CORONERS ACT, 2003

SOUTH *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 4th, 5th, 6th, 7th and 8th days of February, the 20th day of March and the 6th day of May 2019 and the 22nd day of September 2020, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Ricky Dale Noonan.

The said Court finds that Ricky Dale Noonan aged 54 years, late of 14 Natski Court, Morphett Vale, South Australia died at the Margaret Tobin Centre, Flinders Medical Centre, Flinders Drive, Bedford Park, South Australia on the 27th day of September 2019 as a result of hypoxic-ischaemic brain injury attributed to cardiac arrest due to choking. The said Court finds that the circumstances of his death were as follows:

1. Introduction and cause of death

1.1. Ricky Dale Noonan was 54 years of age when he died on 27 September 2015 at the Flinders Medical Centre (FMC).

1.2. A post mortem examination of Mr Noonan's remains, involving a full autopsy, was conducted by Dr Neil Langlois a forensic pathologist at Forensic Science South Australia. Dr Langlois' post mortem report was tendered in evidence during the course of the inquest.[1] Dr Langlois' report expresses the cause of Mr Noonan's death as 'hypoxic-ischaemic brain injury attributed to cardiac arrest due to choking'. The origin of Mr Noonan's death was an incident on the morning of Wednesday 23 September 2015 in which he had choked on food and had experienced a cardiac arrest as a result. At the time of this incident Mr Noonan was a detained patient within one of the wards

[1] Exhibit C2b

of the Margaret Tobin Centre (MTC) which is the psychiatric facility of the FMC. In a moment I will describe the circumstances in which Mr Noonan came to be within this facility. Mr Noonan was discovered by clinical staff of the MTC to be in a collapsed, unconscious and unresponsive state. When resuscitative measures were administered by a hospital emergency team, a bolus of food was found to be obstructing his airway. Mr Noonan was in cardiac arrest. Resuscitative efforts were successful insofar as they were able to re-establish spontaneous return of circulation. However, following Mr Noonan's admission to the FMC Intensive Care Unit, hypoxic-ischaemic changes in his brain with secondary brain swelling and cerebral venous sinus thrombosis were identified. This constituted a fatal brain injury that was the result of the period of cardiac arrest prior to Mr Noonan's resuscitation. In essence, Mr Noonan suffered a fatal brain injury due to lack of oxygen and lack of blood supply to the brain sustained during that period of cardiac arrest. Mr Noonan's cardiac arrest had been the result of the occlusion of his airway during the choking episode.

1.3. Mr Noonan was not able to recover from the irreversible brain injury that he sustained. Accordingly, life support was ceased at the FMC intensive care unit on 27 September 2015, the day of his death.

1.4. Toxicological analysis of the sample of blood taken from Mr Noonan after his collapse and resuscitation detected the presence of quetiapine, haloperidol and clonazepam in keeping with therapeutic and clinical use within the MTC.

1.5. I find that the cause of death is as stated in Dr Langlois' report, namely hypoxic-ischaemic brain injury attributed to cardiac arrest due to choking.

2. <u>Reason for inquest</u>

2.1. Mr Noonan's death was a death in custody as defined in the Coroners Act 2003. Mr Noonan had been an inpatient at the FMC from 12 September 2015 which was eleven days prior to the fatal incident. From the date of his admission to the FMC Mr Noonan had been the subject of successive Inpatient Treatment Orders (ITO) imposed pursuant to the Mental Health Act 2009 (MHA). A Level 2 ITO had been imposed on 18 September 2015. At all material times Mr Noonan had been lawfully detained at the FMC pursuant to the ITO.

2.2. At the time of the fatal choking incident Mr Noonan was accommodated within Ward 5J of the MTC. Ward 5J is the psychiatric intensive care unit within the MTC. It was a closed ward from which egress was not permitted. Although Mr Noonan had his own room within the ward, at the time of the choking incident he was being kept in a dedicated seclusion room. This placement was due to his behaviour on the ward.

2.3. Mr Noonan's ongoing detention pursuant to the ITO, and the fact that his cause of death arose while he was subject to that order, meant that his death was a death in custody. Therefore, an inquest into the cause and circumstances of his death was mandatory pursuant to the provisions of the Coroners Act 2003. These are the findings of that inquest.

3. Issues examined at inquest

3.1. The inquest examined a number of matters surrounding the choking incident and Mr Noonan's death. They included:

- Whether it had been appropriate for Mr Noonan to have been provided with food while in seclusion and for his consumption of that food not to have been supervised.
- Whether he should have been provided with food having regard to the type and levels of medication that had been administered to him.
- Whether directives and requirements in respect of the monitoring of patients within the MTC, and in particular in respect of Mr Noonan while he was in seclusion, had been followed.
- Whether the monitoring of Mr Noonan while in seclusion, be it by direct sight or by CCTV monitoring, had been adequate and appropriate.
- Whether Mr Noonan's choking incident, and therefore death, could have been and should have been prevented.

4. Background to fatal incident

4.1. Mr Noonan had a serious and persistent psychiatric illness. His first involvement with mental health services occurred in 1984. Mr Noonan's psychiatric history is taken from

the statement[2] and oral evidence of Dr Allan Nelson who is a consultant psychiatrist at the MTC and who was very familiar with Mr Noonan's psychiatric and medical history.

4.2. Dr Nelson reports that Mr Noonan had approximately fifty admissions to hospital. Data tendered to the Court indicated that for the most part these admissions involved treatment for his psychosis. Other admissions involved illicit drug intoxication and non-compliance with medication. There are also reported admissions for injury including trauma to his head and wrists. In February 2005 Mr Noonan had undergone a full dental clearance. I observe from Mr Noonan's post mortem report that he is described as '*edentulous*'. It seems clear that Mr Noonan possessed false teeth. However, during the most recent admission to the MTC in September 2015 which culminated in his death, he did not have access to his false teeth within the centre. Evidence was given to the Court by nursing staff who were familiar with Mr Noonan that he avoided using his dentures. It was asserted that in any event he was used to eating solid foods without the use of dentures. One nursing staff member asserted that he loved his food and had '*gums like a steel trap*'.[3]

4.3. Mr Noonan's diagnosis was that he suffered from paranoid schizophrenia with an affective component. There had been times when he would be quite depressed. There were a number of serious suicide attempts, including one in which he slashed the veins in his arm. On many occasions Mr Noonan would present in an agitated and manic state, often in the context of amphetamine use. He also had a history of cannabis use and alcohol abuse.

4.4. According to Dr Nelson, Mr Noonan suffered from persecutory delusions involving people wanting to hurt him.

4.5. Connected with Mr Noonan's illness were a number of charges of assault and the development of delusions about staff and other patients that involved him attacking those persons. In fact, Mr Noonan's last episode of seclusion within the MTC was as a result of him punching another patient to the head for no apparent reason. There is also reference to Mr Noonan having made threats to kill a nurse because of deluded beliefs in respect of his own partner conducting an affair with the nurse. Mr Noonan also had a propensity to enter other patients' rooms and accuse them of trying to kill or

[2] Exhibit C18
[3] Transcript, page 429

attack his dogs. This led to a number of assaults and attempted assaults. According to Dr Nelson these scenarios resulted in Mr Noonan being placed in seclusion as a means of managing these tendencies.

4.6. Mr Noonan was mostly managed with injected medication because he did not take oral medication reliably. The injected medications were usually administered under a Community Treatment Order. Mr Noonan is said to have responded most effectively to the depot antipsychotic haloperidol. This is a slow release medication. From time to time the order would be lifted with the result that Mr Noonan would not take his medication and would then become unwell. In fact, Mr Noonan's final admission to the MTC involved a Community Treatment Order with a trial of oral medication. Unfortunately, he became more unwell and resistive to contact and intervention, presumably due to non-compliance. This reached a point where he could no longer be safely managed in the community and so he was brought into hospital on 12 September 2015.

4.7. I turn now to Mr Noonan's admission commencing on 12 September 2015. A Level 1 ITO was imposed on Mr Noonan on the day of his admission by Dr Dayton Walker, an Emergency Department doctor. This ITO was confirmed the following day by a consultant psychiatrist, Dr Cammell. Mr Noonan had spoken about how people were trying to kill him and his dogs. I do not need to go into his presentation in detail except that he said that he wanted to die with his dogs, had been damaging his unit and screaming constantly for 36 hours. Mr Noonan was very disturbed and was expressing ideas of persecutory delusions.

4.8. On Monday 14 September 2015 Dr Nelson's team took over Mr Noonan's care. Dr Abu-Baker, a psychiatric registrar on Dr Nelson's team, assumed Mr Noonan's immediate care. It was considered important that Mr Noonan recommence haloperidol and an injection was given to him that morning. Antipsychotic and/or sedating medication was provided to him. Mr Noonan was first prescribed with haloperidol tablets together with quetiapine which is an oral sedative. According to Dr Nelson, Mr Noonan expressed a view that this medication assisted with his sleep and that he found it helpful.

4.9. Unfortunately, Mr Noonan's psychiatric condition proved to be difficult to manage. As a result it was contemplated that Mr Noonan should undergo electroconvulsive

therapy (ECT). This was contemplated in order to achieve a more rapid settling of his psychotic and manic symptoms. However, Mr Noonan's death occurred before ECT could be carried out.

4.10. In his statement Dr Nelson describes what appears to be a complex medication regime over the period in which Mr Noonan was in the MTC. A Level 2 ITO was imposed on Mr Noonan at the expiration of the Level 1 ITO. Having regard to Mr Noonan's history and his most recent presentation I find that the ITOs were both lawful and appropriate.

4.11. During the course of Mr Noonan's final admission there were numerous 'code blacks'. A code black is a response to aggression and danger. Mr Noonan was preoccupied with the idea that someone was wanting to harm him and his dogs. On many occasions he entered another patient's room or attacked a staff member, accusing them of trying to kill his dogs. In Dr Nelson's statement he lists the various periods of seclusion within Ward 5J of the MTC. The first seclusion period occurred on 13 September 2015. The final and fatal period of seclusion commenced at about 9pm on 22 September 2015. The separate periods of seclusion number sixteen in total including the final period of seclusion. Dr Nelson's list indicates that the seclusion periods ranged from 2 hours on 14 September 2015 to 18.5 hours on 16 September 2015 and 14 hours and 55 minutes on the following day. A number of these periods of seclusion occurred during the night. Indeed, there is one particular period that occurred during the night of 19 and 20 September 2015 that commenced at 9pm and which lasted for 12 hours and 15 minutes.

4.12. Mr Noonan's penultimate period of seclusion had concluded at 9am on 22 September 2015 following which he was provided with olanzapine and breakfast. He was cooperative but very confused and disorganised. Following breakfast he retired to his own room. He underwent a pre ECT check by an anaesthetist. Later that evening he became unpredictable, violent and aggressive and it was on that occasion that he was seen to punch another patient to the back of the head. This was the incident that resulted in his final seclusion.

4.13. At this stage I should say something of the seclusion requirements that applied within the MTC Intensive Psychiatric Care Unit (IPCU).

4.14. At the time with which this inquest is concerned there was in existence a documented Southern Mental Health Adult Service procedure regarding IPCU seclusion. Its

effective date was 15 November 2010. There was in existence a newer version of this document but it had yet to come into operation due to the fact that at the time of Mr Noonan's seclusion certain features of the seclusion room that would have enabled the revised requirements to take effect were not yet in place. I will say more about that later in these findings.

4.15. The seclusion room had one door which was kept locked from the outside. The patient could not exit the room at will. He or she was effectively locked in until staff broke the seclusion by unlocking the door and entering the room. There was a toilet attached to the room. There was a door to the toilet that had to be unlocked by a staff member. The only window to the room was a small square shaped louvered window that only allowed partial inspection of the interior of the room. The only item of furniture was a mattress on the floor. There was also a blanket and a pillow. It has been said that seclusion was not, and was not meant to be, therapeutic. To the lay person this assertion is not only understandable, but smacks of gross understatement. It is difficult to imagine that prolonged isolation in the seclusion room would have been anything other than utterly demoralising. Unfortunately, as will be seen, in Mr Noonan's case it was necessary.

4.16. CCTV footage of the seclusion room and of Mr Noonan within it was tendered to the inquest.

4.17. Paragraph 2.1 of the documented seclusion procedure stated as follows:

> '**Seclusion must be viewed as an emergency / short-term measure** and should only occur after all other options have been explored, utilised and documented. This may include:
>
> - De-escalation
> - One to one counselling
> - "Being with" the client
> - Time out
> - Distraction
> - Medication.
>
> Other interventions may be considered based on staff clinical judgements and their knowledge of the client.' [4]

[4] Exhibit C26, Appendix A

4.18. Paragraph 2.6 stated as follows:

> '**Seclusion must not exceed four hours without a full medical examination and authorisation for continuation occurring.**'

4.19. Paragraph 2.7 stated as follows:

> '**Seclusion may be terminated at any time by a team consisting of at least the shift coordinator and one other registered nurse.**'

4.20. Paragraph 2.8 stated as follows:

> '**Patients in seclusion are to be continuously monitored.**
>
> - They must be sighted and communicated with at least every fifteen minutes or more frequently if necessary. More frequent observations are indicated in special circumstances such as severe self-harming behaviour, acute intoxication or a medical condition, particularly if they have received sedating medication in the previous two hours.
> - These observations should be documented on the seclusion chart.'

The heading of this paragraph referred to continuous monitoring. The body of that requirement suggested that secluded patients must be sighted and communicated with at least every 15 minutes or more frequently if necessary. However, the intent of the requirement in my view was plain enough. It suggested strongly that a very close if not continuous eye should be kept on secluded patients. Indeed, given that there was in any event a requirement for 15 minute sightings of all patients on the ward wherever situated, one would have thought that for secluded patients there would naturally have been an enhanced degree of scrutiny over and above that 15 minute interval. After all, why else would there be a special requirement in relation to secluded patients if it was not intended to mandate an enhanced degree of scrutiny? Clearly this section of the document was intended to impose an enhanced degree of scrutiny beyond 15 minute observations. During the course of the inquest it became apparent that this requirement was either not universally known or at least not universally understood. The difficulty was that the only window to the seclusion room was the very small louvered window that I have described. A member of the nursing staff would have to crouch in order to look through it. Even then, one would not necessarily be able to see, in whole or even in part, the patient if the patient was lying down or was otherwise stationary. This was a most unsatisfactory means by which a close eye could be kept on a secluded patient. The only reliable means of obtaining direct sight of the patient would be for the door of the room to be frequently opened. No doubt this would have had the result of

disturbing the patient and would possibly have exposed the person opening the door to attack or abuse by the patient. There was a reluctance on the part of staff to disturb a sleeping patient in seclusion.

4.21. During the course of the inquest I detected a large measure of resistance and lack of enthusiasm on the part of nursing staff to observe a secluded patient via this small window. However, within the nearby nurses' station there was a CCTV monitor that depicted the entire seclusion room. This enabled the patient to be constantly viewed by nursing staff within the nurses' station. This means of observation was also imperfect. For instance, it was a less than ideal means of observing the rise and fall of a motionless patient's chest to ensure that he or she was breathing. Nevertheless, it is obvious from the footage that I have seen of Mr Noonan within the seclusion room that a patient's activities could easily be viewed on the CCTV monitor, provided of course it was looked at. The difficulty in assessing a patient's safety via CCTV alone might have involved situations in which the patient was apparently asleep, in which case it might have been difficult to determine whether the person was asleep, over-medicated, unconscious or perhaps even deceased. But it was not as if the CCTV monitor had no utility at all. The difficulty described could hardly have justified not looking at the monitor with sufficient continuity to gauge whether in a given case further investigation of a patient's circumstances at the seclusion room itself was warranted. And as will be seen, continuous monitoring of Mr Noonan by way of the CCTV monitor probably would have prevented the choking incident or its consequences.

4.22. Ms Dulcey Kayes, Co-Director of Southern Adelaide Local Health Network (SALHN) Mental Health who gave evidence in the inquest, told the Court that her understanding of the monitoring practice was that due to the difficulty posed by the configuration of the small viewing window to the seclusion room:

> 'Continuous observation back then was done through the CCTV, because we couldn't see the consumers at the time because of the environment, however the 15 checks would have still needed to have been done'.[5]

To possibly confuse matters, however, Ms Kayes herself sent an email to certain recipients dated 22 June 2015 in which she stated:

> 'Hi just to reinforce, we do not do the 15 minute checks via the CCTV footage I have made it very clear to the team that the camera is not a nursing intervention not (sic) can it speak

[5] Transcript, page 626

to the consumer. The CCTV is only to be used/reviewed for medico legal reasons and or if we absolutely have no vision of the patient before opening the door'.[6]

I say confusing because this tends to overlook the fact that secluded patients required an enhanced degree of monitoring beyond every 15 minutes which was the degree of scrutiny to be accorded to all patients on Ward 5J in any case. It also overlooks the fact that in reality CCTV monitoring was probably, at the very least, a useful tool in assessing whether closer investigation of a patient's circumstances was warranted by actually attending at the seclusion room. In addition, it was a tool that was constantly available for viewing within the nurses' station. It seems odd that the utility of the CCTV monitor was so readily seen as limited. In the event, it would be this tool that ultimately alerted nursing staff to Mr Noonan's predicament, not visual inspection. The evidence satisfied me that regular actual attendance by staff at the seclusion room with an attempt to sight and communicate with the secluded patient was required and that very close inspection of the CCTV monitor in the nurses' station was also required and not just every 15 minutes. A bunch of other circulated emails concerning these requirements and which would not have clarified matters were tendered to the inquest.

4.23. Paragraph 2.15 stated as follows:

'**Mandatory medical review of a patient while in seclusion**

- Seclusion must involve medical review as soon as practicable, but not later than one hour after initial restraint or seclusion. If the standard is not met, sufficient reason will be documented in the person's case notes. (EDM P6-02)
- A mandatory psychiatry review will be undertaken prior to any decision to continue to restrain / seclude a person with an acute mental health issue beyond 4 hours (EDM p6-02)
- The responsible consultant will be notified of any patient who requires greater than eight hours continuous seclusion in any 24-hour period. A consultation by a psychiatrist will be provided at the earliest opportunity. (EDM P3-02)
- Any restraint or seclusion that continues for 12 hours or more is ***a Reportable Event (reportable to Office of Chief Psychiatrist)***
- Any patient who has required greater than 12 hours' total seclusion or restraint during a psychiatric intensive care episode will receive a second opinion assessment from a psychiatrist who is different from the treating psychiatrist. (EDM P3-02)
- If there is more than 24 hours' total seclusion or restraint in three days the matter will be referred for discussion to Director of Clinical Services and clinical team.
- Admission of a person under 18 years to an adult IPCU is ***a Reportable Event (reportable to Office of Chief Psychiatrist)***

[6] Exhibit C17 DK1

- Independent medical review after 2 hours is recommended for a person under 18 years in an adult PICU who has been restrained / secluded (P6-02).'

These requirements were said to be subject to a further stipulation that between the hours of 9pm and 9am the shift coordinator must use his or her clinical judgment to determine the appropriateness of a medical review. However, it is stated that no patient would be secluded for eight hours or more without a formal medical review. Evidence was given during the inquest that the requirements for periodic reviews might not have been adhered to depending upon the circumstances of the patient and the time of day or night. The periods of Mr Noonan's seclusion that exceeded 12 hours ought to have triggered reporting of those facts to the Office of the Chief Psychiatrist who had a duty pursuant to section 90(1)(b) of the MHA to monitor the use of restrictive practices including seclusion of patients subject to ITOs. For the most part, in any three-day period Mr Noonan spent in excess of 24 hours in seclusion. These circumstances ought also have triggered reporting of that fact to the Director of Clinical Services.

4.24. It is against that background that the circumstances of Mr Noonan's choking incident come to be assessed.

5. Staff on duty in Ward 5J

5.1. During the shift in question there were four members of the nursing staff on the Ward 5J. Between them they had responsibility for the care and welfare of patients who in that ward were all detained patients.

5.2. Mr Andrew Bertram is a registered general nurse and registered mental health nurse. At the time of the inquest his current position was as an Associate Nurse Unit Manager. At the time of the incident involving Mr Noonan he was Associate Clinical Services Coordinator. Mr Bertram gave oral evidence in the inquest. In his evidence Mr Bertram described his position as involving a coordination role that coordinates ward management and oversight of clinical and administrative staff. He was effectively a team leader in respect to the nursing staff. On the shift in question he had coordination responsibility for all three wards in the MTC. He began his shift at 7:28pm and was due to conclude it at 7:10am. The incident in question unfolded not long after 5am. Mr Bertram occupied the night coordinator's office which is situated three rooms back from the nursing station and is at the end of a corridor off which the seclusion room exists. In the CCTV footage of the nurses' station Mr Bertram can be seen to be in that

station from time to time. Mr Bertram did not have any personal responsibility for conducting checks on patients or monitoring the CCTV imagery from the seclusion room. Mr Bertram told the Court that the capacity of the MTC was 38 patients. Ward 5J accommodated eight patients. The ward was fully occupied on the night in question. There are two seclusion rooms. Mr Noonan occupied the one closest to Mr Bertram's office. I understood that earlier in the shift the other seclusion room had also accommodated a patient.

5.3. Ms Stephanie Daly was one of three nursing staff who were stationed in the nursing station and who had responsibility including the monitoring of patients within the ward including within the seclusion room. During this shift Ms Daly was the shift coordinator for Ward 5J. In her witness statement Ms Daly described the manner in which patients were allocated between the three nursing staff. Ms Daly indicates that she had been allocated two patients, neither of which were Mr Noonan. Mr Noonan had been allocated to one of the nursing staff, Mr Taimo Kutinyu. However, the evidence suggested that monitoring duties were shared on an ad hoc basis as between the three nursing staff. When examining the CCTV footage of the nurses' station Ms Daly for the most part is seated at the desk in a position that is not directly in front of the seclusion room CCTV monitor.

5.4. Also on duty during the shift in question was Ms Claire Molyneux. Ms Molyneux is a registered mental health nurse. The CCTV footage of the nurses' station places her close to but to the left of the seclusion room CCTV monitor.

5.5. The third member of the nursing staff who was stationed at the nurses' station was Mr Taimo Kutinyu to whom I have referred. Mr Kutinyu has a diploma in Mental Health Studies from the United Kingdom. From 2003 onwards he worked in a variety of mental health settings in the United Kingdom. In 2011 he came to Australia to work as a mental health nurse. He started working at the MTC within approximately two weeks of his arrival in Australia in August of that year. Mr Kutinyu told the Court that he was considered to be suitable to work in Ward 5J because he had worked in four secure units in the past and had undergone training for control and restraint which he asserts are useful skills to have in a setting such as Ward 5J. He is not trained in general nursing but only in the mental health sphere. It can be seen from the CCTV footage of the nurses' station that Mr Kutinyu would have had a clear view of the seclusion room CCTV monitor.

6. CCTV footage

6.1. Inside the seclusion room there was a CCTV camera which captured virtually all of the interior of the room. The camera was monitored in real time within the nearby nursing station. The monitor was situated on a desk at which the nursing staff could and did habitually sit. The monitor was within the line of sight of at least two staff sitting at the desk. The CCTV imagery was also recorded. However, the recording would be interrupted when there was no movement within the seclusion room. For instance, a sleeping patient would probably not be the subject of continuous recording due to that lack of movement. Nevertheless, for monitoring purposes the vision would be constant even when a patient was sleeping and motionless. The recorded footage displayed the time in hours, minutes and seconds. The interruption of recording due to lack of motion within the room meant that a period of just over 11 minutes during which Mr Noonan remained collapsed, unconscious and motionless on the floor was not recorded. This interruption is evidenced by an immediate increment of approximately just over 11 minutes in the time displayed on the CCTV footage as it is replayed. The interruption of the recording occurred after Mr Noonan can be seen to collapse to the floor and was then for several seconds motionless save for slight movement of his legs and an arm. What triggered the resumption of recording is not entirely clear as Mr Noonan does not appear to have appreciably moved since the interruption. However, within several seconds of the resumption nursing staff open the door and enter the room. But I emphasise, all of this 11 minute period was constantly displayed within the nurses' station in real time. It is obvious, and I have found, that Mr Noonan was situated lying on his back on the floor, not on the mattress, for the entirety of that period and was available to be seen.

6.2. Another CCTV camera was trained on the interior of the nurses' station. This was not monitored. However, it was recorded. There is also a time display in this recording that shows the hour, minutes and seconds. It is apparent that when one compares the CCTV footage from the seclusion room with the CCTV footage from the nurses' station that the times displayed are appreciably out of synchronisation. However, in my view the time difference between the times on the two CCTV footages can be established. Evidence was adduced from the Safety, Quality and Clinical Risk Coordinator for SALHN Mental Health Services, Mr David Healey, that in a limited way clarified the discrepancy. Mr Healey's evidence suggested that the discrepancy was approximately

10 minutes. Mr Healey's evidence did not establish which, if either, CCTV footage time display was accurate.

6.3. There is no sound in either footage.

6.4. The events of this night and morning as displayed in CCTV footage from both the seclusion room and the nurses' station are described in a documented sequential timeline that was helpfully tendered to the Court by Mr Bonig, the solicitor who represented the Nursing Coordinator, Mr Bertram. The times of various events are taken from the respective footages. Using this timeline together with other independently recorded events of that night and morning, a reasonably accurate correlation between the differing times displayed on the CCTV footages can be established. As will be seen, the correlation is of some importance.

6.5. I here explain how this correlation can be achieved. In the CCTV footage from the nurses' station Registered Nurse, Stephanie Daly, can be seen to look at the CCTV monitor of the seclusion room and then, within a matter of seconds, makes a phone call. This event occurs quite plainly after Mr Noonan's collapse and discovery. Following that call Ms Daly leaves the room as a matter of apparent urgency. In her oral evidence Ms Daly told the Court that when she looked at the monitor she saw Mr Bertram leaning over the collapsed Mr Noonan and wave to the CCTV camera within the seclusion room. Mr Bertram can clearly be seen doing this in the seclusion room footage. The objective on Mr Bertram's part was to draw the attention of whoever was in the nursing station to the need for emergency intervention to be sought. The phone call that Ms Daly made is to procure that emergency intervention. The time displayed on the nurses' station CCTV footage of when Ms Daly looked at the CCTV to see Mr Bertram waving is 05:22:06. Ms Daly almost immediately initiates a MET[7] call. The time displayed in the seclusion room CCTV footage when Mr Bertram waves at the camera is 05:12:20. This leads me to conclude that the time of 05:22:06 as displayed on the nurses' station footage corresponds to the time of 05:12:20 as displayed on the seclusion room footage. The time difference is thus 9 minutes and 46 seconds. Thus, in order to correlate times and therefore incidents displayed from both CCTV footages, one must subtract 9 minutes and 46 seconds from the nurses' station footage to arrive at the corresponding time displayed on the seclusion room footage. In making these conversions I make due

[7] Medical Emergency Team

allowance for possible imprecision in the conversion. That said, I do not believe the degree of imprecision is significant.

6.6. As to which, if either, of those times is accurate, I observe that the time of 5:11am is recorded in the FMC Department of Critical Care documentation as the time at which a MET was called after Mr Noonan's collapse was discovered.[8] Having regard to the fact that this time is not expressed in a round number, I infer it was meant to have been an accurate recording of the time. The event recorded is Ms Daly phoning for the MET. I thus infer that the times displayed on the seclusion room footage are accurate to within about a minute. Unless anything turns on the precise time of an event, I will assume for the purposes of these findings that the times on the seclusion room footage represent actual time. However, the more important time calculation is that which enables correlation between the time on the CCTV footage from the seclusion room and the time on the CCTV footage from the nurses' station.

7. Activity of Mr Noonan and the nursing staff as seen on CCTV footage

7.1. In this section I will describe the events concerning Mr Noonan that are displayed on the CCTV footage and which were available to be seen in real time on the monitor in the nurses' station. I will refer to times at which various events occurred by reference to the times for the most part described within Mr Bonig's schedule. In order to align the events depicted in the CCTV footage from the nurses' station with those within the seclusion room, as foreshadowed in the previous section I shall subtract 9 minutes and 46 seconds from the times displayed on the footage from the nurses' station. In this section, in order to minimise the confusion caused by the differences in time displayed on the two CCTV footages, I will express accurate times in bold.

7.2. At **03:24:57** Mr Noonan had been supplied with a sandwich and a drink. There is then various activity on the part of Mr Noonan that involves pacing in the room, occasionally lying on the mattress, urinating and fidgeting with what appeared to be hinges on the door of the room. There are also periods during which the CCTV footage skips. I have already mentioned one of them, namely the period following Mr Noonan's collapse. There had been other earlier periods of interrupted recording including between **4:01am** and **4:48am** which I infer was the result of Mr Noonan being virtually motionless. He was lying on his front on the mattress with his head resting on his folded arms. There

[8] Exhibit C12 pages 105-107

is nothing remarkable about the way in which Mr Noonan is lying on the mattress during this period. He was probably asleep.

7.3. At **04:48:53** Mr Noonan rises from the mattress and walks to the door of the room. There is further movement on his part in the form of stumbling and wandering around the room. At one stage he picks up the cup that earlier had been brought into the room.

7.4. At **04:52:32** Mr Noonan sits on the mattress. He appears to put something in his mouth which I find was part of if not the whole of the sandwich which had been delivered earlier. In my opinion this piece of food is that which would obstruct his airway and in effect cause his death. To the uninitiated what then follows, as can be seen in the CCTV footage, is quite harrowing. At various times Mr Noonan appears to be distressed. He is hunched over at times and appears to cough. His hand moves to his mouth or to his abdomen. There are other episodes of apparent coughing. There are other occasions on which he appears to do something in respect of the door of the room. At one point at **04:57:00** he appears to bang on the door. At around **04:57:12** there is a period where Mr Noonan is at the door for several seconds and he appears to cough more violently consistent with an attempt to bring up something from his throat. There is further apparent banging on the door. At **04:58:09** he can be seen to place his left hand in the vicinity of his throat. There is further activity near the door of the room until he collapses.

7.5. The point of Mr Noonan's collapse is at **04:58:49**. The footage demonstrates that Mr Noonan was up and about from **04:48:53** when he rises from the mattress until **04:58:09** when he collapses.

7.6. The collapse occurs when Mr Noonan staggers from his position near the door and falls to the floor of the room. After he falls, he is lying on his back and apart from slight movements of his leg and arm he is motionless. Whereas in the period between **4:01am** and **4:48am** he had been lying on the mattress, he is now lying on the bare floor. His legs are splayed, his left arm is on the floor at an approximate 45° angle from his body and his right arm is bent at the elbow with his hand resting on his upper chest.

7.7. I have already referred to the fact that the footage is interrupted for about 11 minutes while Mr Noonan lay on the floor following his collapse. The footage stops at **04:59:36** and resumes at **05:10:53**. Mr Noonan is in the same position on the floor when the footage resumes. Mr Noonan is still lying on his back with his legs splayed. His right

arm has moved in towards his body by about 2 centimetres. His left hand has not detectably moved at all, but his left wrist is at a slightly more acute angle. To the naked eye, unassisted by repetitive replays of the CCTV footage, Mr Noonan has virtually not moved at all for those 11 minutes. He is completely still and does not move until help arrives. He is in cardiac arrest. I infer that he was in this completely still state for a significant period of time prior to the resumption of the CCTV footage. Throughout the whole of this period Mr Noonan would have been visible in this position on the CCTV monitor in the nurses' station.

7.8. At **05:11:20** the door to the seclusion room can be seen to commence opening. Mr Bertram and Mr Kutinyu enter the room. Mr Noonan is clearly unresponsive. As already seen, at **05:12:20** Mr Bertram signalled to the CCTV camera to which Ms Daly responded in the nurses' station. At **05:12:23** Mr Bertram commences CPR and a mask is introduced. It is not clear that an attempt was made to inspect or clear Mr Noonan's airway at that stage.

7.9. Thereafter other personnel enter the room and other resuscitative measures including defibrillation and the provision of oxygen are administered.

7.10. It is manifest from the CCTV footage that Mr Noonan occupied the same position on the floor and was virtually motionless from the point of his collapse at **04:58:49** to when the door of the seclusion room was opened at **05:11:20**. That is a period of 12.5 minutes.

7.11. It is here necessary to discuss the relevant events within the nurses' station as they correspond to relevant events in the seclusion room. I indicate that the times that I quote in this section are the times displayed on the nursing station CCTV footage minus 9 minutes and 46 seconds as discussed in paragraph 6.5 herein. The footage displays a number of movements of persons to and from the nurses' station throughout the course of the night.

7.12. From **04:49:44**[9] all three members of the nursing staff, namely Ms Daly, Ms Molyneux and Mr Kutinyu, are within the nurses' station and occupying the positions at the desk to which I have already referred.

7.13. At **04:51:37**[10] Mr Kutinyu stands and leaves the nursing station. The evidence suggests, and I find, that at that time Mr Kutinyu conducted monitoring of the patients within

[9] Adjusted from 04:59:30 as inaccurately displayed on the nurses' station footage
[10] Adjusted from 05:01:23 as inaccurately displayed on the nurses' station footage

Ward 5J. I will mention something of Mr Kutinyu's evidence about this exercise later in these findings. At **04:53:16**[11] Mr Kutinyu returns to the nursing station and resumes his seat in front of the seclusion room monitor. This occurred a number of minutes prior to Mr Noonan's collapse to the floor at **04:58:49**. I do not believe that Mr Noonan had collapsed prior to Mr Kutinyu's observation round. If a visual check of Mr Noonan had been conducted by Mr Kutinyu during that round, it is likely that Mr Noonan would have been on his feet or sitting on the mattress and probably would have been visible, at least in part, through the small window to the seclusion room. I think it likely that Mr Noonan ingested the food that would fatally block his airway during this period. As seen above, that event apparently occurs at about **04:52:32**. In any event, I am not certain that Mr Kutinyu would necessarily have detected behaviour on Mr Noonan's part that was out of the ordinary for him. That said, it is clear that Mr Kutinyu did not approach the door or window of the seclusion room during his ward round. I do not believe that he attempted to communicate with Mr Noonan as required by paragraph 2.8 of the seclusion procedure, or that he elicited a verbal response from him. Given that one cannot be completely certain as to when Mr Noonan was overtly in distress from choking, it also cannot be known with certainty whether an attempted communication on the part of Mr Kutinyu would have led to the detection of that distress. Suffice it to say, an attempt at communication should have been made as per the seclusion procedure. To my mind, unless a further visual check of the seclusion room was undertaken while Mr Noonan was collapsed on the floor, the sole means by which his collapse could have been detected was the CCTV monitor. The seclusion room would not be physically approached again until **5:08am** when, as will be seen, Ms Molyneux checked on him.

7.14. From the point when Mr Kutinyu returns to the nurses' station at **04:53:16**, the three nurses remain in the nurses' station in the positions I have already described until Ms Molyneux leaves the room to check on Mr Noonan. It is not apparent from the CCTV footage that any one of the three nurses looked at the seclusion room CCTV monitor until Ms Molyneux looks at it. In my view, while all three nurses were present within the nurses' station from **04:53:16** onwards, Mr Noonan could have been seen on the CCTV monitor to have been acting in the manner that I have described including hunching over, putting his hand to his mouth, apparently coughing and apparently

[11] Adjusted from 05:03:02 as inaccurately displayed on the nurses' station footage

kicking on the door. As well, his collapse onto the floor would have been visible on the CCTV monitor as would have been the several minutes of motionless lying on the floor on his back. As seen in the previous paragraph the collapse occurred at **04:58:49** as displayed on the seclusion room CCTV footage. Using the 9 minute 46 second hiatus, the corresponding time displayed (albeit inaccurately) on the nurses' station CCTV footage would be **05:08:35**. At this time, and during the minute either side of it (to allow for possible imprecision in the correlation of the times) Ms Daly is looking at a computer screen directly in front of her, Ms Molyneux is seen constantly examining a document or computer screen directly in front of her and Mr Kutinyu is constantly examining what appears to be either a mobile phone or other device that he is holding and at times scrolling. None of the three appear to look at or in the direction of the seclusion room monitor.

7.15. If any of the three nurses did look at the CCTV monitor in that period of time, nothing excited their attention or curiosity until Ms Molyneux looks at the monitor as a result of which she leaves the room and checks on Mr Noonan. Prior to that event Ms Molyneux can be seen for most part apparently to be looking at a computer screen in front of her. As far as Ms Daly is concerned, it is not entirely clear what the CCTV footage shows she is doing. At times she is clearly looking at a computer screen in front of her. When Mr Kutinyu returned from his round he appears to have written up a document and then is predominantly seen to be examining a mobile phone or other device.

7.16. Although it is not listed in Mr Bonig's schedule, it is apparent from the CCTV footage of the nurses' station that Ms Molyneux started examining the seclusion room CCTV monitor at **05:07:47**[12]. She can then be seen to draw the attention of Ms Daly and Mr Kutinyu to the CCTV monitor.

7.17. At **05:08:09**[13] Ms Molyneux leaves the nurses' station to check on Mr Noonan.

7.18. At **05:09:51**[14] Ms Molyneux returns to the nursing station and points to the CCTV monitor. Twenty seconds later both Ms Molyneux and Mr Kutinyu stand and leave the

[12] Adjusted from 05:17:33 as inaccurately displayed on the nurses' station footage
[13] Adjusted from 05:17:55 as inaccurately displayed on the nurses' station footage
[14] Adjusted from 05:19:37 as inaccurately displayed on the nurses' station footage

nurses' station. It is known that they then spoke to Mr Bertram and that they made their way to Mr Noonan's room where they found him in a collapsed state.

7.19. It is interesting that whatever it was that excited Ms Molyneux's attention in respect of Mr Noonan, that situation had prevailed for several minutes. I can only infer that nobody had noticed Mr Noonan on the CCTV monitor for those several minutes.

8. The observation charts

8.1. Visual observations of patients within Ward 5J were recorded on a visual observation chart. The visual observation chart provides for the recording of the 15 minute observations of patients on the ward. Against each 15 minute time increment there is provision for the insertion of a code letter that is intended to signify the current activity of the patient. It also provides for any comment that the observer might make in respect of the patient. There is provision for the observing staff member to apply their initials to each entry.

8.2. Tendered in evidence was the visual observation chart for Mr Noonan.[15] It commences at 1945 hours and concludes at 0500 hours against which the term '*code blue*' is written. This represents the calling of the MET in response to the discovery of Mr Noonan's collapse.

8.3. The 15 minute increments are a reflection of the requirement that patients on the ward should be observed every 15 minutes and that their activity be recorded against the times of observation. In relation to Mr Noonan, at 2100 hours he is recorded as being in seclusion from that point. Every 15 minute increment until 0500 hours records Mr Noonan as being in seclusion. Against each 15 minute increment there is the initial of one of the nursing staff members. Of particular note, the entries from 0345 hours to 0500 hours all have the initials of Mr Taimo Kutinyu of which there are six. The first three are written in black ink. The final three are written in blue ink. If this document is to be taken at face value it means that the secluded Mr Noonan was sighted every 15 minutes by one of the nursing staff. In his oral evidence Mr Kutinyu told the Court that Mr Noonan was his allocated patient. However, it appears that this did not necessarily mean that he would be the only member of nursing staff who would attend to his observations. In any event, it is a fact that the last six observations are recorded under

[15] Exhibit C11ca

Mr Kutinyu's initial. Having regard to the evidence as a whole, I was not in any way satisfied that this document accurately reflected 15 minute observations. The system was in reality much more haphazard and ad hoc than that. For instance, some of the evidence suggested that some 15 minutely observations of patients were skipped but that the records would document the skipped observations notwithstanding, on the basis that if, say, a patient was sighted and all was well at 2am and was next sighted and all was well at 2:30am, an entry would be made that the patient had also been sighted at 2:15am on the assumption that all must have been well with the patient at that time. Clearly practices such as these should never have been allow to occur. In the event, I do not believe that Mr Noonan was physically sighted close to the time of the choking incident or collapse at all.

8.4. Aside from patients in seclusion, patients on the ward in general were not under CCTV observation.

8.5. Patients who were in seclusion, and were therefore under CCTV observation monitored in the nurses' station, had an additional observation record maintained in respect of them. This document also recorded observations every 15 minutes and recorded in more detail the particular activity of the secluded patient against each 15 minute observation. These activities included whether the patient was alert, lying or sitting on the bed, lying or sitting on the floor, was pacing and/or disturbed and whether the patient made a verbal response at the time of the 15 minute observation. Much evidence was given in the inquest by various individuals about whether these 15 minute observations were conducted by sighting the secluded patient within the seclusion room through the seclusion room window, whether CCTV observation was sufficient or whether both methods of observation should have been maintained. The document relating to Mr Noonan records by way of a tick that he was duly observed every 15 minutes between 2100 hours and 0515 hours. They variously describe his activity at the time of each observation. It suggests that at the time of the 15 minute observations between and including 0415 hours to 0515 hours that Mr Noonan was '*lying/sitting on floor*'. The last two ticks against the times of 0500 hours and 0515 hours were made by Mr Kutinyu. Although there is no provision for a time of 0455 hours on this chart, someone has written on the document that at 0455 hours there was a '*verbal RSPN*', suggesting that at that time Mr Noonan had made a verbal response. I will discuss the circumstances in which that was written. It was not written by Mr Kutinyu. In any

event, in my view at that time Mr Noonan, although still conscious, was probably in extremis and incapable of making any meaningful verbal communication.

9. Evidence of Mr Taimo Kutinyu

9.1. Mr Kutinyu gave oral evidence in the inquest. He acknowledged that Mr Noonan was his allocated patient.[16] Mr Kutinyu's understanding of the patient observation requirements was that he was only required to undertake observations of a secluded patient via the CCTV monitor. He told the Court that he was unaware of any written stipulation such as that contained within the protocols that I have referred to above. Insofar as he attempted to suggest in his evidence that signs of life such as the rise and fall of a patient's chest through breathing could be detected by looking at the CCTV monitor[17], I would reject that. All other evidence in the inquest, and common sense, would suggest that this is nonsense. To my mind if the rise and fall of the chest through breathing could reliably be detected on the CCTV monitor, it would mean that an inability to detect it on the monitor would be alarming. Accordingly, when Mr Noonan was lying motionless on the floor of the seclusion room, one would ask why it was that the lack of any evidence of breathing was not obvious to Mr Kutinyu.

9.2. Regardless of whether or not Mr Kutinyu understood the written requirements, it was not possible to discern from his evidence a proper basis upon which he could have believed that observations of secluded patients could satisfactorily be conducted simply by, as he put it *'doing the intermittent, the 15 minute check, glancing on the CCTV monitor'*.[18] In addition, why he believed, as he asserted,[19] that the monitoring practices of other members of the nursing staff were universally the same as his was also difficult to understand.

9.3. Thus when Mr Kutinyu went on his ward round at the times that I have mentioned he did not go to the seclusion room and look into it. However, at that time I find that Mr Noonan had not collapsed to the floor.

9.4. As to the notations on both the general visual observation chart and the seclusion observation chart, it is difficult to determine what significance Mr Kutinyu's notations are meant to have. In particular, his tick indicating that Mr Noonan was *'lying/sitting*

[16] Transcript, page 203
[17] Transcript, page 154
[18] Transcript, page 213
[19] Transcript, page 192-193

on floor' at 0515 hours is on any version of events incorrect. It is clear that by then Mr Noonan had been discovered, was in extremis and in the hands of people trying to resuscitate him.

9.5. As to the notation on the seclusion observation chart that at 0455 hours there was a verbal response, this was not Mr Kutinyu's writing. It is possible, however, that when Mr Kutinyu conducted his ward round he heard Mr Noonan making sounds from the seclusion room. I doubt very much that he heard a verbal response as such, or heard anything that could be understood by way of verbal communication, but it is possible that during his round Mr Kutinyu heard Mr Noonan banging on the door and/or making other noises.

9.6. Mr Noonan's collapse occurred after Mr Kutinyu returned to the nurses' station. Looking at the CCTV footage, when Mr Kutinyu returns he appears to write something on a clipboard. These are no doubt the observation charts entries. He then appears to be preoccupied with what appears to be his mobile phone for the duration. Mr Noonan's collapse would have been completely visible on the CCTV monitor but went unseen by Mr Kutinyu. I accept his evidence that he did not see Mr Noonan's collapse on the CCTV monitor. The reason he missed it is because he was not looking at the monitor at the time. I find that no other person drew the fact of Mr Noonan's collapse, at the moment he collapsed, to Mr Kutinyu's attention. Again, the reason for this is that nobody was looking at the monitor. Mr Kutinyu said in evidence:

> 'I'm absolutely sure that I did not see that because if I had seen that, that's quite distressing. That would have meant an immediate and emergence; a code blue.'

And he said in relation to the fall as depicted on the CCTV footage:

> 'It's the way he falls. It's not a controlled fall. It's a fall that suggests he was under some form of distress that needed attending to as soon as. So that would have required me or one of us to call a code black, open the door and attend to him immediately.'[20]

9.7. However, having since observed the recorded CCTV footage since these events, Mr Kutinyu said that what he saw as far as Mr Noonan's position on the floor was concerned would not have concerned him because '*it's not unusual for clients in the seclusion room to lie on the floor rather than the mattress*'. Of course, there is that 11 minute hiatus in the CCTV recording so what Mr Kutinyu saw on the CCTV footage

[20] Transcript, page 224 lines 14-16, lines 22-27

after these events was only a snap shot of Mr Noonan on the floor. Nevertheless, Mr Kutinyu told the Court that on the morning in question he did see Mr Noonan on his back on the floor on the CCTV footage and it did not cause him any particular distress or concern for his wellbeing.[21]

9.8. As to the entries on the seclusion room chart at 0500 and 0515 hours he told his counsel, Ms Doyle, that this meant that he saw Mr Noonan on two occasions while he was lying on the floor. I have already observed that he could not have seen him at 0515 hours lying on the floor except to the extent that Mr Noonan would have been with persons trying to resuscitate him at that point in time. Mr Kutinyu's tick for the 0515 hours observation time, he said, was written in after Mr Noonan's collapse was discovered. Whether it was or was not so entered it is a complete fiction in any event. It may well be that Mr Kutinyu saw Mr Noonan lying on the floor on perhaps one or maybe even two occasions before Ms Molyneux went to see for herself what Mr Noonan was doing. Had Mr Kutinyu taken more notice of Mr Noonan on the floor he would have seen that Mr Noonan was completely and utterly motionless and in an unusual position for an extended period of time, a set of circumstances that caused the more enquiring mind of Ms Molyneux to immediately think that Mr Noonan required actual visual observation at the room. In my view Mr Noonan when laying on the floor required a more careful examination than what mere intermittent glances at the monitor could provide. I now turn to Ms Molyneux's evidence.

10. <u>The evidence of Ms Claire Molyneux</u>

10.1. Ms Molyneux gave oral evidence in the inquest. As already alluded to, Ms Molyneux was the nurse who observed Mr Noonan with the CCTV monitor lying on the floor as a result of which she went to check on him.

10.2. Ms Molyneux told the Court that her understanding of nursing obligations in relation to observations of patients in seclusion was that there were '*15 minutes observations*'.[22] She went on to say that those observations could be performed either through the CCTV monitor in the nurses' station or by attending the room and looking through the small window. She added that this was meant to occur every 15 minutes. As far as her own practice was concerned she said that the '*majority of the time we'd use the CCTV*

[21] Transcript, page 225
[22] Transcript, page 292

monitor'.[23] Asked by me as to whether anybody had suggested to her that CCTV monitoring was sufficient to conduct observations on a person in the seclusion room, she told the Court that she could not remember anyone actually saying that to her, but that she knew it was '*just a common practice*' during every shift that she worked that people used the CCTV monitor.[24] Ms Molyneux asserted that she did not believe that the CCTV monitor was continuously looked at but that she believed that it was meant to be looked at every 15 minutes. She suggested that this responsibility would fall to anyone who was in the nurses' station.[25]

10.3. Ms Molyneux told the Court that Mr Noonan was not one of her allocated patients. This is correct, although the CCTV monitor was plainly visible to her although at an angle.[26]

10.4. Asked by her own counsel, Ms Cliff, as to whether when Ms Molyneux conducted a ward round she would go to the seclusion room she said '*No, not really, I'd check the monitor*'.[27] Ms Molyneux's own 15 minute observation entries regarding Mr Noonan on the night in question were based on CCTV observation. Her last observation of him is recorded by her as having occurred at 0230 hours.

10.5. As to the occasion when she observed Mr Noonan lying on the floor of the seclusion room, an observation that she made by way of looking at the CCTV monitor, and why she decided to check on him, she said:

> 'At the time I don't know, it was just a gut instinct thinking why is he not lying on the mattress and he was lying on the floor in the corner, it looked like an uncomfortable position to be in.' [28]

For Ms Molyneux the significance of the manner in which Mr Noonan was lying was that it was odd that Mr Noonan would choose to lie in an uncomfortable position when there was a mattress that he could have lain on.[29] Ms Molyneux said she could not recall what Mr Noonan had been doing the last time she had observed him. As to what prompted her to look at the monitor in the first place, she said that the monitor screen

[23] Transcript, page 293
[24] Transcript, page 293
[25] Transcript, page 312
[26] Transcript, page 295
[27] Transcript, page 304
[28] Transcript, page 310
[29] Transcript, page 311

was right next to her and that it may have just been out of habit that she happened to turn her head or eyes towards it.

10.6. Ms Molyneux told the Court that when she observed Mr Noonan she spoke to Mr Kutinyu who was sitting right next to her. She failed to ask him how long Mr Noonan had been like that. She did not have a sensible answer to the question as to why she had not made that obvious enquiry.[30]

10.7. Ms Molyneux told the Court that when she went to the seclusion room and looked through the small window all she could see was Mr Noonan from the waist downwards. She could just see his legs. She shouted and attempted to communicate with him via the intercom which I was told was an unsatisfactory means of communication. She did not obtain a response and could not see whether Mr Noonan's chest was rising and falling and so she alerted the other members of the nursing staff.

10.8. In cross-examination Ms Molyneux said that it was never brought to her attention that the CCTV should be constantly monitored, or that it had occurred to her that the very presence of the monitor may have suggested that it needed to be looked at pretty well constantly. She said that she would look at the monitor every 15 minutes. She said that it did not occur to her that there was anything odd about the fact that there was a motion picture of a patient right next to her but that she was only required to look at it effectively as a snap shot in time every 15 minutes. She was asked:

> 'Q. Are you seriously telling the Court that you're all of the same mindset, namely that you'd only look at the monitor every 15 minutes and religiously avoid watching it for the next 14.
>
> A. I'm not saying that we wouldn't look at it more than 15 minutes, but it was a common occurrence that it would be a 15 minute check, whether we looked at it in the meantime may be so, but -' [31]

10.9. Ms Molyneux also told the Court that she could not recall ever observing a nurse going to the seclusion room and endeavouring to communicate with and obtain a verbal response from the patient every 15 minutes.[32]

10.10. In a passage of cross-examination of Ms Molyneux by Ms Doyle on behalf of Mr Kutinyu, which for the most part consisted of leading questions that elicited answers

[30] Transcript, page 312
[31] Transcript, page 320
[32] Transcript, page 321

of either yes or no, Ms Doyle attempted to establish through Ms Molyneux that her checking on Mr Noonan was in effect nothing out of the ordinary and not in any sense in response to concern on her part about him. I gave very little weight to those answers having regard to the manner they were elicited and taking into account what Ms Molyneux had said about the reason she decided to check on Mr Noonan as discussed above. In the event, when questioned by me Ms Molyneux reiterated that she thought that he was lying in an uncomfortable position and she questioned why he was not on the mattress; in my view circumstances that were both to her, and objectively, so unusual that they warranted immediate attention. In my view, it is obvious that Ms Molyneux had been rightly concerned by seeing Mr Noonan's position and that is why she went to the seclusion room. In the event she said '*I just wanted to go and make sure he was ok*'.[33]

10.11. Contrary to what Mr Kutinyu had said in his evidence, when asked by Ms Doyle as to whether it was unusual for patients to fall asleep on the floor in seclusion rooms Ms Molyneux said '*Not that I can remember*'.[34] She said that she could not remember a particular patient lying asleep on the floor although that is not something that she would necessarily remember.

10.12. In cross-examination by Ms Bosboom on behalf of SALHN, Ms Molyneux said that she could not recall being advised that the CCTV camera should not be used to continuously monitor patients.[35] She said that she was also not aware of the requirement that patients should be communicated with every 15 minutes.[36]

10.13. Ms Molyneux also said that Mr Noonan's behaviour as displayed on the CCTV replay prior to Mr Noonan's ultimate collapse would have raised concerns on her part and that she would have gone to the seclusion room to investigate.[37] Clearly then, Ms Molyneux could not have been looking at the CCTV monitor as that activity was taking place. Clearly she did not look at the monitor while Mr Noonan had been in that motionless position for several minutes

10.14. Ms Waite of counsel assisting invited Ms Molyneux to view the CCTV footage from within the nurses' station. Ms Molyneux acknowledged that there was a computer

[33] Transcript, page 328
[34] Transcript, page 331
[35] Transcript, page 337
[36] Transcript, page 338
[37] Transcript, page 343

screen in front of her but that she did not know whether she was using it or not. She said that she could not remember what she was doing at the time, although she acknowledged that she could have been looking at something on the internet or could have been reading a magazine. She said that as far as she could remember not one of the three nursing staff in the nurses' station was allocated to continuously monitor the screen. She characterised this responsibility as a *'team effort'*.[38] To me it sounded very much like a case of everybody having a responsibility to look at the monitor and that therefore nobody did.

10.15. Ms Molyneux said that the writing on the seclusion room observation chart to the effect that at 0455 hours there had been a verbal response from Mr Noonan, was not her writing.[39]

11. The evidence of Ms Stephanie Daly

11.1. Ms Daly gave oral evidence in the inquest. Ms Daly was the third member of the nursing staff situated in the nurses' station. In her oral evidence Ms Daly was asked by her counsel, Mr Durkin, to examine the seclusion procedure document. She said that she could not recall seeing that specific document. Asked as to whether it was her personal practice to rely solely upon CCTV monitoring in respect of 15 minute observations, she said '*no, not at all*'. She went on to say that her personal practice was to keep a very close eye on the secluded patient on the CCTV monitor because it afforded a better view of the patient than the view that could be obtained through the small window in the seclusion room. But she went on to say that the staff would employ both methods of observation. She said the person conducting the general ward round and the 15 minute observations on other patients would also look in on the person in seclusion while somebody else watched the monitor.

11.2. It will be noted that this evidence differed somewhat from that given by Mr Kutinyu and Ms Molyneux who both suggested that CCTV monitoring was the predominant mode of observation. Ms Daly also asserted that she had no recollection of Ms Kayes' email making it clear to the team that the camera was not a nursing intervention or that Ms Kayes had explained verbally that CCTV was an inadequate means of conducting observations of patients in seclusion. Ms Daly rejected the notion, as suggested by

[38] Transcript, page 360
[39] Transcript, page 371

others, that it was not necessary when a patient was settled to observe them every 15 minutes. She said that when making checks of the general ward it was her habit to make a specific check of the seclusion room as well. As to the need to communicate with the patient in the seclusion room on a 15 minute basis, Ms Daly said that this would require the observer to actually enter the room. There were areas within the room that could not be seen from the small window.

11.3. I closely questioned Ms Daly on what she meant by keeping a close eye on the monitor to which she responded '*15 minutely minimum*'.[40] She said:

> 'I meant exactly what you can see in this picture is where Taimo is sitting directly in front of - having a good view, like his primary nurse having a good view of the monitor at all times. So, I imagine that he moved his eyes around at times, but I would imagine also that he was constantly watching'.[41]

She agreed with the proposition that one was expected to look at the monitor sufficiently frequently to ensure that nothing wrong was happening with respect to the patient.[42] If that had been her expectation of Mr Kutinyu it was misplaced.

11.4. As far as Mr Noonan was concerned, Ms Daly asserted that throughout the night she checked Mr Noonan via the seclusion room window and on the CCTV monitor on many occasions. She said that they all did that not only through the seclusion room window but also by way of another window in a nearby corridor that would allow a view from there through the seclusion room window. That other window was on the way to the toilet. Again, the suggestion that the other nurses were conducting such observations was not in accordance with their evidence.

11.5. In her evidence Ms Daly was asked about a written note that she had made after the event that purported to record that at 0455 hours (altered from a time of 0500 hours) on a '*round*', which I take to be the most recent observation round conducted by Mr Kutinyu. Mr Noonan was banging and kicking on the seclusion door. In her evidence Ms Daly said that the source of this information was Mr Kutinyu. Asked as to why the time had been changed from 0500 hours to 0455 hours she said that she had made the notation of 0500 hours but that Mr Kutinyu had said that this was not correct. He had '*checked him at 0455 and he was kicking and banging at the seclusion door*'.[43]

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[40] Transcript, page 430
[41] Transcript, page 430
[42] Transcript, page 431
[43] Transcript, page 375

In cross-examination by Ms Doyle on behalf of Mr Kutinyu, Ms Daly said that Mr Kutinyu had conveyed that information to her after Mr Noonan had been taken to the Intensive Care Unit. Also in cross-examination Ms Daly acknowledged that Mr Kutinyu had not specifically said to her that he had looked through the window and had observed banging and kicking on the door, but she agreed that banging and kicking on the door could be heard from the nurses' station generally.[44] Ms Daly's note did not lead me to conclude that Mr Kutinyu had approached the seclusion room door or window at any time during his final observation round. It is worthwhile observing that when one examines the time of 0455 hours as displayed on the seclusion room CCTV footage Mr Noonan is in the vicinity of the door of the seclusion room. There is movement by Mr Noonan at various times at around 0455 hours that are consistent with him banging or kicking on the door. Whatever his noise making consisted of, clearly it did not overly excite the attention of the nurses in the nurses' station.

11.6. Unlike other witnesses who suggested that the intercom in the vicinity of the seclusion room door was an unsatisfactory means of communication with the occupant of the room, Ms Daly suggested that although it was not very good it could be used. She said that on the night it was sufficiently operational to facilitate communication with the patient; so as to enable a question to be asked as to their welfare or their needs.[45]

11.7. In cross-examination by Ms Bosboom, Ms Daly was asked about the requirement in paragraph 2.8 of the seclusion procedure that stipulated that patients in seclusion must be communicated with at least every 15 minutes and whether she had communicated with Mr Noonan. Ms Daly said that she did using the intercom outside the room. She said that she had offered him fluid but that he did not accept it and that he was making no sense whatsoever, was aggressive and yelling.[46] I do not understand that Ms Daly saw or communicated with Mr Noonan at any time just prior to his collapse. It is clear that Mr Kutinyu was the last person to conduct a ward round prior to Mr Noonan's collapse and that Mr Kutinyu did not see Mr Noonan in person on that occasion.

11.8. As far as use of CCTV was concerned and the suggestion that it was meant to be used for medico legal reasons only, Ms Daly said that she could not imagine why that would have been said because she regarded the CCTV as a '*very useful observation tool*'.[47]

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[44] Transcript, page 400
[45] Transcript, page 492
[46] Transcript, page 403
[47] Transcript, page 407

11.9. Asked as to whether at any stage she had looked at the monitor in the half hour or so before Mr Noonan's collapse she said that she could not see the monitor from where she had been sitting which meant that she did not look at it in that period. She said that she had observed Mr Noonan on the monitor on earlier occasions during the night. When Ms Molyneux drew her attention to Mr Noonan, Ms Molyneux had said something like '*Ricky's laying in a funny position*'.[48] When Ms Daly looked at the monitor she said that she had no way of telling what the situation was regarding Mr Noonan and she did not ask either Mr Kutinyu or Ms Molyneux for how long Mr Noonan had been like that. She did say, however, it was not as if Mr Noonan's position was a position in which people have not slept before, particularly taking into account the extreme psychotic behaviour exhibited by some patients.

11.10. In cross-examination Ms Daly rejected the suggestion that most nursing staff would make the observations of the seclusion room through the CCTV monitor.[49]

11.11. Asked as to what Ms Daly could be seen doing on the nurses' station footage which showed that she was apparently examining a computer screen, she rejected the suggestion that it was general browsing of the internet. She said that in any event she could not see the CCTV monitor from where she was sitting and that she would have had to have risen from her seat to see that screen. I observe that later in the CCTV footage from the nurses' station she could see the CCTV monitor and did see Mr Bertram wave from the seclusion room, but this was in a situation where Ms Molyneux was not between her and the screen. She said that at 5am that morning it was Mr Kutinyu who was designated to maintain observations of the CCTV monitor given that he was sitting next to the screen.

12. <u>The evidence of Mr Andrew Bertram</u>

12.1. Mr Bertram was the Associate Clinical Services Coordinator and was the member of the nursing staff who for that shift had coordination responsibility for all three wards of the MTC. He did not have any personal responsibility in relation to the observation of patients in Ward 5J. Mr Bertram gave oral evidence in the inquest.

[48] Transcript, page 410
[49] Transcript, page 415

12.2. Mr Bertram told the Court that Ms Daly was in effect the nurse in charge of the three nurses on duty in Ward 5J.

12.3. Mr Bertram told the Court that he was involved in the original decision to place Mr Noonan in the seclusion room. The decision was discussed with him and he agreed with it. Mr Kutinyu was allocated to Mr Noonan. Mr Bertram was involved in the transfer of Mr Noonan to the seclusion room. Mr Noonan was given 2mg of intramuscular clonazepam which was administered pursuant to a PRN[50] order.

12.4. In his evidence before the Court Mr Bertram was asked about his understanding of the observation regimes that existed in respect of Ward 5J. He told the Court that 15 minute visual observations were required and that they would be conducted by the nurses walking through the unit and visually observing the patients. His understanding was that patients in seclusion would be monitored on CCTV continuously and that they would also be viewed during the 15 minute physical observations conducted around the ward. During his evidence Mr Bertram was shown the seclusion room procedure document that I have referred to earlier. He acknowledged that the document accurately encompassed the policy that applied in respect of the observation of patients in seclusion. Specifically, he acknowledged that paragraph 2.8 relating to monitoring of secluded patients was consistent with his understanding of the requirement. He also said that given that Mr Noonan was rambling and incoherent, a vocalisation on his part would be a sufficient 'verbal response'.[51] He acknowledged that while the intercom was not very good, it could be used and was operational on the night in question.

12.5. Mr Bertram told the Court that he was aware of the small observation window that then existed in the seclusion room. He regarded this as a point of visual observation in addition to the CCTV monitoring. Mr Bertram also told the Court of his awareness of an updated policy that was in existence in September 2015 which had yet to come into operation. This was due to the fact that the policy required a nurse to sit outside the seclusion room constantly. However, at the time this was not feasible due to the fact that the door to the room was solid and there was no suitable visual access, the only access being the small window. It was expected that once the door to the room was altered so as to enable constant visual access through it, the MTC would be looking at implementing the new policy. Mr Bertram told the Court that in discussion with more

[50] On an 'as needed' basis
[51] Transcript, page 492

senior members of staff, the then current practice of maintaining continuous monitoring by CCTV and 15 minute observations through the small window would be continued until further notice. It will be seen that while this understanding of the requirements coincided with that of Ms Daly, it differed from what was understood by Mr Kutinyu and Ms Molyneux.

12.6. Mr Bertram told the Court that he was not aware of a practice in which secluded patients were observed every 15 minutes only by way of CCTV monitoring, with the recording of a verbal response if they happened to hear any noise from the seclusion room.[52] He also told the Court that he could not recall seeing anything in writing that suggested that simply looking at the monitor was not acceptable.[53]

12.7. Mr Bertram occupied an office at the end of the corridor from the seclusion room. From there he had heard what he described as yelling and screaming and unintelligible vocalisations coming from Mr Noonan in the seclusion room, behaviour that was consistent with previous episodes involving Mr Noonan. Mr Bertram also viewed the CCTV monitor on the occasions when he entered the ward.

12.8. Mr Bertram told the Court that at 3:30am Mr Noonan's seclusion was broken when his room was entered for the purpose of offering him food and fluids. Asked as to why this occurred at such a time he said:

> 'It's just what we did. It's our routine, we were going into - I believe we planned to take some vital signs at that time, check on how Mr Noonan was going, and our routine practice was if we did that we would offer sandwiches and fluids, because the person was in seclusion, they couldn't access any of those things themselves.'[54]

Mr Bertram was asked whether he was aware of the poor state of Mr Noonan's teeth. He said that he was aware of that, although he did not know whether Mr Noonan had dentures at his disposal at the MTC. Mr Bertram was not aware of any food restriction in relation to Mr Noonan. Nor was he aware of any difficulty that Mr Noonan may have had in chewing or swallowing food. On previous occasions he had observed Mr Noonan eat solid food including sandwiches and he had not exhibited any difficulty on any of those occasions.[55]

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[52] Transcript, page 500
[53] Transcript, page 501
[54] Transcript, page 489
[55] Transcript, page 491

12.9. Mr Bertram told the Court that he first became aware of a difficulty involving Mr Noonan at around 5am when Ms Molyneux and Mr Kutinyu came to his office and informed him that they were not happy with the way Mr Noonan was lying on the floor. Mr Bertram then went to the seclusion room where Mr Noonan was indeed lying on the floor. He did not believe that Mr Noonan would have been visible through the small window, although he did not attempt to look through it.

12.10. At a debriefing that occurred later that morning after Mr Noonan had been taken to the Intensive Care Unit of the FMC, Mr Bertram asked the nursing staff when it was that Mr Noonan had last been heard from verbally. He believed that Mr Kutinyu had indicated that this had occurred at 4:55am.[56] Mr Bertram said that his recollection was that it was Mr Kutinyu who had said that he had seen Mr Noonan standing in the seclusion room, but he did not say anything of the manner in which he had been able to detect this, whether by way of direct observation through the window or by way of CCTV.[57]

12.11. Mr Bertram was questioned about certain notations that he had made regarding the suggestion that a verbal response had been elicited from Mr Noonan at 0455 hours. Mr Bertram made his own note of that.[58] He recorded that at 0455 hours the patient was standing in the seclusion room and that there had been 'verbal responses'. It was recorded by Mr Bertram that Mr Noonan had remained aggressive and largely incomprehensible which was in keeping with the rest of the shift. He also noted that at 0505 hours Mr Noonan had been observed to be lying on the floor which was followed by the breaking of seclusion and attempted resuscitation. In addition, there was also the notation of '*0455 hours – verbal RSPN*' (meaning verbal response) written on the seclusion room observation chart. Mr Bertram told the Court that he had written this, also based on information that he believed had been imparted at the debrief.

12.12. In cross-examination by Ms Doyle, Mr Bertram maintained that at the debrief Mr Kutinyu had said that Mr Noonan had been yelling and shouting and banging on the door. To Mr Bertram, yelling was a 'verbal response'. To the suggestion by Ms Doyle

[56] Transcript, page 507
[57] Transcript, page 515
[58] Exhibit C11c

that Mr Kutinyu's comments had been limited to a description of banging and kicking rather than of any vocalisation on the part of Mr Noonan, Mr Bertram said that that was not what he had understood.[59] In the event I was not satisfied that Mr Noonan made any meaningful vocal sound at that time or that Mr Kutinyu said that he had made any such sound.

12.13. I find that at 0455 hours Mr Noonan was still conscious and either walking around the room, was hunched over and at times was visibly at the door. This was all available to have been seen on the CCTV monitor. Mr Noonan may have been making a noise by banging on the door, but I do not believe that there was a verbal response as such. However, one would have thought that banging on the door would have required some scrutiny of the CCTV monitor even allowing for the fact that this was not unusual behaviour for Mr Noonan. Looking at the monitor at this time may have alerted staff to Mr Noonan's predicament. His activity was not limited to banging on the door. Even without sound, and even allowing for the benefit of hindsight and the possibility that staff had become inured to Mr Noonan's more extreme behaviours, the CCTV footage reveals what many might have identified as significant distress on the part of Mr Noonan, as evidenced by apparent vigorous coughing and thumping of the chest. In the event, what excited Ms Molyneux's attention, unsurprisingly, was the position Mr Noonan was in on the floor. Unfortunately this was detected too late for any meaningful medical intervention to be brought to bear on Mr Noonan's predicament.

12.14. Mr Bertram was further cross-examined by Ms Doyle on behalf of Mr Kutinyu. He was specifically asked what he had meant by his suggestion that secluded patients needed to be monitored by way of CCTV '*continuously*'. He agreed that he did not mean to suggest that he expected a nurse to sit at the monitor with their eyes on the screen for the entire time that a patient was in seclusion. He said that he had expected that people were '*keeping an eye on the CCTV, that they're watching it*'.[60] Asked to elaborate on this he suggested that he would have wanted staff to be glancing at the CCTV monitor every few seconds.[61] He acknowledged that he did not recall ever articulating that expectation.[62] He told the Court that it was not his understanding that

[59] Transcript, page 554
[60] Transcript, page 537
[61] Transcript, page 538
[62] Transcript, page 539

nursing staff considered their obligation to be limited to looking at the screen at least 15 minutely and that they might glance at the screen more from time to time.[63] Asked in cross-examination as to what he understood as far as the requirement for 15 minutely communication was concerned he said:

> 'My understanding of communication was - perhaps if I explain it this way. If I was a nurse doing the round and I went to the window of the seclusion room, I would've looked into the person, I would've said 'Are you okay? Is there anything you need?' That would've constituted communication. If the person was asleep I wouldn't have made that vocalisation, because they would've been asleep.'[64]

12.15. Mr Bertram acknowledged that he had seen patients fall asleep on the floor in the seclusion room and not on the mattress.[65] He also spoke of Mr Noonan being disturbed while he was asleep in seclusion, his typical reaction being one of agitation.[66] He also spoke of attempts that had been made in the past to wake Mr Noonan and move him back to his room to see if he would settle there and he said:

> 'Having done that, on almost every occasion that we tried that, and I can recall doing that I'm going to say more than twice, I wouldn't want to be more specific than that. On each of those occasions he became more agitated, and at least one of those occasions he required returning to seclusion.'[67]

12.16. Ms Waite, counsel assisting, asked Mr Bertram what his reaction would have been if, on the CCTV monitor, he had seen Mr Noonan in the position that he was in on the floor. Mr Bertram said that he would have asked himself whether Mr Noonan was asleep and would have gone to the window to attempt to see if Mr Noonan was breathing. If he could detect respirations and was satisfied the person was asleep, then he would conclude that the person was asleep. On the other hand if he could not detect respirations, he would require further action to be taken. Asked this question:

> 'Q. So it isn't a situation that you would see that image over a CCTV monitor and allow them to go two 15-minute intervals before going to check.
>
> A. I wouldn't.'[68]

He added that he would probably check before the 15 minute window concluded.[69]

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[63] Transcript, page 541
[64] Transcript, page 542
[65] Transcript, page 549-550
[66] Transcript, page 551
[67] Transcript, page 551
[68] Transcript, page 574
[69] Transcript, page 575

13. The evidence of Dr Maria Naso

13.1. Dr Naso is a Specialist Consultant Psychiatrist who provided an independent review of the circumstances of Mr Noonan's death. Dr Naso obtained her primary medical qualifications from Flinders University in 1992. She became a Fellow of the Royal Australian and New Zealand College of Psychiatrists in 2002. She is a Senior Staff Psychiatrist at the Modbury Hospital. Dr Naso provided a comprehensive report in relation to Mr Noonan.

13.2. A number of issues raised by Dr Naso, in particular those relating to Mr Noonan's longitudinal psychiatric history and his ongoing treatment, was beyond the scope of this inquiry to investigate. I therefore make no findings based upon Dr Naso's assessment in that regard.

13.3. However, Dr Naso commented on the following relevant matters that arose in this inquest, namely:

- Mr Noonan's medication management;
- Mr Noonan's periods in seclusion;
- The provision of food to Mr Noonan at 3:30am while in seclusion;
- The administration of clonazepam to Mr Noonan;
- Drug induced swallowing difficulties for Mr Noonan;
- The standard of care provided by Mr Noonan's psychiatrist, Dr Nelson;
- Whether Mr Noonan's death could have been prevented.

13.4. Dr Naso observed that Mr Noonan was difficult to manage when he was unwell. Historically he had required lengthy admissions and large amounts of medications. Dr Naso is not critical of the amount of medication which was used in respect of Mr Noonan. The only other comment that Dr Naso made was that she would not have commenced Mr Noonan on Haldol (haloperidol) until she had trialled Risperdal Consta to begin with.

13.5. Dr Naso indicates in her report that she agrees with Dr Nelson's assessment that Mr Noonan did best on injected medications under a Community Treatment Order. She agrees that each time a Community Treatment Order would be lifted Mr Noonan became unwell. Dr Naso comments upon Dr Nelson's assertions that even with the

sedating effect of clonazepam, Mr Noonan had not encountered swallowing difficulties. Dr Naso makes two points about this as follows. Firstly, any medication which depresses brain function like clonazepam has the potential to impact on all motor functioning including swallowing. Secondly, merely because an adverse event had not been directly encountered does not mean that it would not present itself in the future. She observes that persons may be at high risk of aspiration due to sedation even if they have an intact swallowing reflex. She observes that haloperidol and other antipsychotics can all cause problems with swallowing, especially haloperidol. She observes also that drug induced Parkinsonism is relatively common in patients on haloperidol and it causes difficulty chewing and initiating the swallowing reflex. Mr Noonan had Tardive Dyskinesia which is characterised by uncoordinated tongue and oral movements and which can impact on an individual's ability to chew and coordinate tongue movements during swallowing. Haloperidol commonly causes a dry mouth which can also impact on a person's ability to swallow.

13.6. Dr Naso's viewing of the seclusion room footage led her to conclude that Mr Noonan should not have been given food unsupervised. He was highly agitated and uncoordinated. If one considered the likelihood of a dry mouth which is a common medication side effect, the impact of Tardive Dyskinesia and the fact that Mr Noonan did not have natural teeth or even dentures, it is clear that he was at risk of choking. This was particularly so having regard to the large amounts of medication he was administered. Dr Naso refers to a possible explanation for this being a level of complacency given the uncontroverted evidence that Mr Noonan had eaten solid food during prior admissions with no adverse outcomes.

13.7. Dr Naso states that deaths due to choking are relatively rare but they do occur in psychiatric hospitals. These are not easily predicted, but the possible risk associated with this occurrence can be highlighted. There is an increased risk of choking deaths in patients with mental illness compared to the general population. Patients with schizophrenia appear to be vulnerable. Dr Naso opines that Mr Noonan demonstrated this vulnerability when he was eating in seclusion in that he grabbed the sandwich and appeared to place the whole of it into his mouth at once. In short, she asserts that Mr Noonan was always at risk of choking given his lack of dentition, his propensity to eat fast, his Tardive Dyskinesia and possible Parkinsonism, his medications and his level of agitation and motor instability. Although he had never experienced a choking

incident in the past, he was always at risk given those factors. She says that every time he ate solid food he was '*at risk*'.[70]

13.8. Dr Naso independently reviewed each episode that had involved Mr Noonan being placed in seclusion. She believes that the periods of seclusion were all necessary for Mr Noonan's safety and that of other patients and staff. She observes that staff had tried alternative approaches to manage Mr Noonan prior to placing him in seclusion. Staff were aware of the need to trial him out of seclusion and they did this on a regular basis. Dr Naso opines, '*I have no criticism of the time that Ricky was placed in seclusion and note that the staff tried hard to avoid seclusion*'.[71] None of this in my view alters the fact that seclusion of any patient for the periods Mr Noonan endured is a manifestly harsh measure. I will comment separately in relation to the final period of seclusion and whether it had involved any material departure from the documented requirements referred to earlier.

13.9. Dr Naso is of the opinion that Dr Nelson adequately diagnosed Mr Noonan and that Mr Noonan's management plan was sound and evidence-based. She considers it unavoidable that Mr Noonan required periods in seclusion as well as large amounts of medication. The plan for ECT was appropriate having regard to his past response to treatment.

13.10. I have accepted all of Dr Naso's evidence as described in this section. It was essentially not in dispute.

14. <u>Non-compliance with medical review while in seclusion</u>

14.1. I have already referred to this subject earlier in these findings. It will be observed that if these requirements were strictly adhered to there was a need for Mr Noonan to have been medically reviewed at no later than 10pm on the night in question with a mandatory psychiatry review no later than 1am. There was a further requirement that the responsible consultant, meaning a psychiatric consultant, would be notified of any patient who required greater than 8 hours continuous seclusion in any 24 hour period with a consultation with the psychiatrist being provided at the earliest opportunity.

[70] Exhibit C28, page 26
[71] Exhibit C28, page 22

14.2. A medical review in relation to Mr Noonan did take place at 10pm. This was conducted by Dr Rachel Mellor who in September 2015 was a general resident medical officer. At the time of giving evidence in this inquest she was a psychiatry registrar working at the Glenside Hospital. On the night of 22 and 23 September 2015 she was the on-call junior medical officer for psychiatry covering the FMC. During that shift she received a phone call about Mr Noonan being placed into seclusion.

14.3. Dr Mellor gave oral evidence in the inquest. She had little or no recall of these events. Thus her evidence and statement[72] were based on a note in the clinical record that she made on the occasion in question. Dr Mellor indicates that on the medical record there was a plan regarding seclusion for Mr Noonan that had been documented on 20 September 2015 by a psychiatry registrar following discussion with Dr Nelson, the consultant psychiatrist to whom I have referred. In the notes it stated that Dr Nelson had decided that Mr Noonan could stay in seclusion for more than 8 hours and that if Mr Noonan was sleeping at the four hourly or eight hourly marks, he could be left sleeping and be formally reviewed at a later time.

14.4. Dr Mellor's own note timed at 2200 hours on 22 September 2015 recorded a reference to Dr Nelson's advice about seclusion greater than 8 hours and also notes that on the phone that evening she informed Dr Nelson of Mr Noonan's seclusion.

14.5. However Dr Mellor stated that when she reviewed Mr Noonan she did so with a view to determining whether it was appropriate for him to be in seclusion at that time. She was asked this question by her counsel Ms Bosboom:

> 'Q. At 2200 hours was any of your role as you saw it that night to give any direction as to what was then to happen overnight, or did you consider that that would be an ongoing process.
>
> A. Given how junior I was at the time, I didn't have a lot of experience or any expertise in what should happen with a patient like this overnight. So as I've said in my note I was reliant on Dr Nelson and the nurses to guide that process.
>
> Q. Did you think that if there was any reason to reconsider Mr Noonan's seclusion overnight, at any point, then that reconsideration would take place at the relevant time.
>
> A. Yes, my understanding of seclusion is it can be ceased at any time.' [73]

[72] Exhibit C19
[73] Transcript, page 90

14.6. Dr Nelson himself also gave evidence about his plan regarding review. In his statement he asserted that he was not surprised by the information that Mr Noonan had again been placed in seclusion. He considered that the plan that had been devised was appropriate. He was aware that he would need to review the situation regarding Mr Noonan in the morning. Dr Mellor was reviewing Mr Noonan because she was the psychiatry registrar on-call for the FMC.

14.7. Dr Nelson was questioned about non-performance of review at 4 hours in Mr Noonan's case and at 8 hours in the light of the notation in the clinical record that suggested that if he was asleep at the four hour and eight hour marks, his review should be left until he woke up, with the caveat that if there were concerns about his medical status then there would naturally be intervention. He asserted that if there were no concerns, and having regard to the purpose that is to be served by seclusion in attempting to get the patient to settle, then sleep itself could be quite therapeutic.

14.8. In cross-examination Dr Nelson pointed out that given the nursing assessment that there was a continuing need for seclusion, it was unlikely that a four hour review would have changed anything as far as the seclusion arrangements were concerned.[74] Dr Nelson also asserted that in any event there was an expectation that there would be nursing staff monitoring the patient. Indeed, Dr Nelson's expectation at that time was that there would be constant observation on the CCTV monitor together with regular attempts to communicate with the patient.[75] He said:

> 'It was premised on the system as it was at the time and so the assessment based on a person's behaviour, watching what they were doing constantly, as well as going around every 15 minutes, these were things that were on part of me thinking yes, that's an appropriate way to make this assessment.' [76]

14.9. Of course, as things transpired, Dr Nelson's expectations were not completely met.

14.10. The protocol required Mr Noonan to have been reviewed at 1am. However, it is unlikely that he would have been released from seclusion at that time. I agree that if he was asleep there would have been a pointlessness in waking him, and if awake his overall behaviour could not have inspired confidence that he would not have continued to be the disruptive figure that he had been earlier.

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[74] Transcript, page 106
[75] Transcript, page 112
[76] Transcript, page 113

15. Reporting to the Office of Chief Psychiatrist and the Director of Clinical Services

15.1. Ms Bosboom appeared for and on behalf of the SALHN, Dr Mellor and Ms Crouch to whom I have referred. SAHLN is an arm of SA Health. Ms Bosboom advised the Court that she was instructed that Mr Noonan's periods of seclusion were not reported to the Chief Psychiatrist nor to the Director of Clinical Services. This was so despite the fact that the number of the periods of seclusion prior to the final and fatal period exceeded 12 hours and that there were more than 24 hours total seclusion in the space of three days. I observe from Dr Nelson's statement that from 7:20pm on 13 September 2015 Mr Noonan had spent 25 hours and 25 minutes in seclusion in the next 72 hour period. Similarly, from 8:30pm on 16 September 2015 he spent a total of 45 hours and 40 minutes in seclusion over the next 72 hours. Again, from 9pm on 19 September 2015 Mr Noonan spent a total of 28 hours and 40 minutes in seclusion during the next 72 hour period. There was a suggestion in the evidence that Safety Learning System notifications (SLS) may have been sent to and received by the Office of the Chief Psychiatrist, but there was no evidence of that having occurred in respect of any of Mr Noonan's periods of seclusion. In any event, there was no evidence of any intervention in Mr Noonan's management from outside of the MTC. The evidence of Dr Nelson makes it plain that the need for Mr Noonan's seclusion was intractable and ongoing. However, it is acknowledged that the plan for Mr Noonan was that he undergo ECT so it was not as if all hope for Mr Noonan had been abandoned. It goes without saying that all staff at the MTC who had an involvement with Mr Noonan would have preferred not to have seen him in seclusion at all. Of course the outcome of ETC could not be known in advance with certainty.

15.2. It is to be noted that the report of the independent expert, Dr Naso, contained no criticism of the number and durations of Mr Noonan's periods of seclusion. This is no excuse, however, for the fact that it appears that Mr Noonan's plight was either not known outside of the four walls of the MTC or if it was known nothing was done about it.

16. Conclusions

16.1. The Court reached the following conclusions.

16.2. Ricky Dale Noonan was 54 years of age when he died on 27 September 2015. His cause of death was the result of an hypoxic-ischaemic brain injury attributed to cardiac arrest due to choking.

16.3. The choking incident that lead to Mr Noonan's death occurred on the morning of 23 September 2015. The incident involved Mr Noonan's airway being blocked by a bolus of food that he was unable to dislodge from his throat.

16.4. At the time of the choking incident, and at the time of his death, Mr Noonan was the subject of a Level 2 ITO pursuant to which he was detained in an Approved Treatment Centre under the MHA. His death was therefore a death in custody as defined in the Coroners Act 2003. I find that Mr Noonan was at all material times in lawful custody. I find that his detention pursuant to the ITO was appropriate in all of the circumstances.

16.5. Mr Noonan was detained in Ward 5J of the MTC. The MTC is the psychiatric facility of the Flinders Medical Centre. Ward 5J is the Psychiatric Intensive Care Unit of the MTC.

16.6. At the time of the choking incident Mr Noonan was locked within a seclusion room in Ward 5J. The seclusion on this occasion was as the result of Mr Noonan striking another patient within the ward. The seclusion was necessary and appropriate in all of the circumstances.

16.7. Mr Noonan had undergone 15 previous periods of seclusion from the time that he was admitted to the Margaret Tobin Ward on 12 September 2015. Regrettably, I find that all of these periods of seclusion and their duration were lawful and appropriate having regard to Mr Noonan's behaviour and underlying psychiatric condition.

16.8. The relevant requirements that were operative in the MTC, and in particular in respect of a patient seclusion within Ward 5J of the MTC, were that Mr Noonan should have been '*continuously monitored*'. Specifically, the requirement was that Mr Noonan be sighted and communicated with at least every 15 minutes or more frequently if necessary.

16.9. Difficulty in effecting continuous physical observation within the seclusion room was occasioned by the fact the only view into the room while locked was through a very small window that did not allow the whole of the room to be viewed from outside of the room. The window was unsuitable and not fit for the purpose of maintaining continuous or even effective intermittent observation. However, within the nurses' station of Ward 5J there was a CCTV monitor that displayed the interior of the seclusion room in real time.

16.10. I find that the observation practices on the night of Mr Noonan's final seclusion were haphazard and inconsistent in that the requirements were not satisfactorily understood and inconsistently adhered to by staff. I was unable to place reliance on the observation charts that were kept in relation to the monitoring of Mr Noonan in the seclusion room. In the event, I find that Mr Noonan was not continuously monitored in the seclusion room either by direct viewing of him at the room or by way of CCTV monitoring. On the whole, the monitoring of Mr Noonan was at best intermittent and superficial and on any analysis unsatisfactory.

16.11. At approximately 10pm on the night of 22 September 2015 Mr Noonan was medically reviewed by a Dr Mellor while in seclusion. Dr Mellor telephoned the on-call psychiatry consultant, Dr Allan Nelson. Dr Mellor was advised by Dr Nelson that Mr Noonan should continue with seclusion. Mr Noonan was not reviewed again by any medical practitioner prior to the choking incident. A requirement that Mr Noonan be reviewed after four hours of seclusion was not met. In the normal course of events that should have occurred at about 1am on the morning of 23 September 2015. I note from the CCTV records in respect of the seclusion room that it appears Mr Noonan may well have been asleep and stationary on the mattress in the room between about 1:04am and 1:54am. A decision not to review Mr Noonan while asleep, without waking him, in all of the circumstances would appear to be not unreasonable having regard to Mr Noonan's generally agitated state while awake. Any such decision would also have been in accordance with Dr Nelson's stipulations in respect of four hourly and eight hourly reviews.

16.12. At approximately 3:24am the seclusion room was entered by nursing and other staff of the MTC. Mr Noonan was provided with a sandwich and a drink. Mr Noonan, who was possibly asleep before the entry of these individuals, appeared to wake up but remained on the mattress. During this breaking of seclusion Mr Noonan indicated that he did not want to have his vital signs assessed.

16.13. Following that break in seclusion, Mr Noonan for the most part appeared to be unsettled. However, from between 4am and 4:48am it is possible that he was asleep and stationary on the mattress. At about 4:48am Mr Noonan rose from the mattress and was again unsettled. At about 4:52am Mr Noonan appeared to consume food by placing it in his mouth. This was part of, or possibly the whole of, the sandwich that had been delivered to him earlier that night. It is this food that caused Mr Noonan to choke.

16.14. For the next approximately six minutes Mr Noonan moved around the seclusion room and on occasions was appearing to interfere with the door to the room. As well, there are times when he appeared to be coughing and in distress.

16.15. At approximately 4:58am Mr Noonan collapsed and fell to the floor where he remained virtually motionless and on his back for the next approximately 11 or 12 minutes. I find that from the time Mr Noonan ingested the food until the time he collapsed, his activities were either unwitnessed on the CCTV monitor screen in the nurses' station or, if witnessed, were not interpreted as indicating distress or the need to consider nursing or other intervention. I also find that in that same period one of the nursing staff, Mr Kutinyu, had conducted a ward observation round but had not gone to the seclusion room to view or attempt to communicate with Mr Noonan.

16.16. I find that Mr Noonan's collapse and fall to the floor of the seclusion room was not witnessed by any member of the nursing staff either directly or by way of the CCTV monitor in the nurses' station.

16.17. I also find that for the entire period while Mr Noonan remained motionless on the floor in the position I have described he was not seen on the CCTV monitor in the nurses' station despite the fact that three members of the nursing staff were at all material times within that room. This remained the case until Ms Molyneux looked at the CCTV monitor, noticed that Mr Noonan was in an unusual position and that some investigation of his circumstances was required. I find that Mr Noonan's predicament as evidenced by his remaining motionless on the floor of the seclusion room should have been detected at a time significantly before Ms Molyneux saw this on the CCTV monitor in the nurses' station. The fact that he was not seen prior to this was as the result of inadequate scrutiny of the CCTV monitor. I find that although Mr Noonan was probably making some audible noise from the seclusion room prior to his collapse, either by way of kicking or banging on the door, this was not interpreted as indicating any distress on his part, such behaviour in any case being not unusual for Mr Noonan. I do not find that at approximately 4:55am, a few minutes before his collapse, Mr Noonan made any verbal response or any other vocalisation.

16.18. Given the length of time between Mr Noonan's collapse and the commencement of resuscitative measures, I do not believe that the resuscitative measures that were employed would or could have made any significant difference to the outcome. It is more probable than not, and I find, that Mr Noonan had suffered a severe and fatal

hypoxic and ischaemic brain injury prior to the resuscitative measures being commenced.

16.19. It is not possible to determine at what point in the course of the events that I have described Mr Noonan's death may have been prevented by more timely commencement of resuscitative measures. Clearly the earlier those measures were commenced the better Mr Noonan's chances would have been of his death being prevented.

16.20. I find that it was most unwise for Mr Noonan to have been provided with food during the course of his seclusion having regard to a number of matters including the fact that his consumption of food was not supervised or monitored, his poor dentition and the fact that he was medicated. His consumption of the food should have been closely watched until such time as it was all consumed. I find that Mr Noonan's death could have been prevented if his consumption of this food had been closely supervised and monitored.

17. Recommendations

17.1. Pursuant to section 25(2) of the Coroners Act 2003 I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the Inquest.

17.2. Evidence was given during the course of the inquest about a number of measures that at the time with which this inquest is concerned had been contemplated and documented but had yet to come into operation. These included a revised Restraint and Seclusion in Mental Health Services Policy Guideline dated 7 May 2015 that was developed by the Office of the Chief Psychiatrist. As I understood the evidence this document was intended to supplant the document that I have spoken about in these findings that related to the seclusion procedure of the Margaret Tobin Centre specifically. The new 2015 guideline included, among other things, a requirement that visual observation while in seclusion was to be continuous and would occur '*face to face*'.[77] That requirement was to be met in conjunction with other requirements that included 15 minutely observation of behaviour and 15 minutely verbal contact with the secluded person to assess ongoing need for seclusion. There was also a requirement for a medical review after one hour and a further medical review at four hours, with a need to inform a consultant

[77] Paragraph 4.4.2 Observations while Secluded

psychiatrist at that time if the assessment indicates ongoing seclusion. There was also a requirement that a consultant psychiatrist should review the secluded patient at eight hours. These requirements were also to be the subject of more stringent documentation in that each observation point should include a comment on behaviour and conversation, and whether food, fluid, medication or toileting were offered and/or received.

17.3. As already discussed, I was told during the inquest that continuous visual observation occurring face to face was not feasible in the Margaret Tobin Centre due to the nature of the small window. At the time of Mr Noonan's incident there were plans for the doors of the seclusion rooms in the Margaret Tobin Centre to be replaced with doors that would enable a person sitting outside the room to view constantly the secluded patient within the room. Since these events that measure has been implemented with the result that continuous observation of a secluded patient is made with a member of staff sitting outside the room. This measure would have prevented Mr Noonan's choking incident, or at least have mitigated its effects.

17.4. Also tendered to the inquest was a document entitled Chief Psychiatrist Standard relating to Restraint and Seclusion Recording and Reporting. This document was dated 30 July 2015 and had yet to come into operation at the time of Mr Noonan's incident. This document refers to the requirements contained within the Mental Health Act 2009 to which I have referred regarding the use of mechanical body restraints and seclusion.[78] The document requires staff to enter all incidents of seclusion on the Safety Learning System and on any other '*relevant electronic database system*'. It describes a patient's seclusion as a '*critical incident*'.[79] The document sets out various responsibilities imposed upon health service staff involved in the care of people with a mental illness. These responsibilities include the elimination of the use of seclusion where possible and documentation of seclusion incidents including within the Safety Learning System. The document states that seclusion is an option of last resort, hardly a novel concept in 2015. I was told in the course of the evidence that the incidence of seclusion has reduced significantly since Mr Noonan's death. I did not receive any evidence that necessarily supported that contention.

17.5. The Chief Psychiatrist Standard also describes certain responsibilities on the part of the Office of the Chief Psychiatrist including quarterly reporting to the local health

[78] Paragraph 1
[79] Section 4

networks regarding the use of seclusion across all local health networks and the obligation to include data on use of seclusion in the annual report to the Minister for Health and Ageing for tabling in Parliament.[80] I was told that this document is now in operation.

17.6. The Court was also informed that an investigation pursuant to either Part 7 or Part 8 of the Health Care Act 2008 was conducted in respect of Mr Noonan's death. The Court was informed of the recommendations that resulted from that investigation. These recommendations form Attachment 1 to the affidavit of Shannon Renee Fenech.[81] Attached to these findings is a copy of that document. The document sets out four recommendations that were formulated following the investigation and also sets out the corrective actions and outcomes pursuant to those recommendations.

17.7. The Court recommends that the recommended measures be employed in all psychiatric intensive care units in South Australia.

17.8. The Court recommends that in considering whether a secluded patient should be provided with food, that nursing and other staff need to take into consideration the matters identified by Dr Naso in her report, including the medication that the patient has been administered, the state of agitation of the patient and the state of dentition of the patient. Consideration should also be given to the question as to whether in all of the circumstances if the patient is capable of safely consuming food at that point, the reality may be that the patient is suitable to be released from seclusion.

17.9. I direct the recommendations set out in the preceding two paragraphs to the attention of the Chief Executive of SA Health.

Key Words: *Death in Custody; Inpatient Treamtent Order; Choking; Seclusion; Mental Health; Monitoring*

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 22nd day of September, 2020.

Deputy State Coroner

[80] Paragraph 5.3
[81] Exhibit C27, Attachment 1, SRF2

Attachment 1

SRF 2

SAHI - ID number	Responsible Owner	Due Date	Status	Recommendation	Corrective Actions/Outcomes
SAHI-220747	Dr Nance & Acute Nursing Director	Jul-17	completed	1. SALHN MHS develop a clinical guideline and education strategy for Physical Health Assessments (inclusive of nutritional assessment) within an inpatient mental health facility.	Flinders Medical Centre including Margaret Tobin Centre has an existing system in place addressing this recommendation. The Admissions, Transfers and Separation system (ATS) is a hospital wide platform for communicating basic patient related data including diet selection and meals for patients. On admission to a unit an assessment of diet is required in order for patients to receive meals from the kitchen. This information is entered by ward nursing staff using a coding system based on assessment of patients' nutritional requirements. This can be updated at any time during the patient's admission enabling changing patient needs to be recognised. **May 2016** – SALHN Senior Speech pathologist identified that ward 5J consumers may be referred if required for assessment via intranet guidelines and referral processes. **June 2017** – Education provided to staff regarding the need to order a soft diet for consumers with ill-fitting dentures with referral to Dental Services and Speech Pathology assessment. Referral process and criteria for referral to accessing weekend Speech Pathology services developed and communicated to staff. Nursing Admission Checklist updated to include screening for Speech Pathology assessment.

Attachment 1

SAHI-220747	Dr Nance & Acute Nursing Director	Jul-17	ongoing	2. SALHN MHS undertake a review of current nursing observation practice, procedure and auditing process.	Observation requirements for consumers in seclusion now undertaken as outlined in The Restraint and Seclusion in Mental Health Services Policy Guideline (specifically 4.4.2) as mandated by the Office of the Chief Psychiatrist.
SAHI-220747	Dr Nance & Acute Nursing Director	Jul-17	ongoing	3. SALHN MHS develop and implement auditing processes against the SA Health Seclusion and Restraint Policy.	**June 2017** – Margaret Tobin Centre Nurse Consultant review of previous Gap Analysis and implementation of the policy directive with safety planning and post-vention of consumer completed. **January 2019** - SA Health Guide to review of restraint and seclusion (Restrictive Practice Toolkit) utilised for episodes of Restraint and Seclusion **21 January 2019**- Additional Review questions draft prepared for consultation via Acute Mental health Services Governance Committee feedback. (Copy attached).
SAHO - 220747	Dr Nance & Nursing Director	Jul-17	Completed Oct 2017	4.Undertake a review of the physical environment for wards in which the adverse event occurred	**Completed October 2017** - 5J Seclusion room doors have been replaced with doors with a large observation window, with a small speaking hatch so communication can now occur easily with the consumer. A defined place for nurse providing continuous observations marked in seclusion room floors. (Copy of visual evidence attached)Clocks placed within visual site of consumer in seclusion for their orientation.