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 24th day of June 2016 and the 5th day of September 2016, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Steven William Hazlett.

The said Court finds that Steven William Hazlett aged 63 years, late of 6 Brenden Court, Glandore, South Australia died at the Flinders Medical Centre, Flinders Drive, Bedford Park, South Australia on the 26th day of July 2014 as a result of respiratory failure due to chronic denervation atrophy due to peripheral neuropathy (axonal degenerative type) with contributing ischaemic heart disease. The said Court finds that the circumstances of his death were as follows:

1. Introduction and cause of death

1.1. Mr Steven William Hazlett was 63 years of age when he died on 26 July 2014 at the Flinders Medical Centre. His cause of death was determined at post-mortem as respiratory failure due to chronic denervation atrophy due to peripheral neuropathy (axonal degenerative type) with contributing ischaemic heart disease[1], and I so find.

2. Reason for Inquest

2.1. At the time of his death Mr Hazlett was subject to a Level 2 Inpatient Treatment Order imposed under section 25 of the Mental Health Act 2009. As a consequence of that order his death was a death in custody within the meaning of that expression in the Coroners Act 2003 and this Inquest was held as required by section 21(1)(a) of that Act.

[1] Exhibit C2a

3. Background and the circumstances surrounding to Mr Hazlett's death

3.1. Mr Hazlett had a medical history of type 2 diabetes, shortness of breath, depression and anxiety (which was managed through his general practitioner under a mental health treatment plan). He had had two previous admissions to the Flinders Medical Centre in relation to restrictive lung disease and progressive muscle weakness.

3.2. On 8 April 2014 Mr Hazlett caught a taxi to the Flinders Medical Centre as his shortness of breath had worsened since his previous admissions. He was now unable to tolerate lying down. He was admitted to respiratory Ward 6A. Biopsies were conducted in order to identify the cause of the restrictive lung disease and progressive muscle weakness. Mr Hazlett's condition worsened to the point that he could no longer walk lengthy distances.

3.3. On 25 April 2014 there was a lengthy consultation between Mr Hazlett and medical staff and it was decided, with his agreement, that in the event of a cardiorespiratory arrest he would not be for CPR, intubation or defibrillation. By 28 April 2014 it was noted that Mr Hazlett's muscle weakness and shortness of breath was becoming worse even with minor exertion and he was feeling depressed. Throughout the admission detailed notes were maintained and recorded in his progress notes, particularly in relation to his conversations with staff about how he was feeling about his condition.

3.4. On 30 April 2014 a request was made for a psychiatry consult as Mr Hazlett had spoken to staff about suicide and expressed that he was at the end of his tether. This assessment was carried out on 3 May 2014 and it was noted that Mr Hazlett was in a better frame of mind by that stage with no ongoing thoughts of suicide or self-harm.

3.5. Mr Hazlett remained in the Flinders Medical Centre until his death in July 2014. He was consulted on several occasions by members of the psychiatry team.

3.6. In the month before his death Mr Hazlett deteriorated rapidly with progressive neuromuscular weakness. He continued to be regularly monitored with regards to both his physical and mental health and had numerous admissions to the Intensive and Critical Care Unit (ICCU). By 13 July 2014 it was recorded that Mr Hazlett was not for MET calls, ICCU nor CPR or invasive resuscitation, but was to receive comfort care only in the event of a collapse.

3.7. At about 3:30am on 25 July 2014 a code black was called because Mr Hazlett was attempting to get into another patient's bed, was being threatening and offensive to staff and expressing thoughts of self- harm. He was confused and disoriented, hyperventilating and cyanosed. A decision was made to use soft restraints in order to stabilise Mr Hazlett. He was given 1mg of haloperidol and a Level 1 Inpatient Treatment Order was completed. Later that day his detention was reviewed by a senior consultant psychiatrist and it was confirmed. After the confirmation of the order Mr Hazlett was the subject of nurse specialling for the remainder of his stay in hospital.

3.8. Mr Hazlett died at approximately 5:30am on 26 July 2014.

4. Conclusion

4.1. In my opinion Mr Hazlett's care and treatment was appropriate. A reading of his medical notes confirms that he received very attentive care whilst in the Flinders Medical Centre.

5. Recommendations

5.1. I have no recommendations to make in this matter.

Key Words: Death in Custody, Inpatient Treatment Order, Natural Causes

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 5th day of September, 2016.

State Coroner