CORONERS ACT, 2003

SOUTH  *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 13th day of October 2015 and the 9th day of June 2016, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Peter John William Fallon.

The said Court finds that Peter John William Fallon aged 40 years, late of 1 Chelmsford Avenue, Millswood died at the Queen Elizabeth Hospital, Woodville Road, Woodville South, South Australia on the 2nd day of February 2013 of an unascertained cause. The said Court finds that the circumstances of his death were as follows:

1. Introduction

1.1. Peter John William Fallon who was aged 40 years died on 2 February 2013. He was a patient in the Cramond Clinic at the Queen Elizabeth Hospital. An autopsy was conducted and the cause of death was given as unascertained.

2. Background and events leading to Mr Fallon's death

2.1. Mr Fallon had an established history of bipolar affective disorder and psychosis, including admissions to the Flinders Medical Centre and Glenside Hospital for mental health treatment. Since 2010, Mr Fallon had been prescribed Risperdal Consta, 37.5mg in a fortnightly depot injection. He had been compliant with this medication which was provided by his general practitioner. Mr Fallon was a user of cannabis. Mr Fallon was born and had lived a large portion of his life in Victoria. He had a limited mental health history recorded in South Australia.

2.2. On 25 January 2013, Mr Fallon's mother contacted the Emergency Mental Health Triage Service after she became concerned about her son's recent unusual behaviour. Police and members of the Assessment and Crisis Intervention Service (ACIS) attended Mr Fallon's home and detained him under a Level 1 Inpatient Treatment Order. They subsequently conveyed him to the Royal Adelaide Hospital where the Treatment Order was confirmed on 26 January 2013 by psychiatrist, Dr Christina Lawrie. Mr Fallon was kept at the Royal Adelaide Hospital until a bed became available at the Cramond Clinic in the Queen Elizabeth Hospital.

2.3. During his detention at the Royal Adelaide Hospital, Mr Fallon was noted to be experiencing thought disorder with grandiose and persecutory themes of paranoia that he was going to die, though no suicidal or homicidal tendencies were noted. He refused oral medication and began to escalate in aggressive and agitated behaviours, verbally threatening staff. At least one Code Black was called and Mr Fallon was administered Clonazepam and Olanzapine with good effect.

2.4. The transfer to Cramond Clinic occurred on Tuesday, 29 January 2013. Initially, Mr Fallon was admitted to an open ward, however he became agitated when staff refused his repeated requests to leave the ward for a cigarette. He continued to express grandiose beliefs, stating that he was higher than the prime minister. He was anxious that he was going to die and this remained a focus for him. Mr Fallon refused his medications, and on two occasions security was called to intervene and he was placed in the psychiatric intensive care unit (PICU), in a seclusion room. He was also sedated.

2.5. On Thursday, 21 January 2013, Mr Fallon had blood tests. These returned a higher than usual potassium result. A resident medical officer, Dr Thum, reviewed these results and advised that the level was neither too high nor dangerous and simply asked that it be monitored to ensure it did not reach dangerous levels. Resonium was also administered to assist.

2.6. On Friday, 1 February 2013, Mr Fallon was consulted by a psychiatrist, Dr Mohan, in company with Dr Thum. After conducting an assessment of Mr Fallon, Dr Mohan ordered that he continue to be detained under a Level 2 Inpatient Treatment Order until 15 March 2013. Dr Mohan also ordered a change in Mr Fallon's medication, from Risperidone to Olanzapine. That night, Mr Fallon was under the care of mental health nurses, Helen Stewart-Watt and Harjit Dhillon. From 2200 hours, observations were

recorded on his sleep chart at half hourly intervals. Though Mr Fallon was sedated, he was reported to have only sporadic periods of sleep during the night. The staff noted that during the night Mr Fallon had pulled his bed apart and was sleeping on the floor without any pillow or blanket. The last check recorded on the sleep chart was at 0600 hours when Mr Fallon was recorded as having been asleep. He was recorded as having been asleep at every check between 0400 hours and 0600 hours and was last recorded as 'awake in bed attempting to sleep' at 0330 hours. At 0645 hours on 2 February 2013, Mr Fallon was found to be unresponsive. A Code Blue was immediately called and assistance rendered from the Code Blue team which included Dr Jonathon Barlow, a registrar anaesthetist. Despite extensive cardiopulmonary resuscitation efforts, Mr Fallon could not be revived.

3. Cause of death

3.1. The post mortem report mentioned this summary of the major pathological findings:

'Morbid obesity with a BMI of 40.6. Cardiomegaly, right ventricular dilation. Lipomatous hypertrophy of the interatrial septum. Mild and focal increased fibrosis of left ventricular free wall and upper interventricular septum. Pulmonary oedema and congestion. Hemosiderin within renal tubules. Fatty change with eosinophils in the liver. A small scalp bruise. Old frontal cerebral contusions. Scattered immunopositive axonal injury in the corpus callosum and basal ganglia. The finding of cannabinoids detected in the blood.'

3.2. The pathologist stated that the cause of death was unascertained:

'In conclusion, in my opinion, the cause of death is best assigned to the unascertained category. This allows the uncertainty regarding the exact anatomical or functional cause of his death to be recognised whilst also encompassing the possibility that he died as the result of a cardiac arrhythmia to which he would have been predisposed by his enlarged heart, underlying morbid obesity, possibly in combination with increased sympathetic stimulation of his cardiovascular system from agitation and psychiatric disease, idiosyncratic reaction to his therapy and potentially additional electrolyte disturbance.'

4. Nursing observations of Mr Fallon

4.1. I have mentioned the Registrar who attended Mr Fallon after he was found to be unresponsive. That was Dr Barlow. He made a statement and gave oral evidence. He was surprised at the degree of hypostasis he observed in Mr Fallon. He formed the opinion that Mr Fallon had been dead for at least 20 to 30 minutes prior to his arrival.

4.2. The last check that should have been made on Mr Fallon was that scheduled for 0630 hours. It did not occur at that time. Mr Fallon was last observed (before being found unresponsive) at 0600 hours. Unfortunately, the notes were not sufficiently clear to reveal the identity of the nurse who made that observation. However, that observation does record that he was alive when it was made. Thus, even accounting for Dr Barlow's estimation that Mr Fallon had been dead for at least 20 to 30 minutes when he saw him, it would be unsafe to conclude that the 0600 hours observation, whoever made it, was falsified.

4.3. One thing that was quite clear was that at 0600 hours, Mr Fallon was noted to be on the floor uncovered. I would expect that the nurse who observed him at that time would show sufficient humanity to enter the room and at least cover Mr Fallon, including placing a pillow under his head. If that had occurred, it may have been apparent that Mr Fallon was acutely unwell, as it must have been then, or very soon after, that his deterioration set in. It is not now possible to reach any conclusion that Mr Fallon's life might have been saved had these things occurred, but it is extremely concerning, as a matter of proper nursing practice, not say common humanity, that the attending nurse did not cover him and rest his head on something softer than the cold, hard floor.

5. Summary

5.1. Evidence was adduced, as is common in these matters, of system improvements in the recording of observations at Cramond Clinic following Mr Fallon's death. These improvements make it unnecessary for me to make any recommendations in this matter.

5.2. In summary, Mr Fallon had a number of serious medical conditions that predisposed him to sudden death. The pathologist thought any of these could have been the cause of death, but could not fix on any one of them. Thus, Mr Fallon's cause of death was unascertained, but there is no evidence that his detention was in any way directly causative of his death. His detention was lawfully imposed, and his treatment was

generally appropriate, apart from the rather cursory and uncaring nursing care in the hours immediately preceding his death. That poor nursing care however was not, in my opinion, directly causative of his death.

6. Recommendations

6.1. The Court does not see the need to make any recommendations in this matter.

Key Words: Death in Custody; Psychiatric/Mental Illness;

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 9th day of June, 2016.

State Coroner