



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 004527

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

*Section 67 of the **Coroners Act 2008***

Inquest into the Death of Bahman Nouri

Findings of:	Coroner Kate Despot
Delivered on:	16 October 2026
Inquest hearing date:	7 May 2025
Counsel Assisting the Coroner:	Nicholas Ngai, Senior Coroners Solicitor
Keywords:	Death in care; Mental health inpatient facility, compulsory patient, escorted leave, conditions of leave, suicide

INTRODUCTION

1. On 24 August 2019, Mr Bahman Nouri (**Mr Nouri**) was 30 years old when he was found deceased at his cousin's home at 32 Ranmore Grove, Caroline Springs. At the time of his death, Mr Nouri was on escorted leave from the Northern Psychiatric Unit (**NPU**) at Northern Hospital in Epping. At the time of Mr Nouri's death, the Northern Psychiatric Unit was serviced by a team of mental health clinicians from the Northern Area Mental Health Service (**NAMHS**) which formed part of NorthWestern Mental Health (**NWMH**), a division of Melbourne Health.¹
2. Mr Nouri was born in Iran and was seeking asylum in Australia. He was on a bridging visa and worked in the construction industry pending the outcome of his protection visa application.
3. Mr Nouri moved from Sydney about year before his death and resided in Lalor with a friend. He was single and did not have any children. Most of his immediate and extended family resided in Iran. Mr Nouri's only family in Melbourne were his cousin Ms Parisa Noori (**Parisa**), her husband Mr Khaled Noori (**Khaled**) and their two young children. Mr Nouri shared a close relationship with Parisa and Khaled, visiting them two to three times a week. According to Parisa, Mr Nouri enjoyed spending time with their children and they "*loved it when he came to visit*".
4. Mr Nouri did not have any known prior psychiatric history or relevant medical history prior to his admission to the NPU on 15 July 2019.

THE CORONIAL INVESTIGATION

Jurisdiction

5. Mr Nouri's death was a reportable death under section 4 of the *Coroners Act 2008* (**'the Act'**) because his death occurred in Victoria, and was considered *unexpected, unnatural or violent* and to have resulted *from accident or injury*. Moreover, immediately before his death, Mr Nouri was a patient within the meaning of the *Mental Health Act 2014* (**'MHA'**)² and was a person placed in custody or care as defined in section 3 of the Act.

¹ Since July 2022, Northern Area Mental Health Service separated from NorthWestern Mental Health.

² Although this act has since been replaced by the *Mental Health and Wellbeing Act 2022* (Vic), the *Mental Health Act 2014* is referenced in this finding as it was the legislation in force at the time of Mr Nouri's death.

6. Section 52(2) of the Act provides that a coroner must hold an inquest into a death if the death or cause of death occurred in Victoria, and the deceased was, immediately before death, a person placed in custody or care. Given Mr Nouri was a person placed in care, specifically, a patient detained in a designated mental health service and subject to an Inpatient Treatment Order, an inquest into his death was mandatory.

Purpose of the Coronial Investigation

7. The purpose of a coronial investigation of a reportable death³ is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.⁴ The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. The circumstances in which a death occurred refers to the context or background and surrounding circumstances but are confined to those circumstances sufficiently proximate and relevant to the death, and not all those circumstances which might form part of a narrative culminating in death.⁵
8. The broader purpose of any coronial investigation is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the prevention role.⁶
9. The Coroners Court of Victoria is an inquisitorial jurisdiction.⁷ Coroners are not empowered to determine civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment on any statement that a person is, or may be, guilty of an offence.⁸
10. Coroners are empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public

³ The term is exhaustively defined in section 4 of the Coroners Act 2008 (Vic) ('the Act'). Apart from a jurisdictional nexus with the State of Victoria, a reportable death includes deaths that appear to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury; and, deaths that occur during or following a medical procedure where the death is or may be causally related to the medical procedure and a registered medical practitioner would not, immediately before the procedure, have reasonably expected the death (section 4(2)(a) and (b) of the Act).

⁴ Section 67(1) of the Act.

⁵ This is the effect of the authorities – see for example, *Harmsworth v The State Coroner* [1989] VR 989 (Harmsworth); *Clancy v West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).

⁶ The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, compared with the Coroners Act 1985 where this role was generally accepted as 'implicit'.

⁷ Section 89(4) of the Act.

⁸ Section 69(1) of the Act. However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69 (2) and 49(1) of the Act.

health and safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health and safety or the administration of justice.⁹ These are effectively the vehicles by which the coroner's prevention role can be advanced.¹⁰

Standard of proof

11. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. The strength of evidence necessary to prove relevant facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.
12. In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*¹¹. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals or entities, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.
13. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved. Facts should not be considered to have been proven on the balance of probabilities by inexact proofs, indefinite testimony, or indirect inferences. Rather, such proof should be the result of clear, cogent, or strict proof in the context of a presumption of innocence.

Sources of evidence

14. This finding draws on the totality of the material obtained in the coronial investigation of Mr Nouri's death: the coronial brief prepared by the Coroner's Investigator, Constable Justin McKay; further material obtained by the Court; the transcript of inquest; and the written submissions filed on behalf of Melbourne Health prior to the inquest; as well as closing submissions from Counsel Assisting.
15. In writing this finding, I do not purport to summarise all the material evidence but refer to it only in such detail as appears warranted by its forensic significance and the interests of

⁹ See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations, respectively.

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

¹¹ (1938) 60 CLR 336.

narrative clarity. It should not be inferred from the absence of reference to any aspect of the evidence that it has not been considered.

BACKGROUND

16. On 13 July 2019, Sergeant Tim Lane was alerted by Sunshine Police Station watch house staff that a male (later determined to be Mr Nouri) was in the foyer and behaving erratically. Mr Nouri was found by police to have a small hatchet and a Stanley knife concealed in his trousers. Mr Nouri reported to police that he was carrying these items for his own protection, and he voluntarily surrendered these items. Sergeant Lane formed the opinion that Mr Nouri was suffering from a mental health episode and offered to have an ambulance attend to transport Mr Nouri to a hospital or arrange a referral for mental health assistance. Mr Nouri declined these offers and arrangements were made for him to be collected from the police station by a friend.
17. On 15 July 2019, Mr Nouri again came to the attention of Victoria Police when his car was observed stopped in the middle of the left-hand lane on Mahoneys Road, Reservoir. Victoria Police members slowed their vehicle to pull up alongside Mr Nouri's vehicle. Mr Nouri was the sole occupant of the vehicle and, according to attending police members, he appeared "scared". Mr Nouri indicated to the attending police members that he was okay and they directed him to move on.
18. Mr Nouri then drove west on Mahoneys Road with the police members following. They subsequently observed Mr Nouri speeding up and slowing down and swerving between lanes, and directed him to pull over. When they approached Mr Nouri, they stated he "*appeared extremely paranoid, nervous and agitated. His eyes appeared to be big and open and he kept looking around...he was skittish and rambling about people being after him and repeatedly asking us not to kill him*". Police then observed Mr Nouri pull a butcher's knife from the centre console and make "*a sweeping movement with the knife across his body towards First Constable Galliot*". Police directed that Mr Nouri drop the knife and place his hands on the steering wheel. Mr Nouri complied with the direction.
19. Mr Nouri was apprehended by police pursuant to section 351 of the MHA and transported to the Emergency Department at Northern Hospital.
20. Upon assessment by the Emergency Mental Health team at Northern Hospital, Mr Nouri was made subject to a Temporary Assessment Order with a provisional diagnosis that he was

experiencing a psychotic episode. Information provided by Mr Nouri's family to clinicians indicated that he had experienced a recent deterioration in his mental health and that he had expressed fears of being killed in the days prior to his presentation at hospital.

21. Mr Nouri was subsequently admitted to the NPU at Northern Hospital.
22. On 16 July 2019, Mr Nouri was reviewed by the psychiatric team and a Consultant Psychiatrist at the NPU, which is staffed by the NAMHS. According to the Consultant Psychiatrist, Mr Nouri was;

poorly engaged and guarded. He spoke in low volume and limited tone range, providing short answers. A language barrier was evident. Mr Nouri's affect was observed to be mostly restricted. His thought form was linear and his thought process appeared somewhat slow. Mr Nouri reported that prior to the admission he had swallowed two packets of mothballs in an attempt to end his life. However, at the time of the review he denied any ongoing suicidal thoughts or any paranoid ideation. There was no evidence of perceptual disturbances. His insight and judgement were poor. Mr Nouri was diagnosed with first episode of psychosis. He was considered to be at risk of agitation and absconding at the time.

Following this review, Mr Nouri was placed on a Temporary Treatment Order. It was identified that there was a language barrier during this review, and as a result all subsequent reviews were conducted in the presence of a Farsi interpreter.

23. Medical investigations were conducted in relation to Mr Nouri's reported ingestion of mothballs and advice was sought from the Victorian Poisons Information Centre. Blood tests were performed, the results of which were unremarkable, there were no abnormal signs on physical examination, and there were no poisoning symptoms elicited.
24. Mr Nouri was commenced on lurasidone¹² with an initial dose of 40mg. The dose was gradually increased over the following days. On the same day, Mr Nouri was granted escorted leave to visit the Low Dependency Unit (LDU) with his family and friends.
25. Upon further review on 17 July 2019, Mr Nouri reported improvements to his mood and denied any ongoing paranoid beliefs or suicidal thoughts. He denied his previous report of

¹² Lurasidone is an antipsychotic medication used in the treatment of schizophrenia and other psychotic disorders. It is also used to treat low mood in people with bipolar affective disorder.

having ingested mothballs prior to his admission. Consultant Psychiatrist, Dr Laura Romans, noted his “*insight was partial, and his judgment limited*”.

26. Further medical investigations, including blood tests and a physical examination, were undertaken and toxicological concerns in relation to Mr Nouri’s reported ingestion of mothballs were excluded.
27. Mr Nouri was transferred to the LDU on 17 July 2019. An organic screen for the first episode of psychosis, including blood tests and a brain MRI were performed. Results were within the normal range.
28. Mr Nouri underwent a further review on 22 July 2019. He was reported to have engaged well during this review, revealing information about a past relationship and the context of his suicide attempt prior to admission. Mr Nouri’s insight and mental state appeared to be improving, and he was keen to discuss potential discharge dates. The treating team considered a potential discharge at the end of that week and the possible revocation of the Temporary Treatment Order.
29. On the same day, Mr Nouri was granted escorted leave until 26 July 2019, with 30 minutes for the first day and 60 minutes for the subsequent days.
30. On 24 July 2019, Mr Nouri’s family reported concerns regarding Mr Nouri’s non-compliance with his medications. Mr Nouri had indicated that he was hiding the tablets under his tongue and discarding them later. He further reported persecutory delusions, including beliefs that he was being followed and at risk of being killed. A medical review was conducted on the same day. In light of the reported non-compliance with his tablet form medication, his treating clinicians planned to commence him on paliperidone,¹³ which is available in both tablet form and as a long-acting injection. Mr Nouri denied non-compliance with his medications, though eventually agreed to commence paliperidone via injection.
31. On 30 July 2019, Mr Nouri underwent further psychiatric review. He reported improvement in his clarity of thinking following the introduction of the new medication (having had the first of two initiation doses of paliperidone) and denied any side effects. The impression of Mr Nouri at the time was that his mental state was improving but he had residual paranoid symptoms. His management plan at that time was to continue pharmacological treatment, with a second initiation dose of paliperidone to occur in five days. Later that day Mr Nouri’s

¹³ Paliperidone is antipsychotic that used to treat psychotic disorder, including schizophrenia.

treating team met with Mr Nouri, Khaled, Parisa and a family friend. Mr Nouri's treatment plan, discharge planning and community follow up were discussed.

32. On 31 July 2019, Khaled contacted the ward, reporting that Mr Nouri had contacted him to say "goodbye" and inform him that he "*would not be around*". That night, Mr Nouri requested PRN¹⁴ medications to help him sleep. He reported to nursing staff that a man wanted to kill him but did not provide further information. Nursing staff later discovered a metal can lid under his pillow, which was removed. Mr Nouri's risk assessment was increased to medium that night.
33. On 1 August 2019, Mr Nouri was visited by Parisa and her children however he refused to leave the ward reporting that he felt unsafe outside the ward. He reported concerns about men coming to get him. On mental state examination, Mr Nouri was assessed as being withdrawn, guarded, minimising and presenting with poor insight. Mr Nouri was experiencing persecutory paranoid delusions but denied any suicidal ideation. Mr Nouri's overnight observations and monitoring were increased.
34. On 5 August 2019, Mr Nouri was reviewed. He had received his second dosage of paliperidone earlier that day and reported that he was feeling calmer and his sleeping had improved, although he reported feeling disrupted by the frequency of nursing checks which occurred overnight.
35. On 8 August 2019 a Mental Health Tribunal (**MHT**) Hearing was held at Northern Hospital to consider Mr Nouri's mental health care. The MHT granted a 16-week Inpatient Treatment Order. On the same day, Mr Nouri's family reported to his treating team that Mr Nouri had contacted his family in Iran advising them they were not safe and should install cameras around their house. His family also reported that two days prior, whilst on leave, they found Mr Nouri to be hypervigilant. Mr Nouri's treating team added oral olanzapine¹⁵ to his medications.
36. Mr Nouri was reviewed by his treating team on 14 August 2019 at which time he reported to be doing well. He denied any depressive symptoms or suicidal thoughts in the preceding two

¹⁴ The term "PRN" is a shortened form of the Latin phrase *pro re nata*, which translates roughly as "as the thing is needed". The term *prn* is used when prescribing medication, to direct that it be administered only as required e.g. for analgesia.

¹⁵ Olanzapine is a second-generation antipsychotic indicated in the treatment of schizophrenia and related disorders, and bipolar disorder.

weeks. The clinical impression at that time was that Mr Nouri's mental state had *"plateaued and cross-sectionally there was no improvement evident"*.

37. On 20 August 2019, a meeting was held at NPU after Mr Nouri's family made a request for him to be on extended leave. They reported observing improvement over the preceding two weeks; they had not observed any hypervigilance and noticed that he was more relaxed whilst on leave.
38. Particularly, Mr Nouri's family requested five hours of leave so that Mr Nouri could visit their home and spend time with the children. They cited that on two previous occasions Mr Nouri had spent extended time with friends and family without incident.
39. Dr Romans raised concerns that an extended period of leave might lead to Mr Nouri's destabilisation given he was still experiencing some psychotic symptoms. For this reason, Mr Nouri's family were informed that Mr Nouri was required to be monitored closely whilst on leave.
40. Mr Nouri was granted a trial period of three and a half hours of escorted leave, which was to be further reviewed and increased to four hours if no issues arose. Mr Nouri went on three and a half hours leave after the family meeting on 20 August 2019 and no concerns were reported upon his return.
41. On 22 August 2019, nursing staff reported an improvement in Mr Nouri's mental state in that he appeared bright and participated in the ward's barbeque. Mr Nouri's family reported that he appeared anxious and paranoid the day prior, however, they were comfortable to take him on leave again that day and no concerns were reported upon his return.
42. Upon review on 23 August 2019, Mr Nouri reported an improvement in his mental state and attributed this improvement to his medications. Mr Nouri attributed the deterioration of his mental state prior to his hospital admission to the death of his uncle and his visa status. He denied symptoms of depression and reported that he enjoyed spending time with his family. Mr Nouri requested a further extension to his period of leave, noting that it was a one-hour commute to his family's home from the hospital. Mr Nouri discussed his intention to stay with his cousins upon discharge and find employment in the construction sector. Mr Nouri denied thoughts of suicide or self-harm.
43. The reviewing mental health clinician noted that Mr Nouri's mental state had improved over the previous two weeks. However, on cross-sectional mental state examination Mr Nouri

presented with “*no significant change in presentation, namely blunted and restricted in affected, and guarded and minimising*”. Mr Nouri had not expressed any imminent risks to himself or others and denied having suicidal thoughts recently. There were no indications to suggest that a change in his management plan or leave arrangements were required at that time.

44. Mr Nouri had a further period of escorted leave on 23 August 2019 and no new risks or concerns were identified upon his return.

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

Circumstances in which the death occurred – Section 67(1)(c)

45. Upon a mental state examination on 24 August 2019, Mr Nouri was reported to be “*unkempt, dishevelled and malodourous, but cooperative with interventions*”. He denied thoughts of self-harm or suicidal ideation. He also denied perceptual disturbances.
46. Mr Nouri left the NPU ward on 24 August 2019 at 1.25pm with Parisa for approved escorted leave. Mr Nouri and Parisa arrived at her home at about 2.30pm. At 3.00pm that day, Parisa left the house to take her child to an appointment at a medical clinic about two minutes from her home. She asked Mr Nouri if he would come with them, but he declined, saying he was tired and wanted to stay at home. Mr Nouri assured Parisa that he would be fine, and Parisa brought him a blanket and a cup of tea so he could sleep on the couch.
47. Parisa and her children returned home at about 3.30pm. Parisa immediately noticed that Mr Nouri was not on the couch, and her first thoughts were that he had “*run away*”. Parisa’s son went to the rear yard and reported to Parisa that Mr Nouri was “*under the patio*”. Parisa immediately went outside, where she found Mr Nouri hanging from the rafters of the backyard patio. Parisa took her children out onto the street and called emergency services.
48. Victoria Police and Ambulance Victoria members attended the scene shortly afterwards, at approximately 4.00 pm. Mr Nouri was unable to be resuscitated and was confirmed to be deceased by attending Ambulance paramedics.

Identity of the deceased – Section 67(1)(a) of the Act

49. On 24 August 2019, Bahman Nouri, born 11 February 1989, was visually identified by his cousin, Khaled Nouri.

50. Identity is not in dispute and requires no further investigation.

Medical cause of death – Section 67(1)(b) of the Act

51. On 26 August 2019, Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine (VIFM), conducted an external examination and provided a written report of his findings dated 29 August 2019.

52. Dr Bedford noted there was a parchment ligature mark on Mr Nouri's neck. No other significant injuries were identified.

53. Toxicological analysis of post-mortem samples identified the presence of hydroxyrisperidone¹⁶ and olanzapine.

54. Dr Bedford provided an opinion that the medical cause of death was 1 (a) Hanging.

55. I accept Dr Bedford's opinion.

SUBSEQUENT INVESTIGATION

NWMH Internal Review

56. Following Mr Nouri's death, NWMH conducted a Root Cause Analysis (RCA) investigation. The learnings identified as a result of the RCA were:

a) Barriers to communication and assessment resulting from care not provided in a different language has an effect on the day-to-day engagement with consumers and their treating teams. A stronger understand of these barriers and the need to implement strategies such as increased use of visual methods of communication needs to be explored.

b) Improved clinical documentation specific to leave plan for all consumers and their families to support specific leave planning.¹⁷

57. Associate Professor Vinay Lakra (A/Prof. Lakra) of NWMH stated that it was NWMH's expectation that Mr Nouri's family would remain with him for the duration of his approved escorted leave. NWMH advised Mr Nouri's family of the requirements for escorted leave,

¹⁶ Risperidone is an atypical (second-generation) antipsychotic drug effective against the positive and negative symptoms of schizophrenia.

¹⁷ Statement – Associate Professor Vinay Lakra dated 7 April 2022.

including the need for close monitoring and supervision, and that Mr Nouri should be immediately returned to hospital should any issues arise.

NWMH's Policy

58. At the time of Mr Nouri's death, NWMH had a documented internal policy in place, 'Leave Arrangements from Inpatient Units' (**'the policy'**), which provided that:

- 1. Decisions about leave from mental health inpatient units must consider patients' rights and recovery goals and the risks and anticipated benefits of leave to patients, carers and the community;*
- 2. Leave should be planned in advance following discussion within the clinical team, in conjunction with patients and carers*
- 3. For compulsory patients, leave is regulated by the Mental Health Act (MHA) 2014. Decisions about leave are the responsibility of the authorised psychiatrist.¹⁸*

59. The policy provided the following matters to be addressed when consulting with patients and their family or carers:

- If the [patient] is being considered for leave under the effective supervision of a responsible adult, this must be discussed with both the [patient] and carer. If the carer is unable or unwilling to accept this responsibility, any decisions regarding leave should be reviewed.*
- Consideration should be given to the appropriateness of the "accompanying adult", i.e. their ability to exercise appropriate responsibility and effective supervision.*
- Patients and carers must provide contact numbers for the duration of the leave to assist staff with any concerns they may have during the leave period.*

60. The policy also specified that:

¹⁸ Melbourne Health - NWMH Leave Arrangements from Inpatients Units, Version 5.0.

- *Upon returning from leave, an assessment of the patient must occur. The carer should also be consulted to ensure any issues arising from the leave are identified.*
- *Post-leave assessment, collateral from the carer, including any issues arising from the leave, must be documented in the clinical progress/continuation notes.*

Coroner's Prevention Unit advice

61. In the context of the circumstances in which Mr Nouri's death occurred, I requested that this matter be reviewed by the Coroners Prevention Unit¹⁹ (CPU) Mental Health and Disability Team.
62. The CPU provided an opinion that the decision to grant Mr Nouri leave to attend his cousin house in the company of family was reasonable and appropriate. They noted that leave from an inpatient unit is an important component of recovery and the approved period of escorted leave was intended to assist Mr Nouri to gradually transition back to the community.
63. On 22 August 2019, Khaled reported improvements in Mr Nouri's mental state with noticeably less paranoia. Khaled reported that the escorted leave on this occasion had gone well.
64. During a review by Dr Romans on 23 August 2019, Mr Nouri denied suicidal thoughts and reported feeling better since taking medication. Dr Romans noted that Mr Nouri was likely minimising his symptoms but did not demonstrate a formal thought disorder. Leave was discussed during the review, and Mr Nouri reported having successfully visited his cousin during the week. He reported feeling calm and denied concerns over safety.
65. The CPU noted there was nothing in the materials to suggest that Mr Nouri's mental state or level of risk had significantly changed prior to his escorted leave on 24 August 2019. As such, there was nothing that would have required nursing staff to speak to the psychiatrist about withdrawing Mr Nouri's approval to take escorted leave on 24 August 2019.

¹⁹ The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

66. The CPU further advised that Parisa was an appropriate person to accompany Mr Nouri on leave. Parisa and her husband Khaled were very involved in Mr Nouri's treatment and regularly attended hospital throughout his stay and participated in family meetings to support Mr Nouri.

Further information from NWMH

67. Following receipt of the advice from CPU, I requested further information from NWMH concerning their 'Leave arrangements from inpatient units' policy. Mr Peter Kelly, Director Operations of NWMH, provided a statement which indicated that NWMH had updated this policy following Mr Nouri's death. Notably, the updated policy issued in August 2022²⁰ provided further clarification around the necessity to plan and communicate individual care needs with families, carers, kin and other supporters who may be responsible for a patient whilst they are on leave from an inpatient unit.
68. Mr Kelly provided a copy of the revised policy. The revised policy includes the following (additional) guidance:
- a) Leave should be planned in advance following discussions within the clinical team, in conjunction with patients and family/carer/kin/supporters. The plan should address the following matters:
 - i. Involvement of the patient's carer during discussions.
 - ii. Development of a crisis plan.
 - iii. The willingness of undertaking any actions/expectations placed on the carer/family/kin/supporter to be discussed with them separately, and then once willingness is determined, discussed with the patient also present.
 - iv. If the patient is being considered for leave under the effective supervision of a responsible adult, this must be disclosed with both the patient and the family/carer/kin/supporter. If the family/carer/kin/supporter is unable or unwilling to accept this responsibility, any decisions regarding leave should be reviewed.

²⁰ Version 6.2.

- v. Safety and care considerations might include management of medication, suitability for being left alone, driving, safety of the home environment and safety of dependents in a person's care.
 - vi. Consideration to be given to the appropriateness of the accompanying adult.
 - vii. Contact numbers to be provided by the family/carer/kin/supporter.
 - viii. Assessment of the patient upon returning from leave. The family/carer/kin/supporter should be consulted to identify any issues arising from leave. Collateral obtained from the family/carer/kin/supporter must be documented in the medical record.
- b) Decision-making about the purpose and granting of leave must be clearly documented and communicated to the patient, carer and relevant clinical staff. All patients undertaking leave should have a clearly documented risk assessment and risk management plan that are referenced in the leave decisions.
 - c) Staff must document the leave plan, approval from the authorised psychiatrist or delegate, communication of the plan to the patient and carer where indicated, and the departure and return time.
69. Mr Kelly advised that, since Mr Nouri's death, NWMH have taken a more conservative approach to escorted leave, and such leave is approved for involuntary inpatients much more infrequently, although appropriate exceptions are made and each patient's needs are determined on a case-by-case basis.
70. Mr Kelly also stated that, in response to the learnings identified by the RCA, NWMH has undertaken actions to improve patient information materials more broadly. In particular, relevant pamphlets and service information brochures are now available in multiple languages and are also accompanied by simple visual aids, such as infographic posters.

INQUEST

71. I held an inquest into the death of Mr Nouri on 7 May 2025. No witnesses were called during the inquest, as I was satisfied with the information available to me in the coronial brief and in written submissions filed on behalf of Melbourne Health, which encompasses NWMH, on 2 May 2025.

Written submissions

72. The written submissions filed by Melbourne Health assert that the relationship between Mr Nouri's treating team and his family was productive, and Mr Nouri's treating team had confidence in the level of care and supervision provided to Mr Nouri by his family on escorted leave. They further asserted that there was nothing to indicate there were deficiencies in the way Mr Nouri was being monitored by his family.
73. Melbourne Health submitted that there were no indications observed by NWMH or Mr Nouri's family that would have caused them to believe that Mr Nouri was at imminent risk of suicide on 24 August 2019.
74. I agree with these submissions and am satisfied that they are supported by the evidence before me.
75. Melbourne Health further submitted that it would have been unreasonable for NWMH to have advised Mr Nouri's family that he was not to leave their sight, even for a limited period, as if such constant supervision were required it was highly unlikely he would have been approved for escorted leave. Such a requirement would also place "*an impossible onus and responsibility on those who are charged to supervise psychiatric patients on escorted leave*".
76. I accept these submissions.

FINDINGS AND CONCLUSION

77. Having applied the applicable standard²¹ to the available evidence, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:
 - a) the identity of the deceased is Bahman Nouri, born 11 February 1989;
 - b) his death occurred on 24 August 2019 at 32 Ranmore Grove, Caroline Springs, Victoria, 3023, from hanging; and
 - c) his death occurred in the circumstances described above.
78. Based on the available evidence, I am satisfied that Mr Nouri intended to take his own life.

²¹ See paragraphs 10-12.

79. I find that the medical treatment and care provided to Mr Nouri in the period proximate to his passing, including the decision to grant him escorted leave, was reasonable and appropriate. I further find that the decisions made in relation to Mr Nouri's leave arrangements were responsive and in accordance with relevant NWMH policies. The responsibility of caring for a loved one suffering with a severe mental illness is immense. It is evident from the available evidence that Parisa and Khaled provided unwavering and constant support to Mr Nouri.
80. I am satisfied that in the period proximate to his passing, Mr Nouri gave no indication to his family or treating team that he was suicidal or had thoughts of self-harm. On the day of Mr Nouri's death, there was nothing in his demeanour which could have prompted Parisa's concern for his safety. Parisa left the home for only a short time, in circumstances where she was balancing the need to provide supervision of Mr Nouri and care for her child.
2. Whilst I do not find that there were any deficiencies in the communications between Mr Nouri's family and NWMH, it is evident that clarification around the necessity to plan and communicate individual care needs would be beneficial to families, carers, kin or other supporters who may be responsible for a patient who is on leave from an inpatient unit. I commend NWMH on the system and policy improvements which have been made in this regard since the fatal incident.
81. Despite the tragic outcome, I do not consider that Mr Nouri's death was preventable.

I convey my sincere condolences to Mr Nouri's family for their loss.

PUBLICATION OF FINDING

Pursuant to section 73(1) of the Act, findings and comments following an inquest must be published on the internet. Accordingly, I order that this finding to be published on the Coroners Court of Victoria's website.

DISTRIBUTION OF FINDING

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

Ali & Tralan Nouri, Senior Next of Kin

Jon Minter, K&L Gates, Legal representatives for Melbourne Health

Constable Justin McKay, Coroner's Investigator

Signature:



Coroner Kate Despot

Date : 16 October 2026

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