IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 2320

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of:	Joseph Pezzimenti
Delivered On:	8 December 2016
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street Southbank Melbourne 3006
Hearing Dates:	8 & 9 February 2016
Findings of:	Coroner Caitlin English
Representation:	Mr Regos, representing Mercy Health Mr Hamilton, of Counsel Instructed by Nowicki Carbone representing the Pezzimenti family
Counsel Assisting the Coroner:	Leading Senior Constable Stuart Hastings

I, Caitlin English, Coroner, having investigated the death of Joseph Pezzimenti

AND having held an inquest in relation to his death on 8 & 9 February 2016
at Melbourne
find that the identity of the deceased was Joseph Pezzimenti
born on 7 March 1953
and the death occurred on 28 May 2013
at Royal Melbourne Hospital, Parkville
from:

1 (a) GLOBAL CEREBRAL ISCHAEMIA POST CARDIAC ARREST IN THE SETTING OF NECK COMPRESSION

in the following circumstances:

Introduction

1. Joseph Pezzimenti was a 60 year old man who was an involuntary patient at the Werribee Mercy Psychiatric Unit. On 23 May 2013 he was found hanging by the neck from a cord which was attached to a shower tap in his bathroom. Following attempts to resuscitate him, he was transferred to Royal Melbourne Hospital where he later died on 28 May 2013.

Reportable Death

2. Mr Pezzimenti's death is a reportable death pursuant to section 4(2)(a) of the *Coroners Act* 2008 (Vic) (the Act) as his death was '*unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury*'.

3. His death is also reportable pursuant to section 4 (2)(c) of the Act as immediately before his death he was a person '*in care*' as he was an involuntary patient pursuant to the *Mental Health Act* 1986 (Vic).

Mandatory Inquest

4. As Mr Pezzimenti was '*in care*' at the time of his death an inquest is mandated by section 52(2) (b) of the Act.

Focus of the Inquest

5. The purpose of a coronial investigation is to find if possible, the identity of the deceased, the medical cause of death and the circumstances in which the death occurred, in accordance with section 67 of the Act.

6. In this case, identity and cause of death are not in issue.

7. The inquest focused on the circumstances in which Mr Pezzimenti's death occurred.

8. 'Circumstances' refers to the background and events proximate to the death. Whilst the inquiry is not confined to matters of strict causation, neither does it extend to include all circumstances, which might be part of the narrative culminating in death. [1]

9. On 18 November 2015 a Directions Hearing was held to clarify the focus of the Inquest and the witness list.

10. The two main issues to be canvassed at inquest were;

    - the reliability of the risk assessment and mental state examinations in the context of Mr Pezzimenti's reduced communication and,
    - Mr Pezzimenti's access to a ligature, namely the cord from his trackpants.

Personal & health history

11. Mr Pezzimenti was born in Ferrazzano, Italy. He migrated to Australia when he was 7 years old and was raised in Dallas and Moonee Ponds. He married his wife, Janice Pezzimenti, in 1976 and lived in Ascot Vale for 19 years. Together they had three daughters, Gina, Melissa and Elizabeth.

12. Mr Pezzimenti was a qualified mechanic and had previously also worked as a professional boxer and in the security industry. In 1989 he commenced at General Motors in Fisherman's Bend where he worked for a period of 16 years. In approximately 1999 he suffered a shoulder injury at work and he was placed on Work Cover until he was transferred to an office job.

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[1] Thales Australia Limited v The Coroners Court of Victoria and Anor [2011] VSC 133 (11 April 2011).

13. In 2003, Mr Pezzimenti injured his back at work whilst moving boxes. In 2009 he received a workplace settlement.

14. In 2010 Mr Pezzimenti's mental health began to rapidly decline.

15. Mr Pezzimenti's medical history was summarised:

> *'He had a long history of Major Depressive Disorder, Acquired Brain Injury (secondary to previous occupation as a boxer) and somatisation disorder with a number of previous hospital admission[s]...A chronic risk with suicidal ideation and impulsive acts.'* [2]

16. On 7 August 2010, Mr Pezzimenti attempted suicide for the first time by trying to choke himself. His wife intervened and he was transferred to the Werribee Psychiatric Ward. Mr Pezzimenti underwent ten Electroconvulsive Therapy sessions.

17. On 8 February 2011, Mr Pezzimenti attempted suicide for a second time by drinking weed killer. He was transferred to the Emergency Department at Footscray Hospital. He spent months in hospital recovering.

18. In August 2012, Mr Pezzimenti made a third suicide attempt by trying to choke himself. He was transported to Footscray Hospital and then Werribee Psychiatric Ward.

Summary of events proximate to death

19. From 1 March 2013, Mr Pezzimenti was residing at the Mercy Health Community Care Unit, Werribee, where he was part of a rehabilitation program.

20. On 20 May 2013, his treating psychiatrist Dr Okedara planned to transfer him to the Emergency Department at Werribee Mercy Hospital. This was because he appeared very anxious and reported hopelessness. He was agitated and complained of pain in his head and of not being able to talk. Dr Okedara formed the view his suicide risk had increased.

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[2] Statement of Dr Simon Boyd, Page 23, Coronial Brief.

21. After initially agreeing to the transfer, Mr Pezzimenti changed his mind, however he was ultimately transferred under the *Mental Health Act* (1986) as an involuntary patient.

22. According to Dr Okedara, the goals of the transfer were to provide a secure environment for him in Emergency Department or the High Dependency Unit and to enable electroconvulsive therapy to be administered.

23. On 22 May 2013 following two days in the Emergency Department, he was transferred to the Psychiatric Inpatient Unit.

24. That evening, Psychiatric Registrar Dr Shanti Weerasiri reviewed Mr Pezzimenti in the Low Dependency Unit. Communication was difficult as Mr Pezzimenti was not able to speak, he mouthed his words and indicated he had lost his voice.

25. Although Dr Weerasiri's assessment was restricted by Mr Pezzimenti's presentation, she formed the view it was appropriate for him to remain in the Low Dependency Unit, ordered his medication to remain the same and to continue close monitoring of his suicide risk.

26. At 10 am on 23 May 2013, Mr Pezzimenti was reviewed by Dr Boyd with Nurse Jessica Goodman. He was still unable to speak, only mouthing words. Dr Boyd endorsed 30 minute observations and noted no overt risks currently displayed.

27. At 1.45 pm on 23 May 2013 Nurse Vince Fresnido was looking for Mr Pezzimenti who was due for medication at 2pm, could not find him in his bedroom. He checked the bathroom and found Mr Pezzimenti in a sitting position against the bathroom wall with what looked like a cord around his neck.

28. He called a Medical Emergency Team (MET) alert. Nursing staff commenced resuscitation. The ambulance attended. Mr Pezzimenti was transferred to Royal Melbourne intensive care where he died on 28 May 2013.

Sources of evidence

29. This finding is based on the material obtained through the coronial investigation, including the coronial brief and statements. Mr Pezzimenti's death was reported to the Coroners Court when he died in Royal Melbourne Hospital so the coroner's investigator did not attend the scene at Werribee Hospital Psychiatric Inpatient Unit.

30. The other main source of evidence was from the witnesses who were called at the inquest and the tendered exhibits. Six witnesses gave evidence who were Mr Pezzimenti's treating medical staff including the Director of Clinical Services from Mercy Health.

31. A number of internal policy documents from Mercy Health were tendered including Mercy Health Mental Health Risk Assessment and Management Planning Procedure (Exhibit 7) and Psychiatric In-patient Risk Assessment and Visual Observations Procedure (Exhibit 8).

32. I have also taken into account the two letters received from Mrs Pezzimenti dated 19 July 2013 and 26 August 2013 together with the accompanying diary notes and documents.

33. Coronial findings must be made as to the proof of relevant facts on the balance of probabilities. In determining whether a matter is proven to that standard, I should give effect to the principles in *Briginshaw v Briginshaw* [3] when considering the weight of evidence.

Cause of death

34. Dr Kate Strachan, Forensic Pathologist at the Victorian Institute of Forensic Medicine conducted an autopsy on 4 June 2013. Dr Strachan formulated the cause of death as 1 (a) Global cerebral ischaemia post cardiac arrest in the setting of neck compression. I accept her opinion.

[3] (1938) 60 CLR 336

35. Dr Strachan noted in her report that Mrs Pezzimenti had contacted the Coroners Court and asked for an investigation to establish the underlying cause of Mr Pezzimenti's neurological and mood symptoms.

36. Mr Pezziment's brain was examined by Associate Professor Penny McKelvie at St Vincent's Hospital for formal neuropathological examination. Ischaemic changes were identified as consistent with having been sustained on 23 May 2013, there was no evidence of underlying encephalopathy [4] or overt frontotemporal lobe dementia.

Evidence at Inquest

Chronology of Mr Pezzimenti's treatment

- **Community Care Unit and transfer to Emergency Department**

37. Dr Adegoke Okedara, Consultant Psychiatrist at the Community Care Unit (CCU) made a statement and gave evidence at Inquest.

38. Mr Pezzimenti was a resident at CCU from 1 March 2013 until his transfer on 20 May 2013.

39. Dr Okedara described CCU as a rehabilitation facility whereby clients live in units with one or two others, with their own kitchen facilities and a central living area. Clients participate in activities aimed to keep them physically and socially active, and Mr Pezzimenti's stay was intended to improve his psychosocial functioning. He was also treated with psychotropic medications.

40. Dr Okedara noted whilst in CCU Mr Pezzimenti's '*...mental state fluctuated and cognitive complaints were inconsistent. Anxiety symptoms were quite prominent.*' [5]

41. His stay at CCU was not uneventful.

42. On 25 March 2013 Mr Pezzimenti required 1:1 'special' nursing in CCU, '*due to concerns about risks of impulsively attempting suicide.*' [6]

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[4] This is a general term meaning brain disease, damage or malfunction. The major symptom of encephalopathy is an altered mental state. The causes of encephalopathy are varied and include infection, liver damage, anoxia (absence of oxygen supply) or kidney failure.

[5] Coronial Brief, statement Dr Okedara p 19.

43. On 2 April 2013 he was taken to the Emergency Department for *'suspected catatonic symptoms'* and was transferred back to CCU on 4 April 2013.

44. He was given Lorezepam and although his physical symptoms resolved, Dr Okedara stated he became *'disinhibited as he was talkative and over familiar.'*[7]

45. He was still on a Lorezepam trial when on 22 April 2013 Mr Pezzimenti was found by staff with wads of toilet paper in his mouth, he explained he was trying to relieve the dryness he was experiencing. In her letter dated 19 July 2013 Mrs Pezzimenti stated he had been trying to choke himself and throwing up the toilet paper.

46. Dr Okedara stated the Lorezepam trial was then discontinued owing to these two instances of disinhibition and unusual behaviour. [8]

47. On 18 May 2013 Mr Pezzimenti had injuries to his forehead which staff suspected to be self-inflicted. He was taken by his wife to the Emergency Department. He was transferred back to CCU after being medically cleared on the same day. [9]

48. On 20 May 2013 Dr Okedara formed the view Mr Pezzimenti's:

> *'...risk of suicide had increased because he actually wanted to die and did not disclose details and he appeared quite agitated.'* [10]

49. Because of the increased suicide risk, Dr Okedara wanted Mr Pezzimenti to be admitted to a more secure setting, namely the High Dependency Unit, or, if a bed was not available, the Emergency Department where he would receive 1:1 nursing.

50. His plan for treatment was that Mr Pezzimenti be admitted to a more secure setting (either the Emergency Department or the Psychiatric Inpatient Unit (the

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[6] Coronial Brief, statement Dr Okedara p 19.

[7] Coronial Brief statement of Dr Okedara p 19.

[8] Coronial Brief statement Dr Okedara p 19.

[9] Coronial Brief statement Dr Okedara pp 19-20.

[10] Transcript p 10.

High Dependency Unit)) and be treated with right unilateral Electroconvulsive Therapy (ECT). [11]

51. Dr Okedara discussed Mr Pezzimenti's increased risk at the consultants' meeting on 20 May 2013. He recommended the admission to which there was collective agreement. Dr Okedara described Mr Pezzimenti's risk of self-harm and suicide as 'high.'

52. Dr Okedara stated he communicated information about Mr Pezzimenti's risk to the Emergency Department by speaking with the Emergency Liaison Nurse '*who's the link between the community and inpatient/emergency psychiatric services of the hospital.*' [12] He stated both a CCU nurse and Mr Pezzimenti's file accompanied him to the Emergency Department.

53. Dr Okedara's notes indicated he had discussed the plan for transfer to the Emergency Department with Mr and Mrs Pezzimenti prior to the consultants' meeting and they agreed with the plan.

54. Dr Okedara stated in cross examination that, with respect to Mr Pezzimenti going to the High Dependency unit, '*...once he left my care he would have to be reviewed...and they'll have to make the call as to what happens subsequently.*' [13]

55. Dr Okedara agreed Mr Pezzimenti's risk fluctuated from time to time and that he did not expect him to be transferred to the High Dependency Unit irrespective of any changes in his presentation.

56. Mr Pezzimenti subsequently changed his mind about the transfer to Emergency Department and was transferred as an involuntary patient.

57. Dr Okedara indicated he was not surprised Mr Pezzimenti was in the Low Dependency Unit on 23 May 2013 because '*there was a history of fluctuation in his mental state.*' [14]

- **Emergency Department**

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[11] Coronial Brief statement Dr Okedara p 20.

[12] Transcript p 13.

[13] Transcript p 18.

[14] Transcript p 29.

58. On 22 May 2013 Mr Pezzimenti was in the Emergency Department awaiting a bed in the Psychiatric Inpatient Unit. He was reviewed by psychiatric registrar Dr Raja Sadhu as part of a regular review and to arrange preparations for his ECT. He was reviewed on the one occasion by Dr Sadhu, who estimated the review took about 20 minutes.

59. Dr Sadhu assessed Mr Pezzimenti as a high risk for suicide, self-harm, self-neglect, treatment non engagement and medical problems. He asked for a medical review of his abnormal abdominal X-ray and after discussing his management with the consultant, he continued with the same psychotropic medications and ordered investigations to prepare him for ECT while awaiting transfer. These included a full blood examination, urea and electrolytes, ECG and chest X-ray. [15]

60. At Inquest, Dr Sadhu was unable to say whether Mr Pezzimenti's file from CCU had reached the Emergency Department at that point. [16] He was also unclear as to whether Mr Pezzimenti received 1:1 nursing for the entire time he was in the Emergency Department. [17] He could not recall what nursing arrangements were in place on either the day Mr Pezzimenti arrived at the Emergency Department or the day he assessed him.

61. In her letter dated 26 August 2013 Mrs Pezzimenti stated that upon transfer to the Emergency Department Mr Pezzimenti spent '*two days waiting in a cubicle, unguarded or supervised...*'

62. Between 20-22 May 2013 Mrs Pezzimenti received many phone calls and text messages from Mr Pezzimenti and she stated '*I could see that he felt extremely scared and worried that he was about to do something bad.*' [18]

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[15] Coronial Brief statement Raja Sadhu p 41.

[16] Transcript p 38.

[17] Transcript p 41.

[18] Coronial Brief statement Janice Pezzimenti p 14.

- **Transfer to Psychiatric In Patient Unit and assessment**

63. On 22 May 2013, sometime between 5pm and 9 pm Mr Pezzimenti was assessed by Dr Shanthi Weerasiri, psychiatric registrar, in the Psychiatric Inpatient Unit. She estimated the assessment took about 35-40 minutes. [19]

64. Dr Weerasiri stated that when she assessed Mr Pezzimenti, '*...he could not produce voice and communication was by mouthing words.*' [20]

65. Dr Weerasiri stated:

    '*When directly questioned on his suicidality he gestured with hands some ambivalence of those thoughts, indicating to me that although suicidal thoughts were present it was not the main concern to him. He appeared anxious and I gleaned a sense of helplessness in him.*' [21]

66. When asked in examination to explain this assessment, Dr Weerasiri stated that it was '*mostly the voice that he was pointing to and when I did actually question him about the suicide he said- he just gestured with his hand like this.*'[22]

67. When asked to describe what Mr Pezzimenti was doing with his hand, Dr Weerasiri stated: '*...he just wavered his hand like this - and then immediately went to his throat and said that it's the voice...he was focussed on the loss of voice.*' [23]

68. With respect to the decision for Mr Pezzimenti's placement in the Low Dependency Unit, Dr Weerasiri initially stated in evidence it that she did not know whose decision it was, '*but it's usually the Emergency Liaison Nurse, who...liaises with the ward staff to place him prior to the medical assessments.*'[24]

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[19] Transcript p 62.

[20] Coronial Brief statement Dr Weerasiri p 42.

[21] Coronial Brief statement Dr Weerasiri p 42.

[22] Transcript p p 48-9.

[23] Transcript p 49.

[24] Transcript p 50.

69. She believed his placement in the Low Dependency Unit was appropriate because she did not believe Mr Pezzimenti's concern at the time was to suicide, but rather he was concerned about his voice. She did not observe any agitation.

70. After some questioning, Dr Weerasiri indicated that in fact she had recommended Mr Pezzimenti for the Low Dependency Unit. She confirmed under examination by Mr Regos that part of her role was to assess Mr Pezzimenti's suitability for the Low or High Dependency Unit. [25]

71. Dr Weerasiri stated she was aware Mr Pezzimenti's level of risk fluctuated very rapidly and that he was a high risk but stated at the time of his assessment she was of the view he could be managed in the Low Dependency Unit.

72. Dr Weerasiri was not familiar with the Mercy Health Mental Health Risk Assessment and Management Planning Procedure. (Exhibit 7)[26]

73. Dr Weerasiri agreed in cross examination by Mr Hamilton that despite Mr Pezzimenti's history of suicide attempts, of which she was aware, and the referral from CCU and the problems she faced communicating with Mr Pezzimenti, she still assessed him as suitable for the Low Dependency Unit.

74. She did not turn her mind to Mr Pezzimenti's risk from potential ligatures,[27] although she noted he was walking around in bare feet, so stated she was confident he did not have access to shoe laces. When pressed about this further, she indicated she did not turn her mind to other dangers, such as his tracksuit cord, and was '*not 100% sure*' who checks for potential ligature items. [28]

75. Dr Weerasiri did not know what the policy was regarding the removal of potential ligature items in the Low Dependency Unit. She did not know whether potential ligature items are removed to minimise risk in the Low Dependency Unit. [29]

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[25] Transcript p 62.

[26] Coronial Brief pp 44-53.

[27] Transcript p 57.

[28] Transcript p 67.

[29] Transcript p 68.

76. In examination by Mr Regos, Dr Weerasiri stated her assessment mainly focussed on Mr Pezzimenti's risk factors and that part of her assessment was whether he should be in the High or Low Dependency Unit.

77. Other strategies available for the safety of a patient included observation levels and Mr Pezzimenti was placed on the highest level of observations in the Low Dependency Unit, which was every 30 minutes.

78. Dr Weerasiri in re-examination stated she believed Mr Pezzimenti was a chronically high risk of suicide, but not an imminent risk and she believed the risk was contained at the time.

- **Further risk assessment in the Psychiatric Inpatient Unit**

79. Dr Simon Boyd was the medical officer allocated to Mr Pezzimenti upon his admission.

80. On 23 May 2013 at 10 am Dr Boyd interviewed Mr Pezzimenti with nurse Jessica Goodwin in an interview room in the Low Dependency Unit. The purpose of the interview was to conduct a mental state examination.

81. In his statement Dr Boyd indicated he reviewed Mr Pezzimenti's file prior to interview. He confirmed this in his evidence. He was aware of Dr Okedara's recommendation, of Mr Pezzimenti's long history of major depressive disorder, and '*It was documented that there was a chronic risk with suicidal ideation and impulsive acts.*' [30]

82. In cross examination it transpired Dr Boyd had reviewed Mr Pezzimenti's last three days of file notes and was not aware of his previous suicide attempts or methods employed in 2010, 2011, 2012 or 2013. [31]

83. When interviewing Mr Pezzimenti, Dr Boyd explained:

'*It was a difficult interview to conduct because of Joseph's lack of audible communication. He was gesturing to his throat indicating that he could not*

[30] Coronial Brief, statement Simon Boyd p 21.

[31] Transcript p 81.

speak, but at other times during the interview he would whisper or answer in a quiet voice.' [32]

84. In examination Dr Boyd stated Mr Pezzimenti expressed himself through '*a combination of gestures, whispering and a soft voice...if I asked a certain question he would either shake his head or nod or use his hands.*' [33] Dr Boyd stated he used actual words and he could make out what he was saying.

85. He assessed his risk of suicide as:

'*...at the time I thought that there were no overt risks in regards to his acute mental state at that point.*' [34]

86. Dr Boyd was questioned intently about the reliability of his mental state examination and risk assessment in the context of Mr Pezzimenti's limited responses and how it was he came to his conclusions. Dr Boyd stated:

'*...he wasn't forthcoming and he ... wasn't speaking as much and he was saying 'I don't know' a lot and so that's why I spent quite a bit of time with him trying to elicit that information and... towards the latter half of the review he was talking more, or whispering more, and...he gave me that...feeling – oh, well, as I said before he ... through a combination of whispering and gesturing told me that that was not the case, that he wasn't feeling suicidal at that point...*' [35]

87. When asked if he was a risk of suicide he stated:

'*He's obviously a risk because I knew that he had ...a chronic suicidal risk and he was in hospital as an involuntary patient, but at that point I thought that the risk wasn't acute and I felt there was no need to change the management that had already been in place so I continued the LDU and I continued ... the 30 minutely observations.*' [36]

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[32] Coronial Brief statement Simon Boyd p 21.

[33] Transcript p 75.

[34] Transcript p 76.

[35] Transcript p 78.

[36] Transcript p 78.

88. In response to questioning as to how Mr Pezzimenti made 'denials' about current thoughts of self-harm or suicidal ideation, Dr Boyd stated:

> *'I'm not sure whether he told me or he whispered to me ...but I remember spending quite a bit of time on it and that's why ...it was more of a prolonged review than it would be with a standard patient because I wanted to get that information from him, so by the end of the review I was feeling confident from what he communicated to me that that was the case.'* [37]

89. Dr Boyd also considered that Mr Pezzimenti was compliant and willingly spoke to him and seemed to engage more as the interview progressed. His compliance was a factor he took into account when considering his suitability for the Low Dependency Unit.

90. The team Mr Pezzimenti was allocated to upon his admission comprised Dr Boyd and consultant psychiatrist Dr Amy Rooke who was not working on 23 May 2013. In his evidence Dr Boyd was unsure if she was able to be contacted on her day off.

91. In cross examination by Mr Hamilton, Dr Boyd was not familiar with the Mercy Health Mental Health Risk Assessment and Management Planning Procedure, (Exhibit 7) or the Mercy Health Psychiatric Inpatient Risk Assessment and Visual Observations Procedure, (Exhibit 8).

92. Dr Boyd did not appear to have turned his mind to the appropriateness of Mr Pezzimenti having access to potential ligature items. He stated he did not make an observation '*...whether he had a trackpant belt or a cord or anything, that was not something I was aware of.*' [38] He was not sure about what the policy was that applied to those types of items in the Low Dependency Unit. [39]

93. In cross examination Dr Boyd was confident that in his assessment of Mr Pezzimenti at the time his suicidal risk was not acute [40] and it was appropriate for him to be in the Low Dependency Unit. [41]

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[37] Transcript p 91.

[38] Transcript p 80.

[39] Transcript pp 80-81.

[40] Transcript p 86.

94. Nurse Jessica Goodwin was present at Dr Boyd's assessment of Mr Pezzimenti. Nurse Goodwin had nursed Mr Pezzimenti at least two or three times previously and believed she had a fairly good rapport with him.

95. Nurse Goodwin was familiar with Mr Pezzimenti having presented in the past with difficulties with his voice, and whooshing in his head and ringing in his ears. She stated his behaviour during his assessment with Dr Boyd was no different to that which she had previously experienced. [42]

96. Nurse Goodwin recalled Mr Pezzimenti being asked if he had any suicidal idealtion and she was confident the mental health assessment was accurate. She also indicated she could understand what Mr Pezzimenti was '*trying to get across...you could hear there was an audible whisper.*' [43]

97. Nurse Goodwin stated:

> '*...if we felt he was an imminent risk we would have walked him through to HDU, taken all his cords off, all his shoelaces off. We react very quickly if we assess and believe that it's an imminent risk and Joseph who I had nursed previously on other accounts presented as chronic yes, but not immediate acute risk to his health at that moment.*' [44]

98. With respect to whether she considered potential ligatures, Nurse Goodwin stated, '*...if we're placing him in LDU and you're assessing him as a chronic suicidal risk but he's expressing that he has no suicidal ideations or intent at that point, there was no need for me to remove any shoes, shoe laces, ligatures, things like that.*' [45]

99. Mr Pezziment was on 30 minute observations ordered by Dr Boyd. His Inpatient Risk and Visual Observations Form (Exhibit 10) indicates he was assessed as medium risk of suicidality and self-harm and the policy for Mercy

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[41] Transcript p 87.

[42] Transcript p 106.

[43] Transcript p 108.

[44] Transcript p 111.

[45] Transcript p 112.

Mental Health Risk Assessment and Visual Observations procedures states for medium risk observations are to be at a minimum of 60 minutes. [46]

- **Evidence from the Clinical Services Director, Mental Health Services Mercy Public Hospital.**

100. Dr Dean Stevenson provided two statements and gave evidence at the Inquest. He was not directly involved in Mr Pezzimenti's care but is responsible for Clinical Services.

Evidence about the Psychiatric Inpatient Unit

101. He described the Psychiatric Inpatient Unit as comprising the Low Dependency Unit which has 23 beds which are located in single and shared rooms, and the High Dependency Unit, a six single bed unit. He noted the High Dependency Unit is starkly furnished, with the purpose of providing a low stimulus environment. The furnishings are sparse, furniture is bolted to the floor and the television is high mounted on the wall. The external courtyard is surrounded by high walling. There is a small uncarpeted lounge area. The focus is on containment. [47]

102. When applying the obligations of least restrictive environment under the *Mental Health Act*, Dr Stevenson stated the first consideration is whether a person can be treated as a voluntary patient, and the next consideration is whether they are able to be treated in the Low Dependency Unit or the High Dependency Unit.

Applicable Policies

103. He indicated the Mercy Mental Health Risk Assessment and Management Planning Procedure was introduced in 2012 and regular staff training was part of the education calendar.

104. The High Dependency Unit Management Procedure (Exhibit 13) was developed in August 2013 and was introduced into practice in early 2014. He stated:

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[46] Transcript p 116.

[47] Transcript pp 147-8.

'This procedure outlines the admission, transfer and discharge criteria, practices and responsibilities of staff in the High Dependency Unit. Although this procedure does not directly address the assessment of patients for low and high dependency unit, it does provide guidance on the processes relating to admission to the HDU and transfer from the HDU to the LDU.' [48]

105. Dr Stevenson was asked his response to evidence that Dr Weerasiri and Dr Boyd were unaware or unfamiliar with both the Mercy Mental Health Risk Assessment and Management Planning Procedure (Exhibit 7) and the Mercy Mental Health Risk Assessment and Visual Observations Procedure (Exhibit 8)

106. His response was that his staff work from the 'tools,' such as the nine page risk assessment tool and the risk assessment form and visual observations form, so staff use the forms, or tools, as a way of applying the policies. [49]

Changes following Mr Pezzimenti's death

107. After Mr Pezzimenti's death, the following changes were implemented: the ligature audit procedure was completed in July 2013, tap ware was replaced with ligature proof fittings, [50] and a ligature audit was conducted in June 2013. Dr Stevenson's evidence was that work continues with ligature risk review and action to remedy identified ligature risks and pursuant to the ligature audit procedure the ward is audited each year for any ligature points.[51] The policy focuses on structures within the unit rather than clinical practices.

108. When asked about ligature points, Dr Stevenson indicated ligature audits in 2008 and 2009 did not identify the taps as a risk at that time, however curtain railings had been identified and replaced. Further, some doors had been replaced with curtains. New building projects were underway to secure a purpose built unit. Dr Stevenson described it as an '*...on-going challenge...trying to balance...a therapeutic environment with a safe environment...taking into consideration patient ingenuity.*' [52]

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[48] Coronial Brief Statement Dean Stevenson p 36.

[49] Transcript p 134.

[50] Transcript p 141.

[51] Transcript p 137.

[52] Transcript p 142.

Clinical records

109. Dr Stevenson noted one of the challenges concerns the clinical records as the services provided by Mercy Health are scattered across the western suburbs, '*there are times when the patient arrives before the file arrives.*' [53] An example of this problem is that Dr Boyd did not have access to Mr Pezzimenti's CCU file nor Dr Okedara's treatment recommendations, nor knowledge of his previous suicide attempts and methods.

110. Dr Stevenson detailed Mercy Health's plan to move to electronic medical records to solve the difficulties of paper records following patients as they use mental health services that are scattered across the western suburbs.

111. Dr Stevenson indicated that present practice is such that if a patient in the CCU needs admission, the medical treatment plan would be faxed to the triage service in the Emergency Department so the notes would be there when the patient arrived.

Response to evidence at Inquest

112. With respect to evidence that a ligature risk was not considered by staff who assessed Mr Pezzimenti, Dr Stevenson stated that was not part of the consideration because Mr Pezzimenti was assessed as a chronic risk, but not an imminent risk.

113. Because of the mix of patients in the Low Dependency Unit, Dr Stevenson stated that if access to ligatures is seen as a problem, then those patients need to be managed in the High Dependency Unit.

114. Dr Stevenson confirmed that Nurse Goodwin was not solely responsible for the completed risk assessment (Exhibit 10). She had assessed Mr Pezzimenti as a 'medium' suicide risk and she has recorded 30 minute observations, as set earlier by Dr Boyd. [54] This is the highest level of observations applicable in Low Dependency Unit. Any higher level of observations would require transfer to the High Dependency Unit. [55]

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[53] Transcript p 130.

[54] Transcript p 146.

[55] Transcript p 146.

115. Dr Stevenson indicated with the enormous growth in demand for services in the western suburbs, a 24 hour wait in Emergency Department is not unusual.

116. Dr Stevenson was asked about specific training available for staff interviewing someone who, like Mr Pezzimenti was at times mute and unable or reluctant to communicate. He stated:

'*...I think that this kind of issue of very difficult patients who are very very unwell, I think that's more on the job kind of experience. Being exposed to... patients who are unwell is the best learning tool.*' [56]

Chief Psychiatrist's guideline: Criteria for searches to maintain safety in an inpatient unit

117. Dr Stevenson was aware of the Chief Psychiatrist's guideline from July 2014 regarding Criteria for searches to maintain safety in an inpatient unit.

118. Dr Stevenson was asked about Mercy Health's response to the Chief Psychiatrist's guideline. He stated it has been implemented in the High Dependency Unit but: '*we've made a decision that in terms of working within a recovery framework that...it would be very difficult to remove all those items from patients.*' Dr Stevenson indicated that much thought had been given regarding implementation and they had 'tightened up' search processes.

119. Dr Stevenson was informed during the Inquest that North-Western Mental Health had accepted a recommendation by Coroner Spanos in her *Finding without Inquest into the death of CB* [57] that it change its policy that currently allowed patients in the Low Dependency Unit to retain items that are capable of being used a ligature. Dr Stevenson indicated in evidence he would be open to review the response Mercy Health had taken to the Chief Psychiatrist's guideline. [58]

Submissions

- Family's concerns

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[56] Transcript p 156.

[57] COR 2012 4587

[58] Transcript p 162.

120. Mr Hamilton, on behalf of the family argued I should find the medical management of Mr Pezzimenti, particularly by Dr Boyd, was an unsatisfactory standard, and contributed to his death. Secondly, medical staff use of policies was sub-optimal and contributed to Mr Pezzimenti's death. Thirdly, the polices of the Inpatient Unit regarding the Low and High Dependency Units and ligatures, were unsatisfactory; further, it was inappropriate to have Mr Pezzimenti in the Low Dependency Unit and inappropriate that he had access to a ligature.

121. Dr Boyd had not read Dr Okedara's notes from CCU. Dr Boyd did not have information about Mr Pezzimenti's previous suicide attempts which had involved the use of a ligature. Dr Boyd also admitted he had not seen the two policies in Exhibits 7 or 8. Further Dr Boyd had difficulties communicating with Mr Pezzimenti and did not seek to discuss those difficulties with a superior. Finally, Dr Boyd made no assessment of the risk of Mr Pezzimenti having access to potential ligatures.

122. Dr Weerasiri was not aware of the risk assessment policy (Exhibit 7). Other concerns raised with her treatment included her failure to adequately assess the suicide risk, her lack of consideration of ligature risks and her failure to contact Dr Okedara and involve him in Mr Pezzimenti's care.

123. Mr Hamilton criticised the hospital's lack of specific procedures that detail the assessment requirements for patients to be placed in either the High or Low Dependency Unit.

124. Further he raised concerns that there was a lack of ligature policy. He pointed to the lack of policy regarding removal of potential ligatures in the Low Dependency Unit, and the non-compliance with the Chief Psychiatrist's guideline.

125. In summary on behalf of the family he submitted there was an unsatisfactory standard of care by medical staff and a breakdown in communication. Further there was a lack of appropriate policies and implementation of policies. This, it was submitted, combined to contribute to Mr Pezzimenti's death.

- Mercy Health submissions

126. Mr Regos submitted Mr Pezzimenti's death was not attributable to any actions or omissions by Mercy Health staff.

127. Mr Pezzimenti was transferred from the Community Care Unit to the Emergency Department under direction from Dr Okedara. He then spent 20-22 May 2013 at the Emergency Department where he was seen by consultant psychiatrist Dr Manoj Kumar and on 22 May by psychiatric registrar Dr Raja Sadhu. He was transferred to the Psychiatric In-patient Unit in the Low Dependency Unit and assessed by Dr Weerasiri the same evening. She spent 45 minutes with him and determined he was appropriate for the Low Dependency Unit. She also placed him on 30 minute observations. The next morning he was seen by Dr Boyd and Nurse Goodwin. Dr Boyd did not note a deterioration and maintained him in the Low Dependency Unit with 30 minute observations.

128. All medical practitioners responsible for Mr Pezzimenti's care believed it was appropriate for him to be in the Low Dependency Unit.

Conclusions

129. Mr Pezzimenti had been under the care of Mercy Health at various times since approximately 2010 and had some 14 volumes of medical files recording his years of treatment.

130. Dr Boyd's evidence was that he had not seen Mr Pezzimenti's medical file, save for the previous three days. It was not clear whether Mr Pezzimenti's medical record had been transferred from CCU to Psychiatric Inpatient Unit, despite Dr Okedara's confidence his file would go with him to Emergency Department.

131. Dr Stevenson acknowledged there were difficulties with the patient's physical file not always following the patient. Continuity of care is important, and communication between treating medical staff is facilitated by the medical records. I note with the anticipated transfer to electronic records this problem will resolve over time. I am of the view this should be expedited.

132. I accept Dr Okedara's evidence that his assessment of Mr Pezzimenti's increased risk was not static nor was his proposed treatment plan. He expected Mr Pezzimenti would be re-assessed both in the Emergency Department and the Psychiatric Inpatient Unit.

133. I note however, that Dr Okedara's confidence about Mr Pezzimenti's file following him to the Emergency Department and that he would receive 1:1 nursing in the Emergency Department was not confirmed in evidence from other witnesses at Inquest.

134. I am satisfied the assessments by the two doctors and nurse who assessed Mr Pezzimenti following his transfer to the Psychiatric Inpatient Unit were reasonable and that they were able to communicate adequately with Mr Pezzimenti despite the restrictions caused by his loss of voice symptoms. I am satisfied about the reliability of the risk assessment.

135. The evidence supports the medical staff gave consideration to the challenges posed in communicating with Mr Pezzimenti. It is apparent he was not totally mute, but variable in terms of his oral output and the physical gestures he used to express himself.

136. Further I find their assessment that Mr Pezzimenti, although a chronic suicide risk, was not an imminent or an acute risk, and his placement in the Low Dependency Unit appeared to be clinically reasonable. There is no evidence to suggest he was physically agitated, aggressive or actively attempting self-harm behaviours.

137. Risk assessment is tested with regards to the current presentation of the risk, so a history of previous behaviour or deterioration whilst relevant, the main focus is present observations.

138. Although Dr Stevenson gave evidence of '*regular training days and...risk assessment training is part of the education calendar*,' there is clearly room for improvement so that medical staff are at least aware of the relevant procedure documents such as the Mental Health Risk Assessment & Management Planning Procedure and the Psychiatric Inpatient Risk Assessment and Visual Observations Procedure. Neither Dr Weerasiri nor Dr Boyd were sure what policy was applicable in the Low Dependency Unit was regarding potential ligatures.

139. While capacity to predict which patients are at risk of inpatient suicide is poor, the literature does suggest precautions can be taken by inpatient facilities to reduce the risk of inpatient suicide.[59]

140. Mr Pezzimenti was able to use his track pant cord as a ligature to hang himself, and there was no policy applicable to the Low Dependency Unit to remove potential ligature items from the environment.

141. There were no guidelines in place in Victoria at the time of Mr Pezzimenti's death. The Chief Psychiatrist developed a guideline in July 2014.

142. The circumstances of Mr Pezzimenti's death raises a similar issue to that in the *Finding with Inquest into the death of Maree Jones.* [60] In that case Ms Jones died after placing a plastic bag secured with her pyjama cord over her head. At the time she was an involuntary patient under the *Mental Health Act* in the Low Dependency Unit at St Vincent's Hospital.

143. By way of background, as a result of the recommendations in the Chief Psychiatrist's investigation of inpatient deaths 2008-2010, in 2014 the Chief Psychiatrist developed Guidelines - '*Criteria for searches to maintain safety in an in-patient unit - for patients, visitors and staff.*'

144. The Chief Psychiatrist from time to time issues guidelines to provide specialist advice on various aspects of clinical service and to inform mental health practitioners and services about the operation and clinical issues in relation to the *Mental Health Act 2014*.[61]

145. The Guideline, '*Criteria for searches to maintain safety in an in-patient unit - for patients, visitors and staff*' states that for patients admitted to an inpatient service: '*Dangerous and inappropriate items are objects or substances that are seen as unacceptable possessions for patients receiving treatment and care from a public mental health service because they have the potential to place themselves, visitors and staff at risk of harm to self or others... Dangerous*

[59] Chief Psychiatrist's investigation of inpatient deaths 2008-2010, Department of Health , p 12

[60] COR 2013 0655

[61] www.health.vic.gov.au

items may include any objects that could be used to assist in a suicide attempt (for example, plastic bags, scarves, belts, shoelaces or head phone cords).' [62]

146. On 2 February 2015, Coroner Spanos handed down her *Finding without Inquest into the Death of CB.* [63] In that case a young woman died from hanging by a scarf from a wardrobe door in the Broadmeadows In-patient Unit, North Western Mental Health.

147. Coroner Spanos made the following recommendation:

'I recommend that North West Mental Health change its policy that presently allows patients of the LDU to retain items that are capable of being used as a ligature to ensure that it complies with the Chief Psychiatrist Guideline on Criteria for searches to maintain safety in an in-patient unit for patients, visitors and staff.'

148. The response received from North West Mental Health dated 29 April 2015 stated that;

'On 3 September 2014 a memorandum (attachment 1) was issued to all NWMH staff outlining the removal of hazardous items in inpatient units which clearly addresses the need for staff to be vigilant regarding scarves and adhere to the Chief Psychiatrist Guideline on Criteria for searches to maintain safety in an in-patient unit for patients, visitors and staff.

149. In *Finding with Inquest into the death of Maree Jones* I recommended:

I adopt Coroner Spanos' recommendation 1 in the *Finding without Inquest into the Death of CB*[64] and urged St Vincent's Mental Health to change its current policy that allows patients in the Low Dependency Unit to retain items that are capable of being used as a ligature.

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[62] Chief Psychiatrist Criteria for searches to maintain safety in an inpatient unit - for patients, visitors and staff, p 5.

[63] COR 2012 4587. A copy of this finding and responses to recommendations can be found on the Coroners Court of Victoria website.

[64] COR 2012 4587. A copy of this finding and responses to recommendations can be found on the Coroners Court of Victoria website.

Further, to avoid confusion it is preferable for Acute In-patient Units to take a consistent approach on this point and I urge St Vincent's follows the position adopted by North West Mental Health.

150. In response to my recommendation St Vincent's Private Hospital stated, amongst other things:

'*SVMH (St Vincent's Hospital Melbourne) is satisfied that its current approach and policies for ensuring a safe environment for patients are consistent with the Chief Psychiatrist's Guideline. Having given due consideration to your recommendation, SVHM will also be implementing a specific ban on items, including ropes, scarves (excluding scarves used for religious or cultural purposes), including luggage straps, which will come into effect within the AIS (Acute Inpatient Service) from 1 August 2016.*'

151. I am of the view that the circumstances of Mr Pezzimenti's death supports the conclusion that the removal of potential ligature items from Psychiatric Inpatient Units will help ensure the safety of those patients for the duration of their stay.

152. With respect to Mr Pezzimenti's intent, Mrs Pezzimenti has stated that '*In all Joe's previous suicide attempts, he has always done it knowing he would be found and stopped.*'[65]

153. She expressed her belief that he did not genuinely mean to go through with what happened to the extent that he did, rather that he was frustrated with the lack of help and treatment he was receiving.

154. I have considered Mrs Pezzimenti's concerns as well as the trajectory of Mr Pezzimenti's illness and the circumstances of his death. I am satisfied however, that on this occasion on the balance of probabilities that Mr Pezzimenti engaged in the act that caused his death and had the necessary intent to end his own life. He had made multiple previous attempts on his life, some using a similar method. In this instance he has leant his weight against the tracksuit cord and was not naïve to the effects of strangulation. His mental state was not

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[65] Coronial Brief, statement Janice Pezzimenti p 15.

such that he was psychotic or hysterical and thus incapable of forming the intent. Mr Pezzimenti was also familiar with the routine of observations in the Low Dependency Unit and this unfortunately, mitigates against it being an attempt at attention seeking.

FINDING

I find that Joseph Pezzimenti died from 1 (a) Global cerebral ischaemia post cardiac arrest in the setting of neck compression in circumstances where he intended to end his own life.

RECOMMENDATION

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendations connected with the death:

1. I repeat the recommendation in *Finding with Inquest into the death of Maree Jones* where I adopted Coroner Spanos' recommendation 1 in the *Finding without Inquest into the Death of CB* [66] and urge Mercy Health to change its current policy that allows patients in the Low Dependency Unit to retain items that are capable of being used as a ligature.

   I refer to the Chief Psychiatrist's guideline *Criteria for searches in an inpatient unit* which states: '*For patients admitted to an inpatient service dangerous items may also include:...any objects that could be used to assist in a suicide attempt (for example, plastic bags, scarves, belts, shoe laces or headphone cords.)*'

   Further, to avoid confusion it is preferable for Psychiatric In-patient Units to take a consistent approach on this point and I urge Mercy Health to follow the position adopted by North West Mental Health and St Vincent's Hospital.

I direct a copy of this finding be distributed to:

Mrs Janice Pezzimenti

Mr Peter Hamilton Counsel for Mrs Janice Pezzimenti

Ms Melissa Pezzimenti

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[66] COR 2012 4587. A copy of this finding and responses to recommendations can be found on the Coroners Court of Victoria website.

Mr Michael Regos, DLA Piper on behalf of Mercy Mental health

Mrs Mariana Trajkovski, Comminsure

Dr Mark Oakley Browne, Chief Psychiatrist

Herbert Geer on behalf of WorkSafe

Signature:

CAITLIN ENGLISH
CORONER
Date: 8 December 2016