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 27th day of October 2015 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 Braydon Adrian Shueard.

The said Court finds that Braydon Adrian Shueard aged 60 years, late of Oakden MAKK House, 200 Fosters Road, Oakden, South Australia died at the Lyell McEwin Hospital, Haydown Road, Elizabeth Vale, South Australia on the 11th day of March 2013 as a result of sepsis due to pressure ulcers due to immobility on a background of advancing fronto-temporal dementia, diabetes and ischaemic heart disease. The said Court finds that the circumstances of his death were as follows:

1. Introduction and reason for inquest

1.1. Braydon Adrian Shueard, aged 60 years, died on 11 March 2013 at the Lyell McEwin Hospital (the LMH). At the time of his death he was the subject of a Level 3 Inpatient Treatment Order (ITO) that had been imposed by the Guardianship Board pursuant to the provisions of the Mental Health Act 2009. The ITO had been imposed on 6 November 2012 and would have expired on 5 November 2013. Mr Shueard's place of detention pursuant to the ITO was the LMH. Mr Shueard had been the subject of a series of ITOs and orders pursuant to the Guardianship and Administration Act 1993. The Public Advocate had been his full guardian.

1.2. Due to the fact that at the time of Mr Shueard's death he was subject to the Level 3 ITO, his death was a death in custody in respect of which an inquest was mandatory. These are the findings of that inquest.

2. Cause of death

2.1. Mr Shueard had a past history of Type 2 diabetes, ischaemic heart disease with myocardial infarction and fronto-temporal dementia among other illnesses. On 15 February 2013 he had been admitted to the LMH with sepsis due to pressure ulcers on his right heel and sacrum. He was bedbound and had been so since his last admission to LMH in December 2012. In spite of medical and surgical treatment for his ulcers he made no progress and after consultation with the Public Advocate's officer he was given comfort care until he died on 11 March 2013.

2.2. Mr Shueard's case files from the LMH and also from the facility where he had been accommodated prior to his most recent admission to the LMH were reviewed by medical practitioners at Forensic Science South Australia (FSSA). In a pathology review dated 19 March 2013 Dr Iain McIntyre of FSSA, in conjunction with Dr John Gilbert, a forensic pathologist at FSSA, reported that the cause of Mr Shueard's death could be determined from the casenotes with some certainty and so an autopsy was not recommended. It is reported in the document[1] that Mr Shueard's cause of death was sepsis due to pressure ulcers due to immobility in a man with advancing fronto-temporal dementia, diabetes and ischaemic heart disease. I accept that opinion. I find that the cause of Mr Shueard's death was sepsis due to pressure ulcers due to immobility on a background of advancing fronto-temporal dementia, diabetes and ischaemic heart disease.

3. Background

3.1. During April 2012 Mr Shueard had been treated at the Flinders Medical Centre (FMC) after he had been experiencing seizures, a cognitive decline and behavioural change progressing over a four-month period. There was supporting evidence for a diagnosis of fronto-temporal dementia at that time. The deceased required physical and chemical restraint on several occasions to ensure his safety and that of other patients and staff. His aggression diminished, but he continued to make threats to staff and expressed suicidal ideation.

[1] Exhibit C2a

3.2. Mr Shueard had already been diagnosed with dementia, depression and Hashimoto's encephalopathy which is a neuro-degenerative disorder with symptoms of personality disorder, aggression and delusional behaviour.

3.3. On 22 May 2012 the Public Advocate was appointed as full guardian for Mr Shueard. This order was granted to enable the Public Advocate to make decisions about Mr Shueard's medical treatment and his place of residence. The Public Advocate was also granted section 32 powers under the Guardianship and Administration Act 1993.

4. Mr Shueard's residency at MAKK House

4.1. In August 2012 Mr Shueard was accommodated in MAKK House at Oakden after it was deemed that he had early onset rapidly progressing dementia and would not be able to live independently. MAKK House was a facility that provided aged care and mental health accommodation for people unable to manage mainstream residential care.

4.2. In October 2012 Mr Shueard was transferred to Ward 1H at the LMH where he received treatment in an acute psychiatric inpatient unit. There were ongoing difficulties with Mr Shueard. There were prolonged periods of seclusion which were necessary due to anti-social behaviour on the ward. Electroconvulsive Therapy (ECT) was considered. Haloperidol was introduced and its dose was steadily increased in an attempt to manage his behaviour. Benztropine was used to treat the associated tremors that accompanied the haloperidol administration.

4.3. In December 2012 Mr Shueard was transferred back to MAKK House and was managed with his medication. At this time he was sedated resulting in extrapyramidal side effects which are known to accompany this form of sedation. Side effects included rigidity, bradykinesia and a shuffling gait. Mr Shueard became more sedated with decreased food and fluid intake. He was no longer able to walk and muscle rigidity was observed.

4.4. Unfortunately Mr Shueard developed pressure ulcers on his sacrum and right heel. The deceased was first noted to have two small areas of broken skin in the sacral area measuring 5mm x 5mm on 21 January 2013. These were treated with saline and given an Allevyn dressing. Pressure area care with four-hourly repositioning was commenced on 22 January 2013 as directed. An alternating pressure mattress was obtained for the deceased at this time and he received nutritional supplements to aid wound healing.

The size of the injury to the sacral area initially remained stable with an increase in size to 80mm x 80mm noted on 10 February 2013. Various dressings were used including Duoderm, Mepitel, Aquaceal and Midsorb with the aim to protect the area and promote healing. Intrasite gel was used to debride necrotic tissue. The right heel injury was observed on 5 February 2013. This increased in size to 60mm x 60mm by 8 February 2013 but then decreased to 40mm x 40mm by 14 February 2013. This injury was also treated with daily dressings.

4.5. This clinical course was described in the statement of Dr Alice Powell[2] who was a medical officer working at MAKK House.

4.6. Dr Patrick Flynn was a psychiatrist with Mental Health Services for Older People at Oakden. He was the psychiatrist in charge of MAKK House. In his statement[3] he provided a summary of Mr Shueard's background and clinical progress prior to his death. Dr Flynn stated that in the early stages of his care at MAKK House Mr Shueard was dealt with in a careful way due to the unpredictability of his behaviour. Due to his psychiatric state and medical state he was monitored closely. As part of his risk management, at times he had to be secluded from other patients due to his behaviour. His behaviour became increasingly aggressive and unpredictable. Dr Flynn noted that in October 2012 Mr Shueard required care in an acute psychiatric inpatient unit which was Ward 1H at the LMH where difficulties with his ongoing management continued. Mr Shueard caused damage to the ward environment and allegedly injured staff members necessitating prolonged periods of seclusion. He also required a nurse special. A CT brain scan was unremarkable.

4.7. While at the LMH numerous medications were trialled in an attempt to reduce agitation and to moderate his behaviour. Concern was raised in relation to side effects with some of those medications. Electro-convulsive therapy was also considered. Haloperidol was introduced and its dose was steadily increased due to severe agitation.

4.8. Treatment decisions at the LMH were made after extensive collaboration with psychiatrists, a psychopharmacist, other medical specialists and senior nursing staff. There was also input from the Chief Psychiatrist, the hospital Chief Executive Officer and the Director of Nursing. The risks and benefits of using haloperidol at the doses

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[2] Exhibit C6a
[3] Exhibit C5a

involved were explored and it was thought that there was no better alternative to treat Mr Shueard's severe and ongoing aggression.

4.9. Mr Shueard was discharged back to MAKK House in December 2012. Dr Flynn described Mr Shueard's state of sedation and the side effects that included the matters that I have already described. He was maintained on haloperidol but the dosage was decreased. Dr Flynn described Mr Shueard's increasing sedation, decreasing food and fluid intake, his inability to walk and muscle rigidity. Dr Flynn noted the development of the sacrum and heel injuries and also noted that the general treatment of ulcers was monitoring, cleansing and dressing on a regular basis. He added that it is possible that such a wound can deteriorate rapidly depending on bacteria and general health factors. The pressure injuries in Mr Shueard's case became progressively worse due to his ill health and reduced mobility.

4.10. Dr Flynn also noted that the haloperidol was further decreased, but that Mr Shueard continued to make threatening gestures. He became drowsy and pyrexia developed.

4.11. Dr Flynn last saw Mr Shueard on 15 February 2013 at MAKK House. This was for review of his physical and psychiatric progress. There was a deterioration in his level of awareness and he was septic. He was physically unwell and had a temperature. It was evident that the ulcer on Mr Shueard's back had become infected with a malodorous ooze. His psychiatric condition had changed substantially in terms of his conscious state to the point where there was no verbal or physical communication.

5. Mr Shueard's decline in health

5.1. On 11 February 2013 Mr Shueard had developed a fever. Increased observations were conducted over the next few days. By 15 February 2013 there was deterioration in his level of awareness and he was deemed to be septic with high temperatures. The ulcers were now necrotic and, as indicated, malodorous. Mr Shueard had become non-verbal and physically unresponsive and it was on that day that he was transported to the LMH where he would remain until his death.

5.2. On 16 February 2013 an urgent surgical debridement was conducted on the pressure injuries after consent was sought from the Public Advocate. Advanced care directives were discussed and consultation was undertaken by the medical team with the Public Advocate, Mr Shueard's former wife and the LMH Intensive Care Unit consultant.

Continued medical management was agreed. It was determined that in the event of a sudden cardiopulmonary arrest, CPR would not be offered.

5.3. Mr Shueard did not cognitively improve. Assisted oral feeding failed. As a result, a nasogastric tube for nutrition was administered.

5.4. On 25 February 2013 the Public Advocate, a senior Lyell McEwin consultant, a psychiatric registrar and doctors from the medical team decided that Mr Shueard would be placed on a '*care of the dying*' pathway plan. Mr Shueard had earlier expressed a desire to die with dignity. He had also expressed a desire for comfort care in the event of serious deterioration in his health. After a number of days on the care plan he became slightly more alert. However, there was no improvement in his infection, in his temperature or in his elevated heart rate. The nasogastric tube was removed and Mr Shueard was fed what he could manage orally. He slowly declined until he died at approximately 8:15pm on 11 March 2013.

6. The evidence of Ms Bethany Jordan of the Office of the Public Advocate

6.1. Ms Bethany Jordan was a delegated guardian of the Office of the Public Advocate. She provided a statement to the inquest[4].

6.2. In her statement Ms Jordan outlines the involvement of the Public Advocate in Mr Shueard's care. She explained that she met with Mr Shueard on 18 May 2012 at which stage he was an inpatient at the FMC. She explained her role to him, but indicates in her statement that she was not sure how much of this he understood. She also explained the involvement of the Guardianship Board and the institution of the section 32 powers to which I have referred. She also states that at one point there was a transfer to the Repatriation General Hospital for further assessment and treatment. From there it was concluded that Mr Shueard had early onset, rapidly progressive dementia and would not be able to live independently. Ms Jordan explains his transfer to MAKK House in August 2012. She visited Mr Shueard on 17 September 2012 on which day he reported that he liked being at that facility and wanted to stay. He showed the guardian his room and the cards that he had recently received from his children.

[4] Exhibit C7a

6.3. Ms Jordan explains that initially Mr Shueard seemed to settle in well at MAKK House. However, in October 2012 the Office of the Public Advocate was contacted with a report that staff at MAKK House had been unable to manage Mr Shueard's increase in aggression as a result of which he had been admitted to the LMH. It was apparent to the guardian upon a visit during that admission that Mr Shueard was heavily sedated. During this admission to the LMH the Office of the Public Advocate was provided with regular reports in respect of Mr Shueard's presentation and in particular of the difficulties that the LMH was having in managing him. This included a tendency to violence on the ward and other antisocial behaviour.

6.4. Ms Jordan explains that her office became aware of the fact that Mr Shueard was returned to MAKK House in December 2012. On 11 February 2013 her office was contacted by MAKK House staff who reported that Mr Shueard was seriously unwell. The fact of the ulceration to which I have referred was reported to her office. Consent for debridement of the ulcer was sought from the Public Advocate. His multiple health issues and the ulcer were reported. Similarly, difficulties with nutrition were also reported. It was clarified that Mr Shueard was not for resuscitation in the event of cardiac arrest. By this stage Mr Shueard was at the LMH.

6.5. On 25 February 2013 the guardian attended the case conference at the LMH to which I have earlier referred. A number of senior medical practitioners were present. Mr Shueard's recent history was discussed and it was noted that he was now appearing to be drowsy and almost unrousable. The treating team were unanimous that extraordinary measures would be inappropriate for Mr Shueard given his severe comorbidities. It was agreed that he would be referred to the palliative care team for comfort care only. Ms Jordan reported that it was clear from this meeting that Mr Shueard would not live much longer, but would be kept comfortable. On 11 March 2013 her office was notified of Mr Shueard's death.

6.6. I accept all of Ms Jordan's evidence. Ms Jordan's statement contains no adverse comment or observation in relation to the level of care that Mr Shueard received either at MAKK House or at the LMH.

7. Conclusions

7.1. This matter was extensively investigated by Senior Constable First Class Neil Dunne of the Elizabeth CIB. I am grateful for Mr Dunne's comprehensive report. Following his extensive investigation and analysis of the evidence, Mr Dunne expresses the conclusion that the care of Mr Shueard at MAKK House had been appropriate. He reached the same conclusion in relation to Mr Shueard's care at the LMH. I have no reason to differ from those conclusions.

7.2. Specifically, no deficiency in the care and attention afforded to Mr Shueard while detained at the LMH has been identified. Similarly no deficiency in the care and attention afforded to him while at MAKK House has been identified.

7.3. Mr Shueard's detention under the Mental Health Act was lawful and appropriate for obvious reasons.

8. Recommendations

8.1. There are no recommendations to be made in this matter.

Key Words: Death in Custody; Inpatient Treatment Order; Oakden

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 30th day of August, 2019.

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Deputy State Coroner

Inquest Number 27/2015 (0391/2013)