IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2010 3547

FINDING INTO DEATH WITH INQUEST

(Amended pursuant to s76 (a) of the Coroners Act 2008 on 18 December 2013)

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of: JAMES FALZON

Delivered On:	23 August 2013
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne 3000
Hearing Dates:	15 October 2012 4 February 2013
Findings of:	JOHN OLLE, CORONER
Representation:	Dr P. Halley on behalf of Eastern Health
Police Coronial Support Unit	Leading Senior Constable Nadine Harrison, assisting the Coroner

I, JOHN OLLE, Coroner having investigated the death of JAMES FALZON

AND having held an inquest in relation to this death on 15 October 2012 and 4 February 2013
at MELBOURNE
find that the identity of the deeeased was JAMES FALZON
born on 10 November 1944
and the death occurred on 12 September 2010
at Peter James Centre, Mahoneys Road, Burwood East 3151
from:

1 (a) HANGING

in the following circumstances:

1. James Falzon ("Jimmy") was aged 65 years at the time of his death. He resided at 12 Glen Court, Templestowe. At the time of his death, Jimmy was an inpatient at the Peter James Centre (PJC).

2. The coronial brief has fully addressed the circumstances of Jimmy's death.[1] At approximately 11.00pm on 11 September 2010, Jimmy was found hanging in his room. There were no suspicious circumstances.

3. I am satisfied Jimmy's death was suicide.

Background

4. Jimmy was admitted to South Ward at the PJC on 6 September 2010. He was placed on 15 minute observations.

5. On 7 September 2010, Dr Payman diagnosed Jimmy with Psychotic Depression and assessed him to be a high suicide risk. Dr Payman ordered a continuation of 15 minute observations.

6. At the commencement of the inquest, Dr Halley[2] set the tone:

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[1] A copy of the brief will remain on the court file.

[2] Counsel for Eastern Health

"It's apparent that Jimmy had a very loving and caring family. James was put in the care of Eastern Health and in some ways Eastern Health has let the family and James down."[3]

7. Dr Halley identified two shortcomings in Jimmy's care.

8. Firstly, the practice of overnight downgrading of observations from 15 minute observations to hourly observations ("the deficiency"):

> "That has now been eradicated and we are not aware, as an organisation, that was occurring. It shouldn't be occurring. We apologise for that shortcoming.
>
> The second shortcoming is that there were ligature points in the bedroom, in particular the window winders. These had been identified as a low risk previously and it's important to note, Your Honour – and this is no excuse – that in many years, certainly dating back to beyond 2000, there had been no inpatient suicides in South Ward.
>
> However, we did do a review and have identified the window winders as ligature points or potential ligature points and there were other things, such as cupboards in bedrooms and toilet rolls, et cetera, which have all been changed and we have ongoing ligature reviews on a twelve monthly basis."[4]

Co-operation of Eastern Health to the Coronial Inquest Process

9. I acknowledge Eastern Health's co-operation with my investigation. The sincerity of Eastern Health's apology to the family was reflected by a robust internal review, clearly designed to learn lessons and ensure that shortcomings are not repeated.

10. Jimmy's family were concerned with the decision to admit Jimmy to PJC, together with the decision of Dr Payman not to order one on one supervision. However, I do not question these decisions, each of which appears reasonable.

11. My focus is on the lack of adherence to the visual observation requirements aligned to Jimmy's level of risk, as ordered by Dr Payman, together with the failure to remove ligature points.

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[3] Page 1 Transcript

[4] Transcript page 2

Systemic, not individual, shortcoming

12. I do not consider the deficiency as a failing by individual staff involved in Jimmy's care. Rather, this was a system failure, which allowed the modification of visual observation requirements, without regard to a formal risk assessment.

13. The deficiency was compounded by Jimmy's ability to access a hanging point.

Shortcomings are not unique to PJC

14. The deficiency and failure to remove ligature points are not unique to PJC. Sadly, other coronial investigations have identified similar problems.

15. I endorse the recommendations of Coroner Hodgson following an inquest conducted by her into the death of Matthew Spalding (2156/09).

Eastern Health response

Changes relating to observations

16. The practice of routinely downgrading observations overnight to 60 minutes at South Ward, PJC has been eradicated.

17. It is now clearly mandated, by way of a Functional Observations Policy, that observations cannot be downgraded without the imprimatur of the treating consultant psychiatrist and documentation of the same in the clinical notes. Further, the Functional Observations Policy has been promulgated to all current nursing staff and is promulgated as part of the induction of new nursing staff.

18. PJC has developed a current observations stamp which is placed into a patient's notes and which must be signed by the consultant psychiatrist prior to any downgrading of observations from 15 minutes. Without the presence of this signed stamp, observations cannot be downgraded.

19. PJC now has separate patient files for observations and clinical notes. The observation files are colour coded in yellow and are designed to aid compliance with faithfully carrying out observations as directed by the consultant psychiatrist.

20. Eastern Health has developed a new Functional and Visual Observations Chart, which,

rather than being a tick box chart, requires documentation of the exact time of observation, the location of the patient and the activity of the patient. Further, a process of functional observations has been introduced which encourages interaction with the patient at the time of observation as a form of continuing risk assessment.

21. The handover system at PJC has now been strengthened. Handovers between nursing staff occur at the change of each shift. At such handovers, each nurse is provided with a typed Handover Sheet which contains details of the Mental Health Act status, physical location on the ward, observation levels (in accordance with assessed level of risk), falls risk, current mental health status, current medical/physical issues, allied health issues, diet, activities of daily living, daily notes and discharge plan of each of the patients on the ward.

22. The handover occurs in front of the patient journey board (a white board located in the nursing station). The journey board mirrors the information contained on the Handover sheet.

23. In addition to the nursing handovers, at 9am each day a further handover occurs which is attended by the Nurse Unit Manager, consultant psychiatrists, allied health professionals and nursing staff. This handover occurs in front of the journey board and the level of observations of each patient are actively reviewed.

24. South Ward is a 30 bed unit. Routinely there are 3 nursing staff on duty overnight. However, a policy is now in place that enables the deployment of an additional staff member for the overnight shift should there be 7 or more patients on 15 minute observations.

25. In order to ensure compliance with observations, a quarterly observation audit is carried out. Such audit is undertaken by staff from other Eastern Health mental health programs to ensure quality control. In addition, the Nurse Unit Manager undertakes regular random reviews of patient observation charts. Non compliance with the performance and documentation of the mandated observations is considered a disciplinary offence.

Changes relating to ligature points

26. Following this tragic event, a best practice ligature point audit was carried out at PJC.

27. Various ligature points were identified and remedied including:

(i) Removal of window winders in bedrooms;

(ii) Modification of air vents in bedrooms to collapsible air vents;

(iii) Modification of curtain rails to non weight bearing curtain rails;

(iv) Removal of cupboard doors;

(v) Changing door handles;

(vi) Replacement of plastic bags with paper bags;

(vii) Removal of sharp paper towel cutters;

(viii) Lowering of toilet roll holders and soap dispensers in toilets and bathrooms; and

(ix) Removal of clothes hooks in toilets and bathrooms.

28. An annual best practice ligature point audit is carried out at PJC which involves differing external agencies in order to "cast fresh eyes" at each review. Modifications have continued to occur following such annual audits.

Conclusion

29. I accept counsel's submission that Eastern Health takes patient safety seriously and has made systemic changes aimed at preventing events similar to Jimmy's tragic death in the future. Further, that Eastern Health remains vigilant in ensuring the changes that have taken place continue to be adhered to and will continue to improve upon such changes where necessary.

Post Mortem Medical Examination

30. On the 16 September 2010, Dr Michael Burke, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed an autopsy on the body of James Falzon.

31. Dr Burke found the cause of death to be hanging.

32. Dr Burke commented:

"Mr James Falzon was a 65 year old man who, according to the circumstances as detailed in the Victoria Police Report of Death Form No. 83, was a voluntary inpatient at a psychiatric institution. Mr Falzon was in a shared room. The deceased's room mate found Mr Falzon hanging from a window winder at approximately 2340 hours after waking up and going to the toilet. Mr Falzon was extricated from the hanging position by a nurse who initiated cardiopulmonary resuscitation. An ambulance was contacted however resuscitation was unsuccessful.

The postmortem examination showed an abraded injury to the neck with associated fracture of the superior cornu of the thyroid cartilage (larynx). The features were typical of hanging. There were no other injuries to suggest the involvement of any other person in the death.

Toxicological examination showed no evidence of alcohol. Risperidone, mirtazepine, olanzapine, and temazepam were identified within blood."[5]

Finding

I find the cause of death of James Falzon to be hanging.

I direct that a copy of this finding be provided to the following:
Mrs Antonia Falzon, next of kin
Constable Ryan Abbenhuys, Nunawading Police Station, Investigating Member
Eastern Health
The Office of the Chief Psychiatrist

Signature:

JOHN OLLIE
CORONER
Date: **23 August 2013**

Coroners Court of Victoria

[5] Comments section, Dr Burke's report