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 23rd day of February 2018 and the 30th day of August 2019, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Brian John Schulze.

The said Court finds that Brian John Schulze aged 68 years, late of 129 The Cove Road, Hallett Cove, South Australia died at the Flinders Medical Centre, Flinders Drive, Bedford Park, South Australia on the 26th day of August 2015 as a result of ischaemic heart disease (operated). The said Court finds that the circumstances of his death were as follows:

1. Introduction, cause of death and reason for inquest

1.1. On 26 August 2015 Brian John Schulze died at the Flinders Medical Centre (the FMC). He was 68 years of age. Mr Schulze died while subject to a Level 1 Inpatient Treatment Order (ITO) imposed pursuant to the Mental Health Act 2009. His place of detention pursuant to that order was the FMC. For those reasons Mr Schulze's death was a death in custody. An inquest into the cause and circumstances of his death was therefore mandatory. These are the findings of that inquest.

1.2. Mr Schulze's remains were subjected to a post mortem examination which was carried out by Dr Cheryl Charlwood a forensic pathologist at Forensic Science South Australia. Dr Charlwood has reported that Mr Schulze's cause of death was ischaemic heart disease (operated)[1]. Mr Schulze's severe ischaemic heart disease was associated with severe native coronary artery atheroma as well as a stenotic origin of a venous bypass

[1] Exhibit C2a

graft. The reference to the expression 'operated' within the recitation of the cause of death is a reference to Mr Schulze's fatal heart disease having been the subject of a surgical operation in the past, namely the coronary bypass graft. The left ventricular myocardium showed extensive scarring throughout the left ventricle. Dr Charlwood reports that this severe cardiac disease is considered to be the major factor in the death and could also represent the underlying reason for his clinical presentation at the FMC including hypoxia in combination with his clinically diagnosed respiratory failure possibly exacerbated by excess MS Contin administration and minor head injury and falls. MS Contin is an opioid analgesic. I will return to the question of MS Contin consumption that had occurred prior to Mr Schulze's death and to his clinical presentation. I accept Dr Charlwood's evidence in its entirety. I find that the cause of Mr Schulze's death was ischaemic heart disease (operated).

2. Mr Schulze's medical history

2.1. Mr Schulze had a number of comorbidities including insulin dependent diabetes, severe arthritic changes (particularly in his neck), hypertension and ischaemic heart disease with the coronary bypass in 2010, recurrent chest infections and generalised osteoarthritis. In more recent times Mr Schulze was diagnosed with chronic lung disease. In the years preceding his death he required home oxygen.

2.2. Mr Schulze's treating practitioner was Dr David Llewelyn. Dr Llewelyn indicates in his statement[2] that in 2010 he became his regular general practitioner upon the retirement of the doctor whom Mr Schulze had been seeing.

2.3. Dr Llewelyn's statement details the numerous medications that Mr Schulze was prescribed prior to his death. Of note is an MS Contin prescription of 30mg slow-release tablets which Dr Llewelyn explained were prescribed for Mr Schulze's arthritic neck and back. The last occasion Mr Schulze was issued a prescription for this medication was on 13 August 2015. The prescription was for two 30mg tablets per day.

2.4. The statement of Dr Llewelyn details the last consultation that he had with Mr Schulze which was a follow-up appointment concerning dizziness due to a particular anti-angina

[2] Exhibit C9

medication. It was noted on this occasion that Mr Schulze had coped well with the cessation of this medication.

3. Mr Schulze's admission to the FMC

3.1. On 16 August 2015 Mr Schulze was conveyed to the FMC by ambulance due to a number of falls at home reportedly the result of arthritis in his legs. He displayed confusion at this time. On examination Mr Schulze had a right forehead laceration involving his right eye. Investigations were undertaken, including an ultrasound, but they did not show any significant carotid stenosis of his neck or his legs.

3.2. Mr Schulze was discharged on 20 August 2015. However, two days later on 22 August he was readmitted to the FMC Emergency Department due to increased confusion and what was described as 'jerky movements' of his body. The differential diagnosis at that stage was functional decline. There were also concerns entertained about Mr Schulze's ability to cope at home. He was admitted to the FMC. Due to his level of confusion a nursing special was ordered. It was noted that Mr Schulze fluctuated between being confused at times and being quite agitated at other times.

3.3. Mr Schulze experienced falls on the ward and continued to present as confused and agitated at times. A CT of Mr Schulze's brain was ordered. It did not reveal any acute intracranial pathology or any focal infection. Due to his unsteady gait and his high risk of falls, the nursing special remained in place.

3.4. On 23 August 2015 Mr Schulze was reviewed due to his having become tachycardic with a heart rate of over 100 beats per minute. He was noted to be slightly dehydrated. A plan to pursue a full blood examination was documented.

3.5. A note in the clinical record states that on 24 August 2015 Mr Schulze had reportedly taken ten MS Contin tablets prior to his admission. According to a nursing note this circumstance was reported by his wife to medical staff. The plan from this point was to increase his observations to every half hour and to screen him for delirium. The following day the notes reflect that Mrs Schulze and Mr Schulze's general practitioner together checked Mr Schulze's Webster-pack. It appeared that only five MS Contin tablets were missing. The note reflects that at this time Mr Schulze's discharge was being considered with social work input and the requirement for the nursing special had been lifted.

3.6. However, just before midnight on 24 August 2015 a code black was called as Mr Schulze had become agitated. He was described as walking the corridor swearing and becoming aggressive when directed back to bed. He was given risperidone and ultimately settled in the chair next to his bed. The nursing special was reinstated from that point onward.

3.7. Mr Schulze is recorded in the case notes as being very agitated and hallucinating with the jerky movements that had been seen around the time of his admission. His oxygen saturation levels were dropping as he continually removed his oxygen mask during periods of agitation.

3.8. The following morning (25 August 2015) Mr Schulze was assessed by the medical team. It was thought that he might be suffering opioid withdrawal with a polypharmacy infective process. Mr Schulze was administered MS Contin that morning in response to the suspected opioid withdrawal. However, later in the afternoon the medical team was called as Mr Schulze had lost consciousness with a low respiratory rate between 10 and 12 breaths per minute. It was noted that he had received 30mg of MS Contin that morning. Naloxone, which is a drug designed to negate the effects of an opioid drug, was administered with good effect. The administration of MS Contin was suspended at that time. A different form of analgesia needed to be considered.

3.9. Mr Schulze again became drowsy later in the afternoon and another dose of naloxone was administered. On this occasion it did not have the same effect and his Glasgow Coma Score was measured at seven which is low. Mr Schulze was assessed by the Intensive Care Unit (ICU) team and the recorded impression was opioid related hypoventilation. A second differential diagnosis was hypercapnic respiratory failure confirmed with arterial blood gases.

3.10. The ICU team spoke with Mrs Schulze and informed her of her husband's prognosis which at this stage was considered to be poor. In accordance with her husband's documented wishes from the beginning of his admission, Mrs Schulze indicated that her husband was not for ICU treatment, was not for intubation and was not for cardiopulmonary resuscitation. However, he was still to receive ward measures.

3.11. Part of the ICU plan to stabilise Mr Schulze at this time was to administer a further and much larger dose of naloxone to Mr Schulze. When this was administered Mr Schulze immediately responded but was confused, was thrashing about and shouting. A code

black was called at 1800 hours. A CT brain, which had been ordered, was not able to be conducted due to Mr Schulze's level of agitation. It was thought that the agitation and delirium might be due to his respiratory failure.

3.12. At 1805 hours on 25 August 2015 Mr Schulze was placed on a Level 1 ITO by one of the treating doctors, Dr Loo. Dr Loo's order states that the reasons for the imposition of the ITO were that in his opinion Mr Schulze had a mental illness at that point and that because of that mental illness he required treatment for his own protection from harm, including harm involved in the continuation or deterioration of his condition, or for the protection of others from harm and that there was no less restrictive means than an ITO of ensuring appropriate treatment for his illness[3]. The underlying reasons for the imposition of the order were that Mr Schulze was a danger to himself due to a high risk of falls and that he was also a danger to the nursing staff because he had allegedly been punching them due to his confusions. Mr Schulze would die while still subject to that order.

3.13. Over the next twelve hours Mr Schulze's level of agitation continued with code blacks being called. His oxygen saturation levels fluctuated between 78% and 92% depending on his ability to tolerate the oxygen delivery having regard to his level of agitation.

3.14. On 26 August 2015 Dr Randall Long, a consultant psychiatrist, reviewed Mr Schulze and confirmed the Level 1 ITO. Dr Long's confirmation documentation[4] reveals that he examined Mr Schulze at 11:40am on 26 August 2015 and that he confirmed the Level 1 ITO on the basis that he was satisfied that the grounds for the making of the original order made by Dr Loo continued to exist.

3.15. A number of measures were considered for Mr Schulze, including a naloxone infusion to assist with his level of consciousness and his oxygen saturations. A BiPAP machine was also considered in order to assist with the management of Mr Schulze's respiratory distress. When a further CT scan was ordered Mr Schulze suffered his final unresponsive episode from which he was unable to be resuscitated. He was pronounced deceased at 2000 hours on 26 August 2015.

[3] Exhibit C13b
[4] Exhibit C13c

4. Conclusions

4.1. The Court reached the following conclusions:

1) Mr Schulze's detention under the Mental Health Act 2009 was appropriate for the reasons stated by the practitioners who imposed them;

2) The deceased received adequate care during his admission to the FMC;

3) It is evident from Mr Schulze's post mortem examination that he had severe underlying heart disease. Mr Schulze had a documented history of the same and in fact had been the subject of bypass surgery in the past. His cause of death was that heart disease;

4) I do not differ from the conclusion of the investigating police officer, Detective Brevet Sergeant Sherrie Modra, that from her detailed investigation of this matter Mr Schulze received an appropriate level of care for his illness;

5) Mr Schulze's detention under the Mental Health Act did not in any way contribute to his death.

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 30th day of August, 2019.

Deputy State Coroner