testing authored by April Lamande Stock is at pages 19-20 of the brief.

[12] Dr Baber's report is at pages 7-11 of the brief.

28. Toxicological analysis of postmortem samples taken from Ned's body was also undertaken at VIFM and detected hydroxyrisperidone[13], diazepam and its metabolite nordiazepam[14] and olanzapine.[15] No alcohol or illicit substances were detected.

29. Dr Baber concluded her report by formulating the cause of Ned's death as *1(a) Head injury sustained on impact by a train.*

30. I accept Dr Baber's expert advice about the medical cause of Ned's death.

FOCUS OF THE CORONIAL INVESTIGATION & INQUEST

31. The main focus of the coronial investigation including the inquest into Ned's death was on the circumstances in which the death occurred, specifically, the clinical management and care provided to him while he was an inpatient. A secondary and related focus, was on Ned's ability to abscond by scaling the wall of the external courtyard of the psychiatric unit of Maroondah Hospital before staff could intervene. This was a major focus of the family's concerns about the circumstances in which Ned's death occurred.

32. Initially, three witnesses were called to give evidence and be cross-examined about these aspects of the circumstances – Dr Aviva Irene Capelluto, Consultant Psychiatrist, Maroondah Hospital, Inpatient Psychiatric Unit 1 (**Dr Capelluto**); Associate Professor Paul Katz, Executive Clinical Director, Mental Health Program and the Clinical Director of the Adult Mental Health at Eastern Health (**A/Prof Katz**); and Ms Clare Neale, Nurse Unit Manager, Inpatient Psychiatric Unit 1, Maroondah Hospital (**NUM Neale**).

Dr Capelluto's evidence

33. Consultant psychiatrist Dr Capelluto provided two statements and gave evidence at inquest.[16] At the time of Ned's admission, Dr Capelluto was a consultant psychiatrist in Maroondah Hospital working in IPU1. Dr Capelluto had relocated from South Africa to Melbourne in

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[13] According to the toxicologist's report at page 13 of the brief, the antipsychotic hydroxy risperidone (available in Australia as Paliperidone) was at an elevated concentration and a number of factors such as postmortem changes, dose and prescribing history need to be considered in the interpretation of this concentration. Brief, page 13. Paliperidone was commenced at Monash Medical Centre and was one of the drugs used to treat Ned while an inpatient at Maroondah Hospital.

[14] Diazepam is a benzodiazepine derivative indicated for anxiety, muscle relaxation and seizures available in Australia under various brand names including Antenex, Valium. Brief, page 16.

[15] Olanzapine is an atypical (second-generation) antipsychotic drug with similar structure to clozapine used to treat schizophrenia and is also indicated for mood stabilisation and as an anti-manic drug. Brief, page 16.

[16] Dr Capelluto's first statement dated 15 June 2021 includes her formal qualifications and experience and is at pages 32-35 of the brief. Her second statement addressing issues that arose during the early part of the inquest concerning Ned's ability to abscond, notification of the police and the specifications of the courtyard wall is dated 18 July 2022 and is at pages 36-37 of the brief with relevant guidelines at pages 39-122 of the brief. Her evidence is at transcript pages 12-53.

January 2021; began working as a consultant psychiatrist at Eastern Health on 1 February 2021; and was undertaking a 15-month placement on the 'substantial comparability pathway' with the Royal Australian and New Zealand College of Psychiatrists.[17]

34. Prior to her first consultation with Ned, Dr Capelluto obtained a collateral history by reviewing the Maroondah Hospital medical records. She was aware of Ned's one month admission in 2018 and its sequelae and noted the common thread of disorganised thoughts and behaviour that also characterised his 2021 admission.

35. She noted that Ned was transferred to Maroondah Hospital from Monash Medical Centre on an Inpatient Treatment Order; that he had presented with psychotic symptoms and disorganised behaviour precipitated with non-compliance with his previous medication regime; and had been commenced on Paliperidone 3mg twice daily.[18]

36. Dr Capelluto's first review of Ned was on the second day of his admission, 12 February 2021. She was accompanied by hospital medical officer Dr Shirley Chen (**Dr Chen**). Ned gave a history of self-ceasing his medications one week before admission, saying he did not have the financial means to consult his GP. When Dr Chen spoke to Dr Martin, the GP listed for Ned, he advised he had not seen Ned since 2013 and had not seen him for follow-up since he was discharged from the community care team in 2020.

37. During the first review, Ned presented as polite and pleasant, willing to engage but somewhat closed off. Multiple delusional thoughts were the predominant feature of his presentation, including thoughts pertaining to World War II, the Capitol riots in the USA, the 5G network and the metro tunnel. He denied experiencing hallucinations and presented with disorganised thinking and formal thought disorder.

38. Dr Capelluto thought his mood was normal and noted that on questioning he denied any suicidal ideation or intent to harm himself or others. Ned responded to questions without elaborating, displaying a blunted affect. He was cooperative and not irritable during interview. Ned denied using illicit substances prior to his most recent admission but disclosed remote/historical use.[19]

[17] Brief pages 32-35, transcript page 13. See also, transcript at pages 37-38 where Dr Capelluto was questioned by Mr Mukherjee about her induction to Eastern Health.
[18] Risperdal 4mg daily and Olanzapine 15mg daily – see brief page 32.
[19] Brief page 32-33 and transcript pages 22-23. As to historical illicit substance use, Ned said he first used substances at the age of 16; used cannabis through bongs up to 1g per day, as well as ecstasy and methamphetamine a few years earlier.

39. At inquest, Dr Capelluto explained what she meant by blunted affect, or a limited range of expression and stated that such a presentation suggests the possibility of substance use or an underlying mood or psychotic disorder. She also expanded on the concept of a disordered thinking or formal thought disorder whereby a person presents with speech or thoughts that are disorganised, where topics are loosely linked or not appropriately linked, or presents with a 'word salad' where words are uttered that are not linked in any meaningful way.[20]

40. Following this review, Dr Capelluto placed Ned on half-hourly observations. She explained that while she felt Ned presented as quite settled on the ward, it was still early in his admission, and she took a conservative approach preferencing his safety by placing him on half-hourly nursing observations.[21]

41. Ned's second review by Dr Capelluto took place on 19 February 2021 and also included Dr Chen. On this occasion, Ned was pleasant, polite, cooperative, euthymic and neither suicidal, nor apparently a risk to others. Dr Capelluto felt that Ned's psychotic symptoms were softening and that he was less preoccupied with previous delusional themes. However, his insight into his illness and judgement remained limited. Ned shared some of his artwork with Dr Capelluto who thought he was quite a talented artist.[22]

42. They discussed the plan to move from oral Paliperidone which Ned had been tolerating well to an injectable form of the drug. Ned agreed and Dr Capelluto explained the need for a loading dose (150mg) which was administered that day and a second loading dose which was to be given in one week's time (on 26th February 2021) in accordance with clinical recommendations.

43. The rationale for changing to an injectable form of the drug was to improve Ned's compliance. The choice of Paliperidone as an injectable antipsychotic recommended itself as it is available in a three-monthly injection dose that may be considered for a patient after administration of four monthly doses. There is also a six-monthly form of the injection beyond that.[23]

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[20] Transcript pages 23-24.
[21] Transcript pages 24-25.
[22] Brief page 34 and transcript page 25.
[23] Transcript pages 25-28.

44. At the conclusion of this review, Dr Capelluto prescribed hourly nursing observations for Ned given his overall improvement,[24] his relative stability on the ward for eight days without incident and his agreement to the treatment plan moving forward.[25]

45. Dr Capelluto also gave evidence about aspects of Ned's general health that were addressed during his admission to IPU1. Ned reported a history of mitral valve prolapse and underwent review by a cardiologist. A repeat echocardiogram was performed and showed a mild mitral valve prolapse with normal left ventricular systolic function. The cardiologist advised that Paliperidone could be given to Ned and that he should follow-up with his GP for a repeat echocardiogram in three years' time.[26]

46. During her review, Ned showed Dr Capelluto two bite wounds on his left ring finger which he reported were sustained during the altercation with his mother prior to his admission. He was referred to the plastic surgery team who reviewed his finger, prescribed Betadine dressing and recommended monitoring for any infection. According to Dr Capelutto, this wound healed well on the ward with no evidence of infection.[27]

47. The hospital social worker was also involved in Ned's case. Due to the family violence context within which Victoria Police became involved with Ned, and the Intervention Order obtained to protect Mrs Peterson which prohibited him from residing in the family home, Ned's discharge was premised on safe accommodation being found for him.[28]

48. In her statement, Dr Capelluto mentioned seeing Ned on 22 February 2021 about one hour before he absconded. This was not a formal review but an incidental meeting as they each moved around the ward. Ned showed her his finger which was healing and asked when he

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[24] According to the medical records indicate nursing staff nevertheless continued with half-hourly observations after Dr Capelluto's review on 19 February 2021. It is not entirely clear why this occurred. Whether nursing staff knew but did not heed the change intended by Dr Capelluto; whether they exercised their own clinical judgment consciously in this regard to continue with the half-hourly regime; or whether this was a simple error on their part. See paragraph 87 below where this is discussed during NUM Neale's evidence.

[25] In her statement at brief page 33, Dr Capelluto provided a description of Ned on the ward – "Throughout his admission … Edward was polite to the ward staff and not aggressive. He was co-operative and pleasant at all times. His mood was noted to be euthymic although he displayed a restricted affect. He denied having suicidal or homicidal ideation during every interaction and interview which he had with the mental health professionals…His formal thought disorder and delusions softened during his stay in IPU1 although he continued to speak about the same delusional themes but less persistently. His insight was limited into his illness, and his judgement was impaired. He appeared frustrated that the ward staff did not believe that his thoughts were accurate and true, and although he agreed to take medication a whilst on the ward he did remark that he did not really understand why he had been admitted into hospital." Transcript pages 45-46.

[26] Brief pages 33-34.

[27] Brief page 34.

[28] Brief page 34. Note that the IVO had not yet been served on Ned and that there were discussions with the hospital social worker in which Victoria Police asked to serve the IVO on Ned before his discharge from the ward. It is not entirely clear that Ned was aware of the existence of the IVO while he was on the ward or when he absconded. Transcript page 31.

would be discharged. Dr Capelluto reminded him of the plan discussed at his recent review and his agreement with that plan and he *"accepted this and again agreed to the plan"*. According to Dr Capelluto, Ned *"did not present as being at risk of absconding or suicide and appeared settled."*[29]

49. At inquest, Dr Capelutto elaborated on this brief interaction with Ned. She described him as polite and settled. When she reminded him of the plan for a second loading dose with discussions about discharge to follow, Ned was quite accepting and they parted *"quite amicably, quite amenably"* without any apparent agitation, distress, anger or verbal abuse on his part. She described Ned as quite calm when the interaction ended.

50. According to Dr Capelluto, clients commonly ask when they are going to be discharged. It is a question asked many times in a day by many people. On its own, the question does not raise any red flags. Rather, it is more about assessing the patient's demeanour during the interaction and taking into account any concerns raised about them by other clinicians and/or any history of absconding.

51. In evidence, Dr Capelutto drew a clear distinction between 'wandering' as a behaviour that may indicate restlessness or a need to expend excess energy from a 'risk of absconding' proper which would prompt a consideration of risk mitigation.[30]

A/Prof Katz's evidence

52. A statement was provided by Associate Professor Paul Katz, Executive Clinical Director, Mental Health Program and the Clinical Director of the Adult Mental Health at Eastern Health (**A/Prof Katz**) who also gave evidence at inquest.[31]

53. The main request of A/Prof Katz was that he provide a statement addressing the family's concerns about Neds' ability to scale and climb of the external wall of the courtyard abutting unit 1 and abscond that included concerns about the physical environment and how this was possible as well as concerns about possible trigger for Ned to do so, prior instances of absconding from unit 1, and the responses by Eastern Health to these.[32]

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[29] Brief page 34. Transcript pages 45 and 50.
[30] Transcript pages 34 and following.
[31] A/Prof Katz's statement dated 6 August 2021 is at brief pages 125-128, his statement dated 19 October 2023 at brief page 128A and his evidence at transcript pages 53-133.
[32] The concerns in the form of questions posed by the family are replicated in A/Prof Katz's statement – questions 1-10.

54. A/Prof Katz described himself at inquest as a psychiatrist by training and profession employed by Eastern Health where he had two distinct roles – Executive Director of the mental health program overall, as well as Clinical Director of the adult mental health programs (adult and older adult).[33]

55. Ned was an involuntary patient being nursed in unit 1, a low dependency area. Within the unit, Ned was able to move between communal areas, his bedroom and the courtyard which was open each day for all patients to use from 08:30am until nightfall when security would close the courtyard. Unit 1 was a 20-bed unit comprising bedrooms with bathroom facilities as well as a dining room, group room, sensory room, a number of lounge areas and the exterior courtyard.

56. The nurse-to-patient ratio in unit 1 is 1:5 and the prescribed levels of observation are 15/60, 30/60, or 60/60 requiring quarter-hourly, half-hourly or hourly nursing observations of inpatients respectively. The consultant psychiatrist is responsible for setting the appropriate level of observation for each client after reviewing their daily risk assessment and taking into account their obligation under the MHA's "least restrictive principle".[34]

57. As regards any perceived "trigger" for Ned's decision to abscond, A/Prof Katz evidence was that Ned was initially settled on the morning of 22 February 2021. Later, he approached his contact nurse saying he was feeling anxious and needed to "get out of here". The nurse spent time with Ned as did the consultant psychiatrist who told him he needed to have a couple of days' observation following his second loading dose of long-acting antipsychotic depot medication before discharge and he appeared to accept this explanation.[35]

58. A/Prof Katz's evidence about the events leading up to Ned absconding commenced with the nursing assessment that he slept well overnight (23:00-05:00) and was settled upon the arrival of the morning shift (07:00). At 09:00 nursing notes indicate he was feeling anxious and "needed to get out of here". He agreed to talk to the medical team and was settled after talking with the contact nurse. Dr Capelluto reviewed Ned at 10:00 as set out in her evidence and he

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[33] Transcript page 53. Note that Eastern Health also has an infant, child and youth program.

[34] Brief page 125-6. There are many interpretations of meaning to be ascribed to "least restrictive" care in this context The following is an excerpt from the Mental Health and Wellbeing Commission's "Mental Health and Wellbeing principles guidance" – *"Mental health and wellbeing services are to be provided to a person living with mental illness or psychological distress with the least possible restriction of their rights, dignity and autonomy with the aim of promoting their recovery and full participation in community life. The views and preferences of the person should be key determinants of the nature of this recovery and participation (s18). There is no hierarchy of what is considered more or less restrictive.* ***Least restrictive means 'the option most consistent with the person's preferences rather than the one with less time experiencing other restrictions.'***"

[35] Brief page 125.

appeared to accept her reassurances. At 10:50 Ned was seen pacing around the unit; at 10:52 he was seen sitting in the lounge area; very shortly afterwards (10:53) a student nurse informed the ANUM that Ned was seen with a chair; and the ANUM immediately went to the courtyard to find the chair against the wall with no sign of Ned.[36]

59. In response to the family's question about procedures in place to prevent absconding via the courtyard, A/Prof Katz pointed to as suite of Eastern Health practice guidelines relating to Clinical risk assessment and management; Therapeutic engagement and levels of support; Specialling (one on one nursing) and monitoring; and Code Grey (emergency response for agitated or aggressive patients) procedures.

60. At inquest, A/Prof Katz was questioned by my assistant to clarify and expand on aspects of the evidence in his statements, and by Mr Mukherjee on behalf of the family with particular emphasis on the apparent ease with which Ned absconded and Eastern Health's response to previous similar incidents of absconding from the courtyard by scaling the wall.[37]

61. When asked to clarify how a patient's risk of absconding is assessed, A/Prof Katz stressed that the risk of absconding is part of an overall risk assessment that is ongoing; that risk is assessed from a multidisciplinary perspective involving all clinical staff; and that it only provides a snapshot of the patient/consumer at the time it is made. It was his evidence that a heightened risk of absconding alone would not justify use of the Intensive Care Area which was generally reserved for those requiring restraint or sedation for acting out or behaviours of concern, putting themselves or other at risk.[38]

62. A/Prof Katz provided information about previous incidents of absconding in a similar fashion, that is by negotiating the courtyard wall. According to Prof Katz, there were nine such incidents in the 12 months immediately preceding Ned's death, with no harm coming to any of the nine patients, all of whom were either returned to the unit safely or otherwise accounted for. He also provided evidence that there had been no structural modifications or other changes made by Eastern Health following the previous incidents of absconding. [39]

63. Finally, A/Prof Katz's evidence was that there was one security guard on duty when Ned absconded. However, while there was a security guard employed from 06:30 to midnight

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[36] Brief page 126.
[37] Transcript pages 60-105 and pages 105-134 respectively.
[38] Transcript pages 63-66, 79.
[39] Brief page 126 and transcript pages 72-73. See also transcript page 111 - While all nine patients who absconded in the 12 months immediately preceding Ned's death had in common that they successfully negotiated the same wall, they did not necessarily use the same means to do so (in his case a chair).

seven days a week, they worked across both Inpatient Unit 1 and Inpatient Unit 2 and had many responsibilities that took them to various locations within the campus beyond keeping an eye on patients in the courtyard which was not their primary responsibility at the time.

64. As regards any attempt to prevent Ned absconding, A/Prof Katz advised that a Code Grey was not called (and not feasible) as there was only about two minutes between the time Ned was seen with the chair and when staff noticed that he was no longer in the courtyard. In exigent circumstances, such as a staff member seeing a patient escaping, it would be more likely, and more typically the case that they would call an "alarm assist" via their ASCOM device which would bring unit staff to the area within seconds.[40]

65. Significantly, according to A/Prof Katz there had been no incidents of absconding (or attempted absconding) over the courtyard wall since a dedicated security officer had been employed to control the door through which the courtyard can be accessed in daylight hours. Access to the courtyard was limited to broadly daylight hours, 8.00am to 8.00pm when a security guard was on duty in the courtyard. It appears that the mere presence of the security officer has brought about this change.[41] According to A/Prof Katz, neither at the time Ned absconded nor subsequently are nursing staff or security officers expected to physically prevent or restrain a patient/consumer from attempting to abscond or to go "hands on" to use the colloquialism. Nursing staff were and would now be expected to attempt to dissuade absconders or persuade them to remain in the unit.[42]

66. A/Prof Katz confirmed that the courtyard wall scaled by Ned was 2.8 metres in height both at the time and as at the date of the inquest and that following Ned's death, one of the light fittings on the wall that Ned appeared to have used as a hand hold had been removed to dissuade others from doing the same thing, however, other light fittings remained. At least in part, he thought some lighting remained so that the courtyard could continue to provide amenity in the winter months. He agreed that these light fittings were at the same height as the one that had been removed but they were located along the wall at locations where the land slopes away and were effectively higher off the ground.[43]

67. A/Prof Katz was taken by LSC Smith to Ned's daily risk assessment in the medical records, specifically the third listed item "Absconding/Wandering" and indicated that a working group

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[40] Brief page 127ASCO is a Swiss company that provides pagers/alarms commonly used in acute care settings to enable staff to communicate with each in emergencies, among other settings.
[41] Transcript page 68.
[42] Transcript pages 74-76.
[43] Transcript pages 69-71.

was considering risk assessment documentation overall, not just this aspect and not due to Ned's death but more broadly. He added that risk assessment in general is notoriously unreliable and changeable, at best a clinician's impression at a particular time or a "snapshot" of the patient.[44] He also described the prediction of suicide or the assessment of the risk of suicide as notoriously unreliable worldwide by reference to all the literature.[45]

68. At inquest, A/Prof Katz described the Root Cause Analysis (**RCA**) process undertaken by Eastern Health after Ned's death in terms of the methodology applied, oversight within Eastern Health's mental health program and their Morbidity & Mortality Meeting and external accountability to Safer Care Victoria and the Office of the Chief Psychiatrist. He characterised the RCA as a robust process undertaken with transparency and accountability and spoke to progress with each of the RCA's six recommendations.[46]

69. It is apparent that the first two RCA recommendations that were germane to the coronial investigation in that they bear a causal connection with the absconding and thereby with Ned's death. The first recommendation was to increase the visual monitoring of adult mental health patients within courtyard spaces. This had been implemented by ensuring there was a security guard posted to the courtyard between 8.00am and 8.00pm when it was accessible to patients otherwise the door to the courtyard would be locked.[47]

70. The second recommendation was to remove light fittings and any other potential climbing handholds from the courtyard walls. A/Prof Katz's evidence was that the light fitting implicated in Ned's absconding had been removed but that the rest of the recommendation had not been addressed and was still under consideration with various risk mitigation options being considered beyond simply increasing the height of the wall.[48]

71. The other recommendations have less direct, if any, causal connection with Ned's death. They involved streamlining access to Alcohol and Other Drugs (**AOD**) services, increasing therapeutic group offerings and better allocation of rooms to maximise patients' sleep. These

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[44] Transcript pages 79.

[45] Transcript page 89 – "So because of the prediction of – I know you're well aware that the prediction of suicide is notoriously unreliable. That's worldwide. All the literature – even in the most experienced of hands, we just – we just don't get it right, and for a variety of factors, one is the unpredictability. There's often a change in circumstances that was to happen at that time and then impulsivity…"

[46] Transcript pages 80-83. Note that in the case of the nine patients who had absconded over the same courtyard wall in the 12 months immediately preceding Ned's death, no RCA had been undertaken. They would have been the subject to what is called a 'system review tool' at Eastern Health, not of the same order as an RCA, likely undertaken by the clinical director of the particular program stream and program, working together to look for continuous improvement possibilities.

[47] Transcript pages 84-85.

[48] Transcript pages 85-86.

recommendations were aimed at improving conditions for patients and therapeutic engagement in the hope that they would be less likely to want to abscond from the unit.[49]

72. When questioned by Mr Mukherjee about assessment of the risk of absconding, A/Prof Katz reiterated the importance of context, stressing that that the intention of mental health units across the state (indeed their obligation) is to provide the least restrictive care. Units are meant to provide a therapeutic and not a prison-like environment. He recognised the inherent challenge between providing amenity and keeping patients safe from suicide/harm, and bemoaned changes made consequent to adverse events and fatalities that have the effect of further degrading or denuding the therapeutic nature of the environment, such that patients are less likely to engage in treatment and more likely to want to abscond.[50]

73. When Mr Mukherjee asked if he was suggesting that 'suicide proofing' contributed to suicidality, A/Prof Katz clarified that he would not say so but thought that it contributed to a very sub-optimal patient/consumer experience, very different from what is available in the private sector, that doesn't lend itself to clinical recovery.[51]

74. A/Prof Katz went on to say that while striving to eliminate suicide is a laudable aim, it creates unrealistic community expectations that there should be no mortality associated with severe enduring mental illness, and if there is, then there has been something wanting in the treatment provided, whereas in his view, completed suicides are a complication of major, severe mental illness.[52]

75. A/Prof Katz added that if the (then) new MHA brought about a genuine paradigm shift as intended, there would be more people acutely unwell with mental illness being treated in the community rather than in inpatient units. He characterised this as a 'more discerning approach that respects the human rights and dignity of people' with mental illness, such that those with capacity to make a decision not to accept treatment can do so just as they can refuse treatment from any other medical speciality. [53]

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[49] Transcript pages 86-90.
[50] This is to paraphrase the effect of his evidence, repeated throughout, inc. transcript pages 60, 63-65, 93-94, 104-105. See in particular transcript page 94 where he said - *…there is a great concern amongst my counterparts …[regarding] the balance between suicide proofing these units and making them therapeutic … that we haven't got it right. It's heavily, um, weighted on the side, i/e/ trying to suicide proof them, which is impossible … they're becoming more and more barren. And the paradox is, I'm going to put it to you, that that's one of the contributing factors to a lot of occupational violence and absconding that happens in the unit. That's a very barren – very barren environment …"*
[51] Transcript pages 95-96.
[52] This is to paraphrase his evidence at transcript pages 103-104.
[53] Transcript pages 102-103.

76. As it remained that case that the courtyard wall was 2.8 metres high (as at the date of the inquest), Mr Mukherjee took A/Prof Katz to the Australasian Health Facility Guidelines 2015 (**the guidelines**).[54] While the guidelines do not prescribe specific height requirements for external walls/courtyard specifically they suggest a range of between 3.4 and 4.5 metres.[55]

77. A/Prof Katz' evidence in this regard was that he did not operate as a 'solo agent' and that there was a collective of people within Eastern Health concerned with having an inpatient environment that was conducive to recovery and mindful of the risks to consumers trying to scale even higher walls/fences which may led to unintended consequences such as traumatic injury. In any event, he did not have the authority to increase the size of the courtyard wall unilaterally but could participate in a process that might lead to such an outcome.[56]

78. A/Prof Katz was aware following the RCA, Eastern Health sought funding to increase the height of the courtyard wall and/or to comply with the guidelines, but he could not say if any funding had been received and what had been done with it beyond confirming that the courtyard wall was still 2.8m high.[57] The situation changed prior to conclusion of the inquest as will be discussed below.[58]

79. Mr Mukherjee took A/Prof Katz to the medical records and what was known of the timeline of Ned's absconding. He noted that Ned was described as 'becoming anxious/agitated' and the likelihood that he was offered and declined medication prescribed for him for PRN or 'as needs' use. He noted that the clinician involved was a student nurse who he described as astute given her level of experience. Her concerns were escalated to the ANUM as was appropriate and in keeping with expectations of a student nurse. If a more senior nurse had

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[54] The relevant guideline HPU 134 Adult Acute Mental Health Inpatient Unit is at pages 47-71 of the brief. According to the Preamble [brief page 50] – *"This Health Planning Unit (HPU) has been developed by the Australasian Health Infrastructure Alliance (AHIA). This revision has been informed by an extensive consultation process, completed in 2018, which included clinical experts and consumers. This document is intended to support the planning and design process for the design team, project managers and end users. It is recommended that the planning and design process for mental health facilities incorporates a consumer and carer co-design approach."* The brief also contains excerpts from HPU 131 Mental Health – Overarching Guideline at pages 72-103 of the brief, see relevantly, 3.8.9 Courtyards, Terraces and Gardens at pages 94-95; 3.8.10 Perimeter Wall and Fencing at pages 95-96; and Fixtures, Fittings and Equipment at page 96.

[55] "The design height of walls of fencing that form part of a secure boundary should not create a custodial environment nor increase the possibility of falling injuries should an attempt be made by a consumer to abscond. The design should avoid handhold and foothold points to prevent scaling and incorporate barriers to prevent scaling …There are no precise guidelines recommended for fence or wall height and this may vary from 3.5m in a general inpatient acute unit to 4.5m (which generally cannot be scaled by two average height consumers by one standing on the other's shoulders) in high dependency or intensive care units. The consumer profile and topography of the area should be taken into account when determining fence or wall height…and the degree of security required as determined y a thorough risk assessment…" Transcript pages 114-115, referring to page 71 of the brief.

[56] This is to paraphrase his evidence, as I understood it, at transcript pages 115-116.

[57] Transcript pages 118-119.

[58] See paragraphs 89 and 93 below.

made the observation, he might have expected them to do more, to try to de-escalate Ned and prevent him from absconding. Th student nurse was not expected to alert security.[59]

80. After discussion about the apparent speed with which Ned was able to abscond, the available CCTV footage was shown in court and A/Prof Katz was cross-examined about the feasibility of Ned being foiled by a timelier response to the observation by the student nurse that he was taking a chair into the courtyard.[60] A/Prof Katz noted that inpatient psychiatric units are busy place with each nurse typically caring for five very complex, acutely unwell patients as well as other scheduled activities. He implied the response was as timely as could reasonably be expected given those realities, the speed with which Ned was able to negotiate the wall once he had the chair and the lack of security staff within the unit.[61]

81. Mindful of the tragic consequences of Ned's absconding and the family's distress, A/Prof Katz stressed that not everyone who absconds from an inpatient does so for the purpose of suicide and that the majority of people who abscond from inpatient units, whether via the front door or the courtyard, do so because they want to get out of the unit. He agreed with Mr Mukherjee's suggestion that in order to provide care in accordance with the 'least restrictive care' principle, some level of absconding is tolerated.[62]

NUM Neale's evidence

82. Clare Neale, Nurse Unit Manager of Inpatient Unit 1, Maroondah Hospital provided a statement addressing matters that Dr Capelluto was unable to address and gave evidence at inquest.[63] NUM Neal's gave evidence about CCTV monitoring in the unit at the time Ned absconded and the light fitting on the wall that was thought to have assisted him doing so.

83. At the time, there were CCTV cameras in public or common areas within the unit, the footage being displayed in monitors in the nurses' station of base. Clinical staff had access to the monitors and could view footage if they chose to, but there was no provision for ongoing monitoring of the footage, it is mainly used to record incidents. Changes made since Ned's absconding involved placement of additional cameras so that all public or common areas are now covered by CCTV. The footage is now also able to be monitored from the security office

[59] Transcript pages 120-122.
[60] Transcript pages 123-127.
[61] This is the effect of his evidence at transcript pages 122-132.
[62] Transcript pages 132-134.
[63] NUMNeale's statement dated 14 April 2023 is at page 129 of the brief and her evidence at transcript pages 142-182. NUM Neale had more than 25 years' experience as a psychiatric nurse (transcript page 145); outlined her what the role of Nurse Unit Manager encompasses (transcript page 144); and how the unit was staffed (transcript page 145).

located in the emergency department. It is still the case that patients' privacy is protected to the extent that CCTV cameras do not cover their rooms.[64]

84. Another change made in the unit since Ned's death is the allocation of a security guard dedicated to the courtyard during its operating hours. This is an additional resource to the security guard allocated to work across inpatient psychiatric units 1 and 2 more broadly.[65]

85. NUM Neale referred to the multidisciplinary model of care in the unit with nursing staff caring for patients, input from psychiatrists and other clinical staff, as well as assistance from security staff. She described this as a dedicated multidisciplinary team. LSC Smith took NUM Neale to the Inpatient Safety Records which were available to all members of that team and directed her attention to Ned's assessments against the absconding/wandering criterion. She characterised the risk assessments as being the nurse's (or other clinician's) impression of the patient at a point in time, based on what they know of the patient from their own observation, what other team members have communicated and what the patient themselves has communicated.[66]

86. NUM Neale's evidence was that patients' presentations are changeable, sometimes not wanting to stay on the unit, at other times, agreeable to stay. NUM Neale recognised a distinction between wandering and absconding. She thought wandering was a less directed behaviour, where a patient may not know where they want to go, more like a presentation of delirium in the aged care setting, the patient at risk of leaving but not with intent to leave. NUM Neale adopted the suggestion that 'wandering' and 'absconding' had their ordinary meaning.[67]

87. LSC Smith also took NUM Neale to the evidence that Dr Capelluto initially placed Ned on half-hourly or 30/60 observations, relaxing the regime to hourly or 606/60 at her last formal review of Ned on 19 February 2021. It appears nursing staff had continued to nurse Ned on half-hourly observations despite Dr Capelluto's direction. According to NUM Neale, nursing staff are empowered to increase the frequency of observations if they perceive a need, usually a change in the patient's presentation or clinical deterioration. In such cases, NUM Neale would expect the nurse to document their rationale for the change. In the absence of a documented rationale, NUM Neale thought it likely they simply overlooked the change and

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[64] Transcript pages 146-148, 163.
[65] Transcript page 148.
[66] Transcript pages 149-150.
[67] Transcript pages 150-153.

continued to nurse Ned on half-hourly observations. This was the assumption NUM Neale made on first reviewing the records after Ned's death.[68]

88. NUM Neale was also questioned about the student escalating her concerns about Ned to the ANUM and the ANUM's action thereafter. NUM Neale testified that, generally, nursing staff would keep the ANUM aware of any changes or concerns regarding a patient as they occur. There would then be a discussion with the ANUM about the matter, perhaps with some planning around a response to the change or concern. NUM Neale was clearly familiar with what happened in Ned's case and supportive of the actions of the student nurse and ANUM on this occasion. She was not critical of the failure to raise alarms, whether via the ASCOM unit or to call a Code Grey given the quick timeframe. According to NUM Neale, "most of the people in the unit at any given time don't want to be in hospital, so this is something we manage every day" without recourse to alarms. [69]

89. Mr Mukherjee challenged NUM Neale about what changes had been made at Maroondah Hospital since Ned's death to make it more difficult to a patient to abscond via the courtyard wall beyond the removal of the light fitting used as a handhold and the addition of a security guard dedicated to the courtyard. <u>NUM Neale testified that the work "had just started on extending the courtyard wall</u> by placing an extension on it". According to NUM Neale, work had started on the footings external to the courtyard wall. She noted there were three courtyards in total and could not say when the work would be finished or how much higher the wall would be when the work was completed.[70]

90. Consistent with the evidence of A/Prof Katz, NUM Neale stated that the decision to increase the height of the wall was a difficult one to arrive at as they (presumably Eastern Health) wanted "to keep the environment as non-prison-like as possible, remembering that it is a healthcare facility that should be as homely as possible, more like a residential unit". According to NUM Neale, at other health services where she had worked, walls had been increased in height, but patients have still been able to abscond, and more commonly through the front door.[71]

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[68] Transcript pages 153-155.
[69] Transcript pages 157-159, 165.
[70] Transcript pages 166-168. At transcript page 170, NUM Neale clarified that some discussion about increasing the height of the courtyard wall had taken place before Ned's absconding and was not entirely attributable to it.
[71] Transcript pages 167-169. Later, NUM Neale clarified that some discussion about increasing the height of the courtyard wall had taken place even before Ned's absconding –

91. Mr Mukherjee took NUM Neale to the medical records where Ned's absconding was documented and the timeline of events. He suggested that a duress call could have been made if the will had been there and Ned could have been prevented from absconding. NUM Neale could not say as she was not there at the time. However, based on her review after the event, she felt that Ned was observed to be settling, and she would not have expected a duress alarm to be called 'over a chair'. Had Ned been seen by a permanent member of staff (rather than the student nurse) taking a chair and walking towards the wall, she might have expected the duress alarm to be used. However, the student nurse was within the scope of her practice and acted appropriately in informing the ANUM.[72]

Concessions made by Eastern Health

92. On 5 December 2023, following a request from the family for additional witnesses to be called (Nicole Martins, Ned's contact nurse on 22 February 2021; Balwant Singh, the ANUM; and the as yet unidentified student nurse) the inquest was adjourned to a date to be fixed to allow time for enquiries to be made to identify the student nurse; for statements to be obtained from all three witnesses; and a decision made about the need to hear from them at inquest.

93. Upon resumption of the inquest on 8 August 2024, Mr Halley made two concessions on behalf of Eastern Health and provided additional relevant information in the form of instructions conveyed in open court:

(a) The primary concession was that the wall of the main courtyard adjacent to IPU1 was not of sufficient height to prevent him from absconding. Rectification works were in progress; a mainframe was in place; panels had been constructed; and when installed by 26 August 2024, the courtyard wall would be 3.8 metres in height, an increase of 1.0 metre from its height when Ned absconded; and one which Eastern Health confidently believed will be adequate to prevent absconding.[73]

(b) The second concession was that given the wall was not of sufficient height at the time, the appropriate remedial action that should have been put in place by Eastern Health was to have a security guard present in the courtyard when patients have access to the

[72] Transcript pages 178-182. The duress alarm here is the Code Grey mentioned elsewhere.
[73] Transcript 8 August 2024 pages 1-2. The height increase would then be applied to the other two smaller courtyards by 6 September 2024. Mr Halley's instructions in this regard were provided by Mr Rohan Long, Executive Director Infrastructure and Support Services, Eastern Health.

courtyard. That action has now been put in place as has been heard in evidence but should have been in place at the time.[74]

Additional evidence about Ned's absconding

94. Registered Psychiatric Nurse Nicole Martins (**RPN Martins**) was Ned's contact nurse on the morning of 22 February 2021. She provided a statement and gave evidence at inquest.[75]

95. As Ned's contact nurse, RPN Martins was responsible for managing his care in terms of medications and monitoring him on the ward, monitoring his mood and mental state and managing any other therapeutic interventions that were required. Ned would have been one of five patients allocated to RPN Martins for the particular shift.

96. RPN Martins did not recall previously nursing Ned but when taken to the Inpatient Safety Record agreed that she had been his contact nurse on 15 February 2021. The Inpatient Safety Record for that day was completed by another nurse who discussed their assessment with RPN Martins. Relevantly, Ned was assessed as having some safety issues against the absconding/wandering criterion with a notation 'high profile'. According to her evidence, RPN Martins thought the notation 'some safety issues' signified that Ned may have expressed a wish to be discharged or may reflect a history of absconding or wanting to leave the ward. She was less familiar with what 'wandering' meant in this context. Her interpretation of 'high profile' was that Ned stayed in common areas of the ward where he could be seen by staff. I understand that this was considered a protective factor.[76]

97. At inquest, RPN Martins expanded on her statement and the retrospective note she made in the medical records after Ned absconded.[77] Ned was settled at the commencement of the shift. However, at about 10.30am another nurse told her Ned appeared anxious and was pacing up and down the corridor. RPN Martins approached Ned, asked him if he was alright and he said words to the effect that he 'just needs to get out of here'. RPN Martins asked whether he wanted to talk to in the courtyard and he agreed. When she asked him why he felt he needed to leave, he said, 'he just needs to get out of here' and was not willing to elaborate. She asked him explicitly if he would remain while she organised the treating team to review him and he

[74] Transcript 8 Aug 2024 pages 2-3.
[75] RPN Martins' statement dated 1 March 2024 is at page 390 of the brief and her evidence at transcript (8 Aug 2024) pages 4-26. RPN Martins completed her Bachelor of Nursing studies in 2018 and commenced working at Eastern Health in 2018. As at the date of her statement, she was a clinical case manager at Maroondah Early Psychosis Team and had worked primarily in mental health throughout her career.
[76] Transcript (8 Aug 2024) pages 4-6. This was explicitly stated later when RPN Martins in cross-examination by Mr Mukherjee at transcript (8 Aug 2024) page 15.
[77] The progress note time-stamped 14:31:23 is at page 286 of the brief, and the statement at page 390.

agreed. RPN Martins offered Ned PRN olanzapine which he declined saying 'the meds make me feel worse'. When they returned to the ward, Ned sat down in the living area and appeared to settle.[78]

98. RPN Martins discussed Ned as a potential AWOL risk with the ANUM noting that he had expressed a desire to be discharged but agreed to remain until he could be reviewed by the treating team. They discussed whether Ned required transfer to the ICA and RPN Martins was of the view that he was safe to remain the LDU as he was agreeable to remain pending review. As they discussed Ned, they could see him sitting in the TV lounge appearing settled. RPN Martins asked the ANUM to keep an eye on Ned as she had been asked to attend an admission review of another patient.[79]

99. When RPN Martins returned from that review, she heard about Ned absconding, amended the Inpatient Safety Record for 22 February 2021 and, later that day, made the retrospective progress note. RPN Martins was unsure how she came to ascribe 10:52am as the time the student nurse observed Ned take a chair out into the courtyard and report the occurrence to the ANUM, and that an unspecified staff member advised her that Ned had absconded at 10:55am.[80]

100. The student nurse referred to in this finding was identified by a review of the IPU1 staffing rosters on 22 February 2021 and contact with the nursing agency through which her placement was arranged.[81] Albina Thai (**RN Thai**) was studying nursing at Deakin University and in February 2021 was in the second week of a three-week placement as a second-year student nurse. During the relevant shift she was paired to work with RPN Martins assisting her to care for Ned and her other allocated patients.[82]

101. RN Thai testified that she was inducted to the ward upon commencement, that she could not recall any specific training or materials in relation to the risk of patients absconding but, as a student nurse, understood her that if she saw someone absconding, her responsibility was to escalate her concerns to Ms Martins and, as she was not there at the time, to the ANUM, as she did.[83]

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[78] Brief page 390, transcript (8Aug 2024) pages 8-9.
[79] Brief page 390, transcript (8 Aug 2024) pages 9-10.
[80] Brief page 390, transcript (8 Aug 2024) pages 11-13, 19-21.
[81] RN Thai's statement dated 6 February 2021 is at page 389 of the brief and her evidence at transcript (8 Aug 2024) pages 26-35. RN Thai completed her nursing studies in March 2022 and became a registered nurse in August 2022. As at the date of her statement, RN Thai was working in the emergency department of the Victorian Heart Hospital.
[82] Brieg page 389, transcript (8 Aug2024) pages 26-28.
[83] Transcript (8 Aug 2024) pages 28-29.

102. As regards what prompted her to bring the matter to the attention of the ANUM, RN Thai testified that she could recall no earlier interactions with or observations of Ned before she found herself in the lounge area and saw him pick up a chair and carry it outside to the courtyard which had its own (fixed) furniture. She could not recall Ned appearing agitated or stressed, it was just the strangeness of him taking the chair outside. RN Thai testified that she did not see what Ned did with the chair but believed he put it by the fence. Her last visual memory of Ned "was of him carrying the chair, going towards the door". As soon as she spoke to the ANUM they both went out to the courtyard. Ned was nowhere to be seen, and the chair was by the wall leading them to conclude that he had climbed over the wall. [84]

103. In re-examination by Mr Halley, RN Thai clarified that when she saw Ned pick up the chair, she did not form a view as to whether he was an AWOL risk, merely that it was strange that he would do so. Further, that she alerted the ANUM as Ms Martins was not available and that she and the ANUM went to the door and look into the courtyard.[85]

104. Balwant Singh was the ANUM in the unit at the time Ned absconded. He provided a statement and attended the inquest.[86]

105. Understandably, ANUM Singh could not recall the exact conversation he had with RPN Martins regarding Ned on 22 February 2021, now whether the words AWOL or absconding or anything like that had been used. In his statement, he recalled that RPN Martins was going to attend a psychiatrist's review of another patient and said, "Ned appeared to be a bit unsettled or words to that effect". At inquest, his vague memory was that she said, "Ned appears to be a bit vague or weird or something to that effect".[87]

106. In any event, what ensued was a discussion about the need for Ned to be transferred to the ICA which RPN Martins did not think was necessary. They then discussed the need to increase Ned's observations to half-hourly. The discussion took place in the nurses' station between 10.30-11.00am and Ned could be seen sitting in the TV lounge area nearby, apparently settled.[88]

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[84] Transcript (8 Aug 2024) pages 30-34.
[85] Transcript (8 Aug 2024) pages
[86] ANUM Singh's statement dated 19 March 2024 is at page 392 of the brief and his evidence is at transcript (8 Aug 2024) pages 35-49. According to his statement, ANUM Singh had been working as a psychiatric nurse at Maroondah Hospital since becoming a registered nurse some 15-16 years earlier, including 13 years as an ANUM.
[87] Page 392 of the brief and transcript (8 Aug 2024) page 36-37.
[88] Page 392 of the brief.

107. After this discussion with RPN Martins, RN Thai came to the nurses' station and told ANUM Singh that Ned had taken a chair outside into the courtyard. They promptly went into the courtyard, however, Ned had already absconded.[89] At inquest, ANUM Singh testified that he immediately associated the information from RN Thai with a possible attempt to abscond. He could not say how long after the discussion with RPN Martins this occurred. Nor could he identify the source of the 10:52am time attributed to this discussion in the retrospective progress note written by RPN Martins.[90]

108. In cross-examination by Mr Mukherjee, ANUM Singh testified that it was common for patients to ask about their discharge, sometimes as often as every two or three days. He agreed that there was a difference between a patient asking, 'when can I be discharged' and saying, 'I need to get out of here' or words to that effect. He testified that on each occasion, nursing staff consider the individual patient's presentation before determining the appropriate response. Risk levels are assessed daily and as ANUM, he "relies on nursing staff who are working on the floor to bring any concerns to his attention". He also applies his own judgement and any input from the doctors – they work as a team.[91]

STANDARD OF PROOF

109. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, having regard to the 'Briginshaw sliding scale'.[92] When finding facts, a coroner has to reach a comfortable or reasonable satisfaction having regard to all of the available evidence relevant to the questions in issue in the investigation.[93] When considering whether that level of satisfaction has been achieved, regard must be had to the seriousness of the allegation; the inherent likelihood or unlikelihood of an occurrence of fact, and; the gravity of the consequences flowing from a particular finding.[94]

110. This is particularly so with regard to adverse comments or findings about an individual in their professional capacity which should only be made when a coroner has reached a state of

[89] Ibid.
[90] Transcript (8Aug 2024) pages 37-38, 42-44. Note that ANUM Singh had previous experience with a person absconding from the courtyard using a chair, before Ned absconded. Transcript (8 Aug 2024) page 43.
[91] Transcript (8 Aug 2024) pages 41-42.
[92] Briginshaw v Briginshaw (1938) 60 C.L.R. 336.
[93] Anderson v Blashki [1993]2 VR 89 at 96; Secretary to the Department of Health and Community Services v Gurvich [1995] 2 VR 69 at 73;
[94] Briginshaw v Briginshaw, op cit, at 362.

comfortable or reasonable satisfaction based on the evidence that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death.[95]

111. It is axiomatic that the materiality of <u>any departure from applicable standards must be assessed without the benefit of hindsight</u>, only on the basis of what was known or should reasonably have been known at the time, and not from the privileged position of hindsight. Patterns or trajectories that may become apparent subsequently or may even be obvious once the tragic outcome is known, are to be eschewed in favour of a fair assessment made from the perspective of the individual at the material time.

FINDINGS AND CONCLUSIONS

112. Applying the standard of proof to the evidence before me, I find as follows:

(a) The identity of the deceased is Edward Timothy Peterson, 19 December 1995, aged 25.

(b) Ned died on 22 February 2021 at railway tracks in the vicinity of Cricklewood Drive, Frankston.

(c) The cause of Ned's death is head injury sustained on impact with a train.

(d) There is nothing in the available evidence to suggest that anyone else was involved in Ned's death or that he died in suspicious circumstances.

(e) The available evidence does not support a finding that there was any want of clinical management or care on the part of the clinical staff of Eastern Health during Ned's admission that caused or contributed to his death.

(f) In so finding, I note the very short time between Ned being seen taking a chair into the courtyard by the student nurse, her escalation of her observations to the ANUM and the ANUM's attendance at the courtyard to find the chair in situ with Ned already gone.

(g) The available evidence does not enable me to determine Ned's intention when he absconded, specifically, if he did so with the intention of taking his own life.

[95] Ibid.

(h) Ned's movements between the time he absconded shortly before 11.00am on 21 February 2021 and when he was observed in the vicinity of the railway line where he died shortly before 6.00pm are largely unknown.

(i) The possibility that Ned's intention to take his own life was formed after he absconded and/or impulsively remains open.

(j) The available evidence supports a finding that Ned intentionally placed himself on the railway line with the intention of ending his life, likely while his judgement was impaired by his mental illness.

(k) Eastern Health are commended for the concessions properly made during the inquest, namely that the wall of the main courtyard adjacent to Inpatient Unit 1 was not of sufficient height to prevent him absconding; and that the appropriate remedial action that should have been put in place was to have a security guard present in the courtyard when patients have access to the courtyard.

(l) The uncontested evidence was that no patients had absconded by scaling the courtyard wall since the deployment of a security guard to the courtyard, even in the absence of improvements the courtyard wall by way of increasing its height and the removal of the light fitting that was used as a handhold/foothold.

(m) In the twelve months immediately preceding Ned's death, nine patients absconded from the unit by scaling the courtyard wall. The uncontested evidence is that those patients either returned to the unit or were otherwise accounted for and that no deaths ensued. This is fortunate.

(n) The evidence at inquest was that Eastern Health conducted an internal review in relation to each of the nine incidents. I acknowledge that it is beyond my remit to investigate those reviews. That said, the relevant patient cohort comprises people with serious mental illness who are acutely unwell. The possibility that some absconding patients will be at risk of self-directed harm or even misadventure, leading to death, should be considered when conducting such reviews.

(o) I convey my sincere condolences to Ned's family and friends for their loss.

PUBLICATION OF FINDING

Pursuant to section 73(1) of the Act, unless otherwise ordered by the coroner, the findings, comments and recommendations made following an inquest must be published on the internet in accordance with the rules. I make no such order.

DISTRIBUTION OF FINDING

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

Joanne Peterson family, Senior Next of Kin

Shine Lawyers

Eastern Health c/o MinterEllison Lawyers

Transport Accident Commission

Senior Constable Matt Whichello, Coronial Investigator

Leading Senior Constable Clinton Smith, Coronial Support Unit

Signature:

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Paresa Antoniadis Spanos

Deputy State Coroner

Date: 19 May 2026

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*NOTE: Under section 83 of the **Coroners Act 2008** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.*