STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest	Inquest into the death of Michael David John Nolan
Hearing dates	2,3 & 4 February 2016
Date of findings	14 March 2016
Place of findings	NSW State Coroners Court, Glebe
Findings of	NSW State Coroner, Magistrate Barnes
Catchwords	CORONIAL LAW – death in custody, prison mental health; self-harm risk assessment
File number	2013/20175
Representation	Sgt Bronwyn Lorenc Advocate assisting the Coroner Ms R Mathur and Mr B Griffiths for NSW Department of Corrective Services Mr S Woods and Mr L Sara for Justice Health and Forensic Mental Health Network Ms M Walker and Ms C Pandolfini for the Nolan Family Ms L Toose for Registered Nurse Barbara Sullivan

Findings	**The identity of the deceased** The person who died was Michael David John Nolan **Date of death** Mr Nolan died on 21 January 2013 **Place of death** Mr Nolan died at the Metropolitan Remand and Reception Centre, Silverwater, New South Wales **Cause of death** The cause of death was exsanguination due to an incision in the radial vein of his right wrist. **Manner of death** Although I conclude Mr Nolan deliberately inflicted the fatal wound I am unable to ascertain whether he intended to cause his death.

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The Coroners Act 2009 (the Act) in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death. These are the findings of an inquest into the death of Michael David John Nolan

Introduction

On 21 January 2013, Michael Nolan was found by correctional officers dead in his cell at the Metropolitan Remand Reception Centre (MRRC). It was obvious that he had bled profusely from an incision in his wrist. He was 30 years of age.

Because Mr Nolan died in custody an inquest into his death is mandatory. I am required by the Act to find various particulars in relation to the deceased and the circumstances of his death. In this case, because it was readily apparent the fatal injuries had been self-inflicted, the inquest has focused on whether correctional authorities and Justice Health practitioners adequately managed the risk of Mr Nolan's self-harming and appropriately treated his mental illness.

The evidence

Social History

Michael Nolan was born in Sydney on 17 March 1982. He was the only son of Rosemary Nolan and David Nolan. He had two sisters. It is reported that he suffered developmental delay resulting in what was later diagnosed as mild retardation.

His parents separated when he was about five. It is reported he had conflictual relationships with his mother's subsequent partner. He left school at year six and was functionally illiterate. In 1999, he suffered a severe head trauma which apparently left him with an acquired brain injury.

Throughout his adult life Mr Nolan was a poly-substance abuser. At various times he used marijuana, heroin and various prescription drugs. At various times he was on a methadone treatment program and on occasions he suffered from drug and alcohol withdrawal and drug induced psychosis.

The evidence before the court contains assessments undertaken by psychiatrists and mental health practitioners between 2003 and the year of his death. Almost all refer to his mental retardation and acquired brain injury. Some make reference to a personality disorder. There is inconsistency among the assessors as to whether he also suffered from a major mental illness. Some of those who reviewed Mr Nolan considered he suffered from conduct disorder and poor judgement and impulsivity. Others diagnosed him as suffering from major depressive disorder, schizophrenia, organic psychosis, persistent auditory hallucinations and impulsivity.

There are also numerous reports of his expressing homicidal and suicidal ideation. There was a high level of agreement that Mr Nolan lacked insight into his condition and had almost no ability to reality test any decision he might make. He was reported as having very limited self-control and emotional regulation – that is an inability to monitor decisions and actions.

It was generally accepted that Mr Nolan provided a very challenging set of symptoms and disorders for those seeking to keep he and those around him safe. It seems likely that throughout his adult life Mr Nolan was in almost constant mental health crisis. The first recorded self-harming attempt was recorded in 1999 when it was reported that he attempted to self- immolate and hang himself while in custody at Cobham Juvenile Detention Centre. There were to be other attempts or threats of suicide both when he was in custody and when he was in the community.

It seems he was never in gainful employment and spent the majority of his adult life in correctional custody. When he was in the community, he habitually abused illicit drugs and committed various criminal offences. He was not compliant with medication regimes and made irregular contact with mental health service providers.

Criminal justice history

Mr Nolan first came to the attention of police when he was about 12 years old. Since then he was charged 80 times with a wide variety of offences including the use or threatened use of violence, larceny, breaking and entering, wilful damage and the like.

Mr Nolan first entered the adult correctional system in June 2000. Thereafter he was taken into custody on 15 separate admissions. From his initial incarceration it became apparent that Mr Nolan would be at risk of deliberate self-harm and a risk of harming others. As a result he was frequently housed in acute crisis management units.

In the period between his first incarceration as an adult in 2000 and his death in 2013, Mr Nolan spent the majority of his life in custody. He engaged in acts of self-harm both when he was in custody and when he was in the community.

Final period of custody

On 26 November 2013, Mr Nolan was taken into custody charged with three counts of “Break and enter a building with intention to injure”. He was bail refused by police and appeared in court the following day where the magistrate directed he be taken for a mental health assessment pursuant to s33 of the *Mental Health (Forensic Provisions) Act 1990* (the Mental Health Act).

Mr Nolan was assessed of being mentally ill within the terms of that Act and admitted as an involuntary patient to Cumberland Hospital. Over the next two weeks he received psychotropic medication and was monitored regularly. On 7 November he was assessed as no longer fulfilling the criteria for involuntary treatment and was in according with the Mental Health Act released back into the custody of police and again taken before the court.

The magistrate before whom Mr Nolan appeared apparently had concerns about his mental state and so directed he be further assessed pursuant to s33. That assessment also occurred at the Cumberland Hospital. The doctor who saw Mr Nolan on that occasion concluded in his written assessment that the patient “*does not have a mental illness*.” I conclude that what he intended to convey was that Mr Nolan was not at the time he was seen mentally ill or thought disordered within the terms of the Mental Health Act. Accordingly, he was given back into police custody

without further treatment and the next day Mr Nolan was again brought before the court and remanded in custody.

On 9 November he was transferred to the Parklea Correctional Centre. On reception he underwent a physical and mental health assessment during which his drug withdrawal and mental illness symptoms were noted along with his extensive history of self-harming. He was initially placed in a normal cell but on 18 November threats of self-harm caused him to be moved to a safe cell, placed on 24 hour observations and denied access to sharps or ligatures.

On 23 November Mr Nolan actively participated in a RIT review and guaranteed his own safety. Accordingly his access to a hygiene pack with a disposable razor was reinstated but three days later, on 26 November he cut his left wrist and made an incision behind his left ear. He explained that he was acting in response to auditory hallucinations. He was placed back in a camera cell with nil sharps and 15 minute observations. The next day he was transferred to the MRRC.

On account of having previously had violent interactions with other prisoners at the MRRC, Mr Nolan was placed on a Protection Non Association order (PRNA).

On 7 December 2012, Mr Nolan was placed in the Mental Health Screening Unit (MHSU) so that his complex care needs could be assessed and a care plan devised. While he was in there a comprehensive mental health assessment was undertaken by a psychiatrist, Professor David Greenberg, who had been involved in treating Michael during previous terms of imprisonment. Contrary to the assessment of the Cumberland Hospital medical officers, Professor Greenberg was firmly of the view that Mr Nolan was acutely psychotic and mentally ill within the terms of the Mental Health Act.

By 7 January 2013, Mr Nolan was assessed as no longer being at risk of self-harming. He purported to guarantee his safety and that of others. He was moved to M block but the same day again threatened self-harm. Accordingly he was moved back to a safe cell in Darcy 1. The next day, 8 January, he explained that he had been unsettled by being required to exercise with other prisoners in M block. It was agreed he would be housed in a single cell regular cell in Darcy 2 with limited contact with other prisoners until a bed became available in the mental health step down pods Hamden 17/18. He was to receive regular psychiatric reviews. He was allocated cell 77.

On 15 January, Mr Nolan was reviewed by Dr Sarah Spencer, a Justice Health psychiatrist. She assessed his acute risk of suicide as low at that time. He told her he had no ideas of suicide or self-harm. He continued to report auditory hallucinations. She said he told her he was "*alright*" but keen to move from Darcy to Hamden pods. She said he was future focused, discussing his charges and not overly anxious about possible outcomes. They discussed some dissatisfaction Mr Nolan had with his medications. Dr Spencer agreed to trial him on other but these first required blood screening which she ordered.

She considered the plan to house him in a single cell in Darcy 2 pod until a place in the Hamden mental health step down pods 17/18 became available was appropriate.

Although Dr Spencer considered Mr Nolan to be at low risk of immediately self-harming she recognized that his mental state was very changeable and she accordingly arranged to see him again in a week's time.

Nothing else of note is included in the brief or correctional records until the day of Mr Nolan's death. It is appropriate to note however, that conditions in Darcy 2 pod were taxing. The unit was very crowded and the cell next to that occupied by Mr Nolan was being converted from a regular cell to a "safe cell". This undoubtedly generated a lot of loud and intrusive noise. During this period, Mr Nolan was locked in his cell for most of the day.

Day of the death

Because Mr Nolan was on a non-association order, he could only be let out of his cell when all others prisoners were in theirs. In effect this meant he could not expect to be out of his cell for more than an hour a day. In practice, this regime was not strictly adhered to and Mr Nolan was let out of his cell for short periods during the day to get hot water for tea and to access the telephone etc. Further, he had contact with Justice Health nurses three times per day: twice for the dispensing of his prescribed medication and once for the administering of his opioid replacement therapy.

The area outside of his cell was under constant CCTV observation. Accordingly, his movements on the day of his death can be established with a fair degree of accuracy and the versions of witnesses can be cross referenced to this recorded vision.

Breakfasts were distributed to all prisoners in their cells soon after 8:00am. At 8:21 Mr Nolan was released from his cell. He can be seen going off camera for a brief period before returning at 8:24 carrying a drinking cup. His door is left open and he moves around the area of his cell. During this period he received medication from a nurse. His cell was secured at 8:58 and the other prisoners in the block were then released.

At 10:17 Mr Nolan was again released from his cell for a short period.

After his death, a number of prisoners variously reported that on the day of his death Mr Nolan was expressing concern about remaining in Darcy 2 pod; was threating self harm and/or was manhandled by the correctional officers. I accept that he was almost certainly expressing dissatisfaction with his custodial arrangements but I have also come to the view that those witnesses have exaggerated what occurred.

When interviewed on the day of Mr Nolan's death, inmate Angus O'Casey said he heard the deceased tell a guard that he wished to kill himself. He said Mr Nolan was in tears and said "*I don't want to be alive*" and "*I want to die*" Guards then "*threw Mr Nolan into his cell*."

When called to give evidence at the inquest, Mr O'Casey said he had no memory of the incident as he suffered from an acquired brain injury.

Inmate Jay Hopgood said that he saw Mr Nolan in tears asking for medication and asking for a light for his cigarette. Correctional officers forced him back into his cell – "*there was a bit of a scene.*"

Neither of those inmates knew Mr Nolan. Noah Filimoehala, on the other hand, had known him for about 10 years and had socialised with him outside of prison. He said that on the day in question, he spoke to Mr Nolan through the flap in his cell door and Mr Nolan complained about the noise being created by the adjacent cell being renovated. He also said that Mr Nolan asked him if he could get him some drugs, but Mr Filimoehala told him there were none in the pod at that time. He said he gave Mr Nolan some cigarettes.

Senor Correctional Officer Adrian White had contact with Mr Nolan over a number of years at the MRRC. He knew him to be a very difficult prisoner to manage who was demanding of staff time. He also acknowledged that in his last period of incarceration in Darcy 2 pod, Mr Nolan was kept in difficult circumstances for a lengthy period on account of the ongoing renovations and his non association order. He said that was difficult to alleviate on account of the shortage of single occupancy cells and the high occupancy rate of the pod. He was adamant that had Mr Nolan threatened self-harm the RIT procedures would have been activated. He also denied that Mr Nolan was agitated on the day in question and said that had he been distressed he would have referred him to a mental health nurse. In fact that is what occurred.

Registered Nurse Barbara Sullivan had on-going contact with Mr Nolan through-out his last period of incarceration. She recalled that during the morning of 21 December she was asked by a senior correctional officer, who I accept was Mr White, to see Mr Nolan as he was agitated and "*playing up".*

Accordingly, she saw Mr Nolan in a holding cell adjacent to the pod. She knew he had been assessed as suitable for transfer to Hamden pods 17/18 but she also knew that he could not be housed there on account of other inmates already there with whom he had a history of conflict.

She said Mr Nolan told her he was anxious to get to Hamden. She understood why that would be so. She asked him if he would be content with a move to Hamden pods 15/16 and he agreed. She told him she would pass on that request. Nurse Sullivan said Mr Nolan did not appear distressed and he did not make any threats of self-harm or give her any reason to believe he was at risk of that. Otherwise she would have activated the RIT procedures as she had done previously in relation to this prisoner.

He went back to the pod and she went to her workstation and completed a Health Problem Notification form which was a mechanism to inform those responsible for prisoner intra-centre transfers that a prisoner had been assessed as suitable for transfer to a particular pod. She also completed an electronic referral to the same effect.

The CCTV recorded vision shows Mr Nolan returning from that meeting. His body language suggests he is not happy about having to go back into his cell but there is

no indication that he is distressed or resisting. Officers ushered him towards the cell, but no physical contact was required. This occurred at approximately 10:30am.

Throughout the next few hours various prisoners can be seen approaching the cell and talking through the door flap. At various time correctional officers also look through the flap and slide meals under the door. At 2:40 pm Mr Nolan leaves his cell with a drinking cup in his hand. He returns about two minutes later and appears to speak with a correctional officer at his cell door for about a minute. He is then locked in his cell and does not leave thereafter.

The death is discovered

At 7:15pm a correctional officer and a nurse were conducting the evening medication round in Darcy 2 pod when they opened the door to cell 77 and found Mr Nolan lying on the floor, next to his bunk, with his head towards the door, with a pool of blood beside him. One of them called a medical emergency and then both entered the cell to examine Mr Nolan. They could find no signs of life. The cell was secured while awaiting the attendance of paramedics and a crime scene log was commenced.

Ambulance officers were on scene by 7:35pm. They confirmed that Mr Nolan was deceased and that no resuscitation could be attempted.

Police were at the pod by 8:30pm and detectives from the Corrective Services investigation Unit (CSIU) took over the investigation.

It was immediately apparent that Mr Nolan had lost a significant amount of blood from a wound to his right wrist. There were pools of blood in a number of discrete areas around the cell: on the bedding; near the shower and around the body. Within a congealed pool of blood on the cell floor was found a dismantled, prison issued, disposable razor. The head had been broken open and the blade removed. The plastic handle had been melted and the blade attached to it, forming a makeshift knife. Numerous spent matches were in an ashtray nearby.

In each cell there is an intercom the occupant can activate to speak to correctional officers. It is referred to in jail parlance as the knock up button. If the call is not responded to by officers in the pod when the prisoner is housed, the call goes through to a central office that is manned continuously.

The knock up button was working when tested by a CSIU officer on the night of Mr Nolan's death. There were no obvious blood smears on the button. The officers on duty in the pod at the relevant time said they had heard no activation of the intercom by the prisoner in cell 77 throughout the relevant period. Due to a malfunction in the relevant software, the intercom system was not able to be interrogated to ascertain whether an activation was recorded from the cell at the relevant time.

The autopsy evidence

On the 22 January 2013, Michael's father identified his body to police. The body then underwent an internal autopsy by an experienced forensic pathologist.

The examination found two small scratch abrasions on the right frontal area of the head. These were not of significance. The autopsy also found two incisions in the

lateral aspect of the right wrist. That section of the wrist showed that one of those incisions penetrated the right radial blood vessel. No other trauma was found to the body and when it was subject to a whole body x-ray no abnormalities were discovered.

Toxicology testing showed the presence of methadone in the amount of 0.88 mg/L. Although that level is within in the toxic range in view of the fact that Mr Nolan was a long time user it is unlikely to have had adverse effects on him. The level found in his blood was consistent with his prescribed dose of 95mg daily.

Olanzapine was also found within a therapeutic range. Mr Nolan had been prescribed both drugs while in prison. The pathologist was of the opinion the incisions in Mr Nolan's wrist occurred at least a few hours before death.

She cited exsanguination resulting from the incision to the radial vein as the primary cause of death.

Expert psychiatric opinion

All of the relevant information gathered during the course of the investigation was provided to Dr Tanveer Ahmed, an independent experienced consultant psychiatrist. Dr Ahmed provided the court with a report and gave evidence.

In his report, he wrote that Mr Nolan could be diagnosed as suffering from a combination of paranoid schizophrenia exacerbated by underlying acquired brain injury, with a possibility of developmental delay. Having reviewed the Cumberland Hospital records for the period during which Mr Nolan was last there, 27 October to 7 November 2012, Dr Ahmed expressed the view that the decision to discharge him was not unreasonable. He did however disagree with the assessment of Dr Kota that Mr Nolan did not have a mental illness. In oral evidence, Dr Ahmed acknowledged that by the end of his in-patient treatment at the Cumberland Hospital it was reasonable to assess Mr Nolan as not being mentally ill within the terms of the Mental Health Act. Dr Ahmed also agreed that further hospitalisation was unlikely to be of assistance to Mr Nolan, and in those circumstances it was not unreasonable to discharge him back into police custody to be taken before the court.

Having reviewed the Justice Mental Health Service records Dr Ahmed considered that the management plan instituted for Mr Nolan on 5 January 2013 was appropriate. However, in his report he expressed the view that the assessment that Mr Nolan was at low risk of suicide made following a RIT meeting on 8 January was not supported by the evidence. He pointed out that Mr Nolan satisfied almost all of the factors contributing to risk of suicide in a correctional setting with few or none of the protective factors. As a result he considered Mr Nolan should have been assessed to be in the moderate to high risk range.

Dr Ahmed was of the view that the risk assessment tools used in the Mental Health Service are not the problem but they were inappropriately applied in this case.

When he gave oral evidence at the inquest, it was explained to Dr Ahmed that the assessment had been made by a forensic psychiatrist with many years' experience working in prison mental health and that her assessment was not meant to indicate

that Mr Nolan was not at a chronic heightened risk of suicide. Rather, the psychiatrist, Dr Spencer, had concluded that that Mr Nolan was not at such acute or immediate risk that he could not be safely housed in a mental health step down pod. The acute crisis which had caused him to be removed to the Mental Health Screening Unit had been resolved.

In those circumstances, Dr Ahmed withdrew his criticism of the assessment and care planning for Mr Nolan. He accepted that the medication given to Mr Nolan was appropriate as was his regular psychiatric review.

Conclusions

Michael Nolan had a difficult life. I accept his sister's account of Michael as a boy succeeding at and enjoying football but that happiness was short-lived. I also accept his sister's account of the affection his parents and sisters had for Michael which was reciprocated by him. I offer the family my sincere condolences for their sad loss of their son/brother at such a young age.

From at least his teenage years, Michael Nolan experienced difficulties as a result of intellectual and personality limitations. Congenital disabilities cumulated with an acquired brain injury, fluctuating mental illness and the long term effects of illicit drug use. This constellation of cognitive, perceptual and attitudinal disorders generated very complex and challenging treatment needs. They also resulted in aberrant behavior that precipitated frequent interaction with the criminal justice system and numerous relatively short periods of imprisonment. When he was not in prison, Mr Nolan lived an unstable and transient life punctuated by episodes of drug induced psychosis and chronic mental illness. He engaged in numerous instances of serious self-harming both in the community and when he was in custody.

Most mental health patients benefit from a continuity of care involving, among other things, the development of a therapeutic alliance between the patient and the clinicians. This would be of particular importance for a patient like Michael Nolan who had very limited insight into his various conditions and who was prone to paranoid delusions.

Mr Nolan's symptoms included a high level of changeability; impulsivity; and unpredictable, aggressive outbursts. His limited intellect and his thought disorders hindered his capacity to respond constructively to the stressors he encountered in the community and in custody. He struggled to cope by being demanding and manipulative and engaging in self-harming. These responses compounded the challenges to providing him with effective mental health care. Sadly and ironically, the behaviors precipitated by Mr Nolan's conglomeration of disorders made continuity of care almost impossible. His chronic elevated risk of self-harm or suicide never abated.

A meaningful understanding of how Mr Nolan came to die in his cell in January 2013 would require a review of his treatment as an in-patient, in the community and in custody over many years. A detailed analysis of the treatment options and their impact on his psychosocial condition over that time would be necessary to explain how he came to be in Darcy 2 pod on the day of his death. The short answer is that he could not cope by himself, his family was unable to help and the various

government agencies he interacted with only gave short-term solutions. An understanding of why that was and how it could be remedied is beyond the scope of this inquest. Therefore, somewhat artificially, this inquiry has focused only on the last couple of weeks of Michael's life.

I turn now to my conclusions in relation to the issues raised in relation to that period.

Mr Nolan was discharged from the Mental Health Screening Unit on 5 January at his request. He did not wish to remain in the MHSU and threatened to hang himself unless he was moved. On successive days he again made threats of self- harm and the RIT processes were appropriately activated. On 8 January he was assessed as no longer being at such risk of immediate self-harm as to necessitate his placement in a safe cell. Accordingly, he was moved to Darcy 2 Pod, to be accommodated in a single cell and to exercise alone on the understanding that he would be moved to Hamden 17/18 mental health step down pods when a bed became available and his non association requirements could be satisfied. In the meantime, he would be regularly reviewed by the mental health staff in Darcy and he would continue to receive his prescribed medication.

I am satisfied that these assessments and the implementation of the plan were appropriate.

On 15 January, Mr Nolan was reviewed by a Justice Health psychiatrist in accordance with the plan formulated when he was discharged from the MHSU. I accept the evidence indicating her assessment and treatment of Mr Nolan's condition was appropriate having regard to his history and presentation. There was no persuasive evidence that she should have sought to have Mr Nolan returned to the MHSU or housed in a "safe cell." His medication was also appropriate as was the psychiatrist's willingness to explore the utilization of other psychotropic drugs after appropriate blood screening had been undertaken. The autopsy results demonstrate the prescribed medication was administered. Criticism by the court appointed expert of the assessment undertaken on this occasion was withdrawn when the expert was made aware of the Justice Health psychiatrist's qualifications and experience and the basis of her conclusions.

I conclude that because of his intellectual and psychiatric deficiencies; his propensity to abuse drugs and his personality disorders, Mr Nolan was always at a heightened baseline risk of suicide – that is, he was always more at risk than a member of the general public and that applied whether he was in the community or in prison.

However, I also accept that a large section of the prison population is in a similar state. All of the prisoners with similar disabilities cannot be kept under constant observation. Rather, prison mental health services have to monitor and review at-risk prisoners regularly, ensure they are adequately medicated and respond to their changes in mental state as those become apparent.

I am satisfied this happened in relation to Mr Nolan. His dying does not necessarily demonstrate a failure of Justice Health or Corrective Services policies or practice.

He was seen three times per day by a nurse. When he exhibited signs of being at increased or greater risk of self-harm the RIT procedures were activated. I don't accept that he met that threshold on the day of his death – being restless, frustrated and manipulating staff was not an indicator of increased risk of self-harm, rather it was a usual state for Michael Nolan. He was frustrated and complaining – but he was often like that. His conditions were made worse by the length of his stay in the Darcy 2 pod and the renovation of the adjacent cell. It would have been preferable for him to have been placed elsewhere, but that was complicated by his non association status.

In hindsight, it would have been better had he not been given a disposable razor. However, I accept the policy provided he could have one if he did not meet the risk of self-harm threshold. It was not explained why in other parts of the prison inmates were only given temporary access to razors in exchange for the prisoner's identification card. Nor can it be shown that had that system been in place in Darcy 2 pod it would have made any difference to the outcome for Mr Nolan.

The evidence persuasively demonstrates that no one else entered Mr Nolan's cell after lock-down until he was found deceased and that only he could have caused the fatal injury to his wrist. I have given careful consideration to whether Mr Nolan intended to take his own life when he caused the injury. He had self-harmed previously in circumstances where he could have killed himself had he been so inclined. I accept that on this occasion he did not seek to summon help as he had previously done – on the balance of probabilities the knock up button was not activated. Conversely, the self-inflicted wound was relatively slight – it was not done accidentally but he may well have mistakenly believed he would not die from the injury before the next cell inspection occurred. I am left uncertain as to Mr Nolan's intentions.

Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence given at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

The identity of the deceased

The person who died was Michael David John Nolan.

Date of death

Mr Nolan died on 21 January 2013.

Place of death

Mr Nolan died at the Metropolitan Remand and Reception Centre, Silverwater, New South Wales.

Cause of death

The cause of his death was exsanguination due to an incision in the radial vein of his right wrist.

Manner of death

Although I conclude Mr Nolan deliberately inflicted the fatal wound I am unable to ascertain whether he intended to cause his death.

Recommendations

Pursuant to s 82 of the *Coroners Act 2009*, Coroners may make recommendations connected with a death. I am satisfied that the relevant authorities have constructively engaged with the circumstances under which this death occurred. I conclude that there are no recommendations that I could make that would reduce the likelihood of similar deaths occurring in future.

I close this inquest.

M A Barnes
NSW State Coroner
Glebe Coroners' Court