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 21st day of October 2011 and the 15th day of November 2012, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Mark Andrew Butler.

The said Court finds that Mark Andrew Butler aged 49 years, late of 63 Second Avenue, Klemzig, South Australia died at the Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 4th day of July 2009 as a result of pneumonia, hypoxic brain injury and cardiac arrest. The said Court finds that the circumstances of his death were as follows:

1. Introduction and cause of death

1.1. Mark Andrew Butler was 49 years of age when he died on 4 July 2009 at the Royal Adelaide Hospital. An autopsy was conducted by Dr Carl Winskog, senior consultant forensic pathologist with Forensic Science South Australia[1]. Dr Winskog gave the cause of death as pneumonia, hypoxic brain injury and cardiac arrest, and I so find.

2. Reason for Inquest

2.1. At the time of his death Mr Butler was subject to a 21-day mental health detention order and, accordingly, his was a death in custody within the meaning of the Coroner's Act 2003 and this Inquest was held as required by section 21(1)(a) of that Act.

[1] Exhibit C2a

3. Background

3.1. Mr Butler had begun to use drugs and alcohol as a teenager. He was a heavy user of illicit drugs between the ages of 15 and 31 when he ceased using drugs and alcohol apart from marijuana. He came under the care of psychologist, Dr Jennings, in 2009. He had depression and anxiety on a background of longstanding marijuana abuse.

3.2. Indeed, a toxicology report of blood samples taken before Mr Butler died, along with a post-mortem sample, revealed traces of THC indicating usage until his final admission to hospital[2].

3.3. Mr Butler had suffered from diverticulitis and hypercholesterolaemia. However Mr Butler also had a fear of hypodermic syringes and this played a role in the incident which led to his death.

4. The events leading to Mr Butler's death

4.1. As at 5 June 2009 Mr Butler was living in private rental accommodation with his brother. His brother found Mr Butler lying on the floor in the lounge room on that day complaining of stomach pain. They attended the Royal Adelaide Hospital Emergency Department and the admission notes show that Mr Butler was suffering from severe generalised abdominal pain. An IV line was established and Mr Butler was referred for X-ray examinations to exclude any perforation as a result of his diverticulitis. He was prescribed morphine for pain.

4.2. The following morning, 6 June 2009, he was seen by a colorectal doctor and provided with IV antibiotics. Throughout that day he was provided with morphine for pain relief. On 9 June 2009 the abdominal pain worsened and a CT scan of the abdomen was booked for the following day. On 10 June 2009 Mr Butler began to complain of chest pain radiating across his chest and difficulty breathing. An ECG was ordered which appeared to be normal but as a pulmonary embolus could not be excluded a CT pulmonary angiogram was ordered. The abdominal CT and the CT pulmonary angiogram were both undertaken. The abdominal CT showed a perforated diverticulum with free gas under the diaphragm which was the cause of the chest pain. The CT pulmonary angiogram was normal. Mr Butler underwent an emergency anterior resection that evening[3]. In the immediate aftermath of his surgery Mr Butler

[2] Exhibit C3a
[3] A Hartmann's procedure

had a Patient Controlled Analgesia Infusion Pump which enabled him to dispense his own fentanyl pain relief as required. Over the ensuing days he was distressed at attempts to take blood for tests. Indeed, on 12 June 2009 a Code Black was called when Mr Butler became very agitated at the prospect of his blood being taken however he was reassured that there would be no more attempts to take his blood that day. From that time Mr Butler was assigned a nurse special.

4.3. Medical staff at the hospital, including the psychiatry team, arrived at a differential diagnosis of a post-surgical, post-anaesthetic delirium together with marijuana withdrawal which was causing Mr Butler to think that the medical staff wished to harm him. He was prescribed olanzapine, a sedative. On 13 June 2009 a Code Black was called when Mr Butler began throwing objects at patients and acting aggressively towards staff. On arrival of the Code Black team Dr Fielke found Mr Butler lying in bed with his gown around his waist and his genitals exposed[4]. Mr Butler was calm but he repeatedly asked the doctor to get it over with and kill him. She stated that he shoved his jelco arm in her face and told her to get on with it. He denied that he had had an operation, he denied being in pain but he said he had a headache. As Dr Fielke leaned over him he grabbed at her stethoscope and lanyard which was around her neck. The lanyard broke off and Dr Fielke moved backwards and security guards moved in. Mr Butler was reported as spitting and hitting out and an oxygen mask was put over his face to stop that happening. Mr Butler pulled out his indwelling catheter. Dr Fielke then detained Mr Butler stating that he was paranoid, had no insight and had psychotic features. Dr Fielke ordered that the fentanyl pump be stopped and Mr Butler was then shackled to his bed.

4.4. A psychiatric registrar was called and he diagnosed Mr Butler with post-surgical, post-anaesthetic delirium.

4.5. At that stage the treating staff wished to conduct a CT scan of Mr Butler's abdomen to ensure that there was no problems with the surgical repair. However, the dilemma was to get Mr Butler sufficiently mentally stable so that he could go into the CT scanner. At 1:03pm that day Mr Butler managed to free himself from his shackles. He then grabbed a fire extinguisher from the wall and advanced upon one of the nursing staff. That staff member was very frightened and covered her face with a curtain. Mr Butler then ran off with the fire extinguisher down the hallway. He was naked. A Code Black team was called. Mr Butler ran down a corridor and then down

a flight of stairs past some nurses and was followed by security guards. CCTV footage[5] shows that at 1:05pm Mr Butler was running down a corridor with a fire extinguisher in one of his hands. Two security guards were chasing him followed at a distance by two nurses. Mr Butler then stopped running and turned to face the security guards. He held the fire extinguisher with two hands as if to swing it. One of the security guards stated that Mr Butler said words to the effect 'get back you bastards'[6]. The security guards continually requested Mr Butler to put down the fire extinguisher. Mr Butler then picked up the fire extinguisher with one hand and ran off down the corridor out of sight. At this point the security guards were very concerned because Mr Butler was moving towards a public space which was likely to have a number of people in it. Fortunately the security guards were able to remove the fire extinguisher from Mr Butler who then stumbled against a wall. All of the security guards then grabbed him and forced him to the floor. The nurses then ran up and one of them, a Ms Rudd, gave evidence that she was holding his head and protecting his airway[7]. Mr Butler was thrashing about and fighting the restraint. He was being held face down. No pressure was applied to Mr Butler's chest or back, according to the statements of all of the staff involved. However, within a couple of minutes Mr Butler was noted to be gagging and he was then turned over and found to be unresponsive. The two nurses commenced CPR and a Code Blue was called at 1:15pm. The Code Blue team arrived within a couple of minutes and took over the CPR with a cardiac trolley. It was then discovered that Mr Butler had suffered a cardiac arrest. He was transferred to the ICU, intubated and ventilated but it became apparent that he had suffered an hypoxic brain injury. Mr Butler remained in the ICU until 1 July 2009 when he was sent to the ward for palliative care. He was pronounced deceased on 4 July 2009.

4.6. A psychiatric review was obtained in this matter from Dr Long[8]. It was Dr Long's opinion that Mr Butler's heavy cannabis use and a possible withdrawal syndrome may have predisposed him to post-surgical delirium. Dr Long stated as follows:

> 'In summary, Mr Butler seems to have developed a delirium in the setting of chronic cannabis dependence, increased agitation from a cannabis withdrawal syndrome and after an operation to repair a gastrointestinal perforation. The contribution of analgesia and possible surgical complication may have produced the delirium. Increased agitation

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[4] Exhibit C14
[5] Exhibit C24
[6] Exhibit C10a
[7] Exhibit C9a
[8] Exhibit C18a

> due to the necessary use of hard shackles may have worsened the paranoia and delirium. The use of intramuscular olanzapine with high anticholinergic effects may have worsened his confusion.
>
> The patient's ability to break free from shackles and become aggressive requiring an assertive violence response was unpredictable.' [9]

4.7. Dr Long described this as a complex and challenging case with a dramatic and atypical presentation of a delirium. It was Dr Long's opinion that although a number of clinical errors occurred, particularly in the failure to diagnose the relationship between the delirium and the chronic cannabis dependence, there was no clear and obvious link between the clinical errors and the final fatal outcome. The clinical harm occurred when the patient broke free from his shackles and it was necessary to apprehend and restrain him. Dr Long commented that the event of Mr Butler being able to break free of his hard shackles is a relatively rare event. I detect from his report that Dr Long was not overly critical of what was a very difficult case to manage.

4.8. A special heart examination was carried out by Professor Thomas[10]. Professor Thomas noted that Mr Butler suffered from coronary artherosclerosis of 66%. It was his view that the collapse may be attributed to cardiac arrhythmia related to the underlying cardiomyopathy and ischaemic heart disease.

5. Recommendations

5.1. I have no recommendations to make 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 15th day of November, 2012.

State Coroner

[9] Exhibit C18a, page 15
[10] Exhibit C6a