



## FINDING OF INQUEST

*An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 18<sup>th</sup> day of May and the 8<sup>th</sup> day of July 2022, by the Coroner's Court of the said State, constituted of Ian Lansell White, Deputy State Coroner, into the death of Phillip David Cardwell.*

*The said Court finds that Phillip David Cardwell aged 53 years, late of 1/56 Avenue Road, Cumberland Park, South Australia died at the Flinders Medical Centre, Flinders Drive, Bedford Park, South Australia on the 21<sup>st</sup> day of May 2017 as a result of lung abscess with empyema. The said Court finds that the circumstances of his death were as follows:*

### **1. Introduction, cause of death and background**

- 1.1. Phillip David Cardwell was born on 23 September 1963. He died on 21 May 2017 at the age of 53. Mr Cardwell had a history of schizophrenia and at the time of his death he was an inpatient at the Margaret Tobin Centre.<sup>1</sup> Mr Cardwell was afflicted with schizophrenia throughout his adult life.<sup>2</sup> This caused his thoughts to be disordered and thinking to be jumbled. He developed some unusual beliefs and preoccupations.
- 1.2. On 29 May 2017, a post-mortem examination of Mr Cardwell's remains was performed by Dr Stephen Wills, a forensic pathologist at Forensic Science South Australia.<sup>3</sup> Dr Wills concluded from this examination that the cause of Mr Cardwell's death was

---

<sup>1</sup> MTC

<sup>2</sup> Exhibit C6 - Affidavit of Dr Michael Nance, consultant psychiatrist at the MTC

<sup>3</sup> FSSA

lung abscess with empyema.<sup>4</sup> I accepted Dr Wills' conclusion and make a finding accordingly.

- 1.3. By law, Mr Cardwell's death was a death in custody pursuant to the Coroners Act 2003, as amended.<sup>5</sup> He was subject to an Inpatient Treatment Order<sup>6</sup> issued under the Mental Health Act 2009 at the time of his death. Therefore, this Inquest was mandatory under the Act.
- 1.4. Mr Cardwell had coped well in the community for a number of years although he struggled to care for himself. He required a lot of community support. He was a heavy smoker with a poor diet. He was overweight making himself vulnerable to a range of physical illnesses. He lived in public housing accommodation in Cumberland Park and was on a disability support pension.
- 1.5. Both of Mr Cardwell's parents were deceased and his brother was last known to reside in New South Wales. He had an uncle and an aunty that resided in Victoria which had intermittent contact with him.<sup>7</sup>

## 2. **Medical history**

- 2.1. Mr Cardwell's general practitioner for 20 years was Dr Seng Kim Low. Dr Low practised at the Southern Clinic at Clovelly Park. Dr Low has provided details about the medications that Mr Cardwell was on prior to his admission to the MTC in May 2017.<sup>8</sup> One of those medications was clozapine which is an antipsychotic medication. Mr Cardwell had been on clozapine for an extended period of time. On this admission, he was under the care of Dr Michael Nance, a consultant psychiatrist at MTC. According to Dr Nance, in early 2017 there was a period of time when Mr Cardwell had not taken his clozapine.<sup>9</sup> He was admitted to MTC as an involuntary patient under an ITO for approximately five weeks. During that admission he was re-established on

---

<sup>4</sup> Exhibit C2

<sup>5</sup> The Act

<sup>6</sup> ITO

<sup>7</sup> Exhibit C8, Statement of Mr Brian Holman, an uncle of Mr Cardwell

<sup>8</sup> Exhibit C7, Statement of Dr Low

<sup>9</sup> Exhibit C6, Statement of Dr Michael Nance

clozapine by gradually increasing his dose. He also had a course of electroconvulsive therapy. This treatment improved his mental state and he was discharged home.

### **3. Events leading to Mr Cardwell's death**

- 3.1. On 9 May 2017, Mr Cardwell visited Dr Low. Dr Low stated that on that occasion Mr Cardwell had come in for a prescription and a flu injection.<sup>10</sup> He had just come out of hospital prior to that appointment. Dr Low stated that during that appointment Mr Cardwell was a little bit more distracted and not as cooperative usual. Dr Low listened to Mr Cardwell's lungs which sounded quite well.
- 3.2. Mr Cardwell was home from his extended hospital stay for approximately 11 days before the Community Mental Health Team<sup>11</sup> became concerned that his mental health was deteriorating again and he was becoming more disorganised. He was taken back to the MTC as a voluntary inpatient by his CMHT on 15 May 2017 and was re-admitted directly to the MTC that day.
- 3.3. As part of his readmission, a series of blood tests were taken which showed evidence of a significant infection. An ITO was placed on Mr Cardwell on 16 May 2017. There were concerns at that time that Mr Cardwell did not have the capacity to make decisions about his medical treatment due to the current state of his psychiatric illness. He was transferred to the acute medical unit at the Flinders Medical Centre<sup>12</sup> on 16 May 2017 where he spent several days stabilising his physical state and for the commencement of intravenous antibiotics.
- 3.4. The ITO was confirmed on 17 May 2017. On Thursday, 18 May 2017 while Mr Cardwell was still in the acute medical unit, he was noted to have some difficulty breathing with a mild cough. He was diagnosed as having right lower lobe pneumonia which was improving on antibiotics and also a possible urinary tract infection. It was thought that his physical state had improved by that time. He was changed from intravenous antibiotics to oral antibiotics, which according to Dr Nance is the usual

---

<sup>10</sup> Exhibit C7, paragraph 12

<sup>11</sup> CMHT

<sup>12</sup> FMC

practice when an infection is resolving. The oral antibiotics are then continued for several more days depending on the nature of the infection.

- 3.5. On 18 May 2017, Mr Cardwell was transferred back to the MTC. On Friday, 19 May 2017 there was some residual evidence of the pneumonia in his right lung base. Mr Cardwell was short of breath on mild activity. The plan was to continue his oral antibiotics. According to Dr Nance, Mr Cardwell still did not have a fever which is a basic measure of the recurrence of infection.
- 3.6. On Saturday, 20 May 2017 Mr Cardwell had settled well overnight and did not have a fever. The on-call psychiatrist briefly saw him in relation to the dose of his antipsychotic medication. The remainder of that day was noted as uneventful. Mr Cardwell was recorded as having a normal temperature and some shortness of breath with a wheeze. He was given a Ventolin inhaler to help his breathing. He went to bed that evening and was heard calling out about the government and the toilet which was usual behaviour for him.
- 3.7. Registered Nurse Geraldine MacFarlane described that at about 11:58pm she went into Mr Cardwell's room and saw him on the floor adjacent his bed. She called a Code Blue and a number of other staff attended. CPR was commenced. A tracheotomy was performed during resuscitation attempts, however all attempts were unsuccessful and Mr Cardwell died in his room.

#### **4. Clozapine**

- 4.1. The possibility of clozapine contributing to Mr Cardwell's death was considered. Dr Nance detailed that Mr Cardwell's usual dose of clozapine was 400mg at night and 100mg in the morning.<sup>13</sup> When he was first readmitted on 15 May 2017 he was given a reduced dose in order for MTC medical staff to investigate if he had been taking his clozapine regularly prior to that admission. Therefore, on 15 May 2017 he was given 200mg at night only.
- 4.2. On 16 May 2017 he was given 300mg at night. This dosage increased from 17 May 2017 onwards when he was given 400mg at night. Dr Nance explained that 400-500mg

---

<sup>13</sup> Exhibit C6

is a fairly typical dose.<sup>14</sup> Dr Nance stated that clozapine had a number of significant side effects and risks that required monitoring. These side effects included that the body can cease to make white blood cells needed to fight off infection. To manage that effect, regular blood tests to check the white cell count were required. There is a thorough established procedure whereby the clozapine cannot be dispensed if the patient has not had the required blood tests within the correct intervals. In Mr Cardwell's case, the procedure for regular blood testing was followed.

- 4.3. A sample of Mr Cardwell's blood was taken at the post-mortem examination. This sample was tested by FSSA concerning the toxicology of his blood at the time of death. A toxicology report from FSSA stated that approximately 2mg of clozapine per litre in the blood was detected.<sup>15</sup> Dr Wills commented that:

'The possibility that the deceased may have been experiencing supra-therapeutic levels of clozapine cannot be entirely excluded by post-mortem. Interpretation of the post-mortem blood concentration is made very difficult by the phenomenon of post-mortem redistribution whereby the concentration detected after death may be greater than that which was present in life. Clozapine may be subject to potentially very significant redistributions and although taking a sample from a peripheral site may reduce this effect it cannot be quantified or eliminated. However, considering the degree of his respiratory pathology, adverse drug effect appears unlikely and redistribution would appear a more reasonable explanation for the level detected in the post-mortem blood.'<sup>16</sup>

I accept Dr Wills' opinion.

- 4.4. This Inquest has also addressed the possibility of whether an assault of Mr Cardwell had contributed to his death. As detailed in the Investigating Officer's report, Mr Cardwell was assaulted by another inpatient at the MTC on 13 April 2017.<sup>17</sup> However, the post-mortem examination ruled out the possibility of an assault on that occasion contributing to his death. Dr Wills concluded:

'There was no indication at post-mortem that the earlier alleged assault had contributed to his death in any way.'

---

<sup>14</sup> Exhibit C6, paragraph 20

<sup>15</sup> Exhibit C3a

<sup>16</sup> Exhibit C2a, Dr Wills' report

<sup>17</sup> Exhibit C14, report of Detective Brevet Sergeant Melanie Ellis

It was also observed by Dr Nance that:

'The patient responsible for the assault of Mr Cardwell at the Margaret Tobin Centre on 13 April 2017 was in a separate ward than Mr Cardwell on the date of his death and that ward was secure.'

Therefore, I have excluded the possibility of any further assault on Mr Cardwell by that same individual on the evening of his death.

- 4.5. There were concerns surrounding the reporting of Mr Cardwell's death and the removal of his body. Mr Cardwell's life was declared extinct at the MTC at about 12:55am on 21 May 2017. However, police were not notified until 9:36am. By the time the police were notified and attended, Mr Cardwell's body had been taken to the morgue and the room had been cleaned. These concerns were addressed in the statement of Ms Susan Lonie, the Clinical Risk Manager for Southern Adelaide Local Health Network.<sup>18</sup> Ms Lonie stated that:

'Although the acting director of Clinical Services Shannon Leary rightly identified that Mr Cardwell was a detained person who should remain where he was when he died and pending police arrival, the hospital co-ordinator on the night, Dagmar Lockwood directed otherwise.'<sup>19</sup>

She detailed that:

'Hospital coordinators including Mr Lockwood have been given a refresher course on what is considered to be a death in custody and what follows from that.'

According to the Investigating Officer's report, these procedural errors were subsequently addressed by the FMC, Clinical Risk Management and '*...there was no adverse effect on the subsequent coronial investigation*'.<sup>20</sup>

## **5. Conclusion and recommendations**

- 5.1. I agree with the conclusions of Detective Brevet Sergeant Melanie Ellis that Mr Cardwell was in lawful detention at the time of his death.<sup>21</sup> Detective Ellis did note:

'Whilst I have no specific concern about the treatment in care provided to the deceased, I question whether further medical exploration may have been warranted considering the

---

<sup>18</sup> Exhibit C9

<sup>19</sup> Exhibit C9, paragraph 18

<sup>20</sup> Exhibit C14

<sup>21</sup> Exhibit C14

deceased's general poor condition in conjunction with the stated risks associated with clozapine side effects.'

5.2. This concern was reviewed by Dr Steven Hedger, a physician and staff specialist at the FMC.<sup>22</sup> He noted that Mr Cardwell was reviewed by the acute medical unit at 12:50pm on 18 May 2017. It was noted that he had no shortness of breath, no cough, no complaints and that he was medically cleared. Dr Hedger also stated that Mr Cardwell did not have a repeat chest x-ray of 16 May 2017 because it was not indicated as necessary. On that basis, I conclude it was acceptable that no further medical exploration was indicated as necessary and that there was no deficit in the care provided to Mr Cardwell.

5.3. I make no recommendations in this Inquest.

*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 8<sup>th</sup> day of July, 2022.*

---

*Deputy State Coroner*

Inquest Number Inquest Number 31/2020 (0932/2017)

---

<sup>22</sup> Exhibit C15