IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2007 / 3955

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: Kelvin Robert Davidson

Delivered On:	29 September 2014
Delivered At:	65 Kavanagh Street Southbank 3006
Hearing Dates:	20 January 2012
Findings of:	PETER WHITE, CORONER
Representation:	Mr I Davidson on behalf of the relatives of the deceased Mr B O'Shea on behalf of Alfred Health
Police Coronial Support Unit	Leading Senior Constable R Treverton

I, PETER WHITE, Coroner having investigated the death of Kelvin Robert Davidson

AND having held an inquest in relation to this death on 20 January 2012

at Melbourne

find that the identity of the deceased was Kelvin Robert Davidson

born on 26 November 1931

and the death occurred on 4 October 2007

at Baringa Psychiatric Facility at Caulfield Medical Centre

from:

1 (a) HANGING

in the following circumstances:

Background

1. Kelvin Davidson (Mr Davidson), aged 75 years was admitted to the Baringa Aged Psychiatric Inpatient Unit on 27 September 2007 at 4 pm. He had never been married and had no children. His sole next of kin was an elder brother, Irving Davidson, who visited him frequently.
2. Mr Davidson had a complex medical history, which included a lengthy list of physical complaints coupled with a less documented psychiatric history that included incidents, possibly dating back to his 20's. [1]
3. In February 2007, Mr Davidson was admitted to the Albert Road clinic where he engaged in violent self harming activity, which included the cutting of his wrists and an attempted hanging. He was subsequently made an involuntary patient after being transferred to the Emergency Department of the Alfred Hospital. Following his discharge from the Alfred, Mr Davidson spent time at the Royal Freemason Home and then lived at the Rosstown aged care facility.
4. At this time he was described in the following terms:

    'possessing a very dependant personality type with poor coping skills and a marked intolerance of any level of personal distress. He had an anxious personality and his independence was waning as he aged.'

[1] See exhibit 1 the statement of Psychiatric Consultant De Maria Tsanglis at page 1.

5. Mr Davidson voluntarily admitted himself to the Baringa Unit within Caulfield Hospital on 27 September 2007.

6. Initial observations by consultant psychiatrist, Dr Maria Tsanglis, were that he appeared vague and confused. He described to staff a need to correct past wrongs.[2] Dr Tsanglis' initial management plan was to monitor his mental state, conduct a thorough organic screen, including a CT scan, and liaise with his family members.

7. Mr Davidson was initially maintained on 30 minute observations decreasing to standard visual observations on 28 September 2007.

8. At shortly after midnight on 29 September, that is some 48 hours after his admission, Mr Davidson was discovered by Baringa nursing staff, self harming by cutting his wrists with a razer. A Code Blue was called.

9. He was transferred to the Alfred Hospital for management of his wrist wounds and transferred back to Baringa at approximately 5 am on the same day, with one to one nurse cover from that time. After the incident he expressed remorse but also offered that,

   'he should have finished the job off.' [3]

10. One to one nursing continued overnight but ceased at 7 am on 30 September, with visual observations to continue from that time, every 15 minutes.

11. Over the course of the following days, Mr Davidson was monitored with observations each 15 minutes and with a one to one night nurse. On the night of 2 October Mr Davidson's one to one overnight observations were discontinued by Dr Tsanglis as Dr Tsanglis noted that he had not,

   'expressed any further self-harm ideation and there were no acute concerns expressed about his mental state.'[4]

12. His brother visited Mr Davidson on the evening of 3 October. He was compliant with treatment and was settled but was noted to be agitated at times. At 10 pm, he was administered with 20 mg of tamazepam to induce sleep and was described as settling quickly to sleep.

<u>4 October 2007</u>

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[2] Ibid page 3.
[3] Ibid.
[4] Ibid page 4.

13. He awoke at 2.15am and returned to bed after visiting the bathroom.

14. At approximately 3 am on 4 October Mr Davidson was found hanging, with a long sleeve shirt tied around his neck and to the handrail in the toilet, having used his shirt as a noose. The handrail used by Mr Davidson was approximately 80 cm from the ground.

15. The on duty nurses Eddie Millar and Alice Jamieson after being alerted, untied the noose, called MICA and commenced CPR. Mr Davidson was pronounced deceased at 3.35 pm following the arrival of MICA officers.

Finding

16. At the time of his death, Mr Davidson was being maintained on 15-minute observations. It appears that he entered the bathroom area immediately after the 2.45 am check and was subsequently located shortly before 3 am, by another patient who was about to enter a toilet cubicle.

17. I find that Mr Davidson took his own life while suffering from mental illness. He was not assisted by any person in this action.

18. I further find that the risk assessment prepared in respect of Mr Davidson was reasonable.

19. The provision of handrails for use by elderly patients in the toilet was also reasonable and the annual audit of possible hanging points within the facility was both reasonable and appropriate.

20. I also find that the downgrading of Mr Davidson's observation level from one on one nursing support to 15 minute observation level was undertaken by nursing staff following an external consult with Dr Tsanglis.[5] I note that the evidence did not reasonably suggest that Mr Davidson was not sufficiently well, to endure such a change.[6]

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death:

[5] See the further evidence of Dr Tsanglis at transcript page 33.
[6] See discussion at transcript page 15, the further testimony of Dr Tsanglis.
See also the comments of Mr Irving Davidson at transcript page 46, concerning his approval of the 'very diligent' care he considered was being provided to his brother during the relevant period.

21. I note with approval that 15-minute observations at Baringa are now conducted somewhat more randomly, so that patients may not anticipate exactly when such an observation may occur.[7]

RECOMMENDATIONS

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

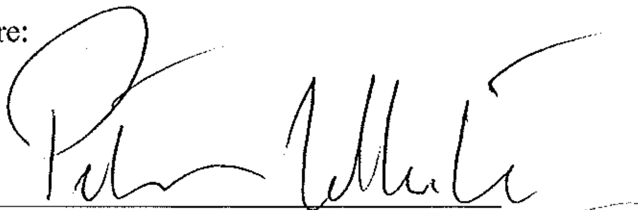
Recommendation one:

I recommend to Alfred Health that in all cases of observation down grade from special nursing level, that a consultant medical officer review the patient concerned in person and record details of the clinical reasons for so deciding.

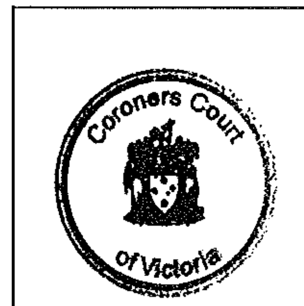
Recommendation two:

I further recommend that in all cases described in recommendation one above, where a consultant medical officer is unavailable to see a patient receiving special nursing and recommended for downgrade, that any approval for an observation downgrade by such consultant should only be given through an IT approval system, which includes a time stamped document review, and a further clinical review setting out the consultant medical officers reasons for so deciding.

I direct that a copy of this finding be provided to the following:
The family of Kelvin Davidson
The Chief Psychiatrist in the State of Victoria
The Chief Executive, Alfred Health Attention Mr O'Shea
Signature:



PETER WHITE
CORONER
Date: **29 September 2014**



[7] See evidence of Enrolled Nurse Mullineux, at transcript page 30.