IN THE CORONERS COURT
OF VICTORIA
AT WARRNAMBOOL

Court Reference: COR 2017 6372

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Findings of:	**MR JOHN OLLE, CORONER**
Deceased:	**JP**
Delivered On:	**7 February 2019**
Delivered At:	**Coroners Court of Victoria,** **65 Kavanagh Street, Southbank**
Hearing Date:	**7 February 2019**
Coroners Assistant:	**Sgt Ross Treverton**

HIS HONOUR:

BACKGROUND

1. JP, a 39-year-old man of aboriginal heritage, died on 19 December 2017, at the ICU at Northern Hospital. At the time of his death, JP was being treated for septicaemia secondary to the self-injection of faeces whilst an involuntary mental health patient at the Northern Area Psychiatric Unit 2 (NPU) on 17 December 2017.

2. JP had an extensive psychiatric history dating back to his early teenage years. He had experienced a long childhood history of neglect and abuse, violence, aggression, substance abuse and exposure to severe mental illness in family members. He was diagnosed with schizophrenia at the age of 19.

3. JP's drug history includes:

   - Inhalant use from the age of 12
   - Heroin and amphetamine use from the age of 16
   - Heavy prescription and non-prescription drug use
   - Methadone program commenced 2012
   - Cannabis, tobacco and alcohol use.

4. Other history includes:

   - 30 inpatient admissions to mental health units in Tasmania and Victoria since 1998
   - Deliberate self-harm, including self-mutilation, injection of foreign substances including faeces into his testicles, resulting in loss of his testicles
   - Frequently being lost to follow-up
   - Poor compliance with medication.

5. Further, JP exhibited extreme violence and aggression to medical attendants and carers:

- Frequent requirement for seclusion/restraint
- Ingestion or insertion of foreign bodies requiring surgical procedures for removal
- A significant forensic history.

CORONER PREVENTION UNIT (CPU)

6. The Coroners Prevention Unit (CPU) is a specialist service for Coroners created to strengthen their prevention role and provide professional assistance on issues pertaining to public health and safety. Independent specialists assist in the investigation and development of recommendations surrounding deaths occurring during the provision of healthcare. They assist in identifying factors that may help improve patient safety and risk management in such settings.

7. At my request, independent specialists of the mental health and medical teams, respectively of the CPU have reviewed both JP's mental health treatment following admission to the Northern Area Mental Health Service Inpatient Unit (IPU) at the Northern Hospital proximate to his death, and his medical treatment upon transfer to the ED and ICU on 17 December 2017.

MENTAL HEALTH TREATMENT

8. My investigation has been greatly assisted by the statement of Consultant Psychiatrist and Director of Clinical services for Northern Area Mental Health, Dr Kurt Wendelborn, together with the medical records detailing JP's psychosocial, psychiatric forensic and substance use histories and the results of an internal review.

Psychiatric diagnosis and self-harm history

9. JP's psychiatric diagnosis were schizophrenia, cluster B personality traits and ICE/opioid dependence. He is noted to have experienced childhood trauma, subsequent posttraumatic stress disorder and had an acquired brain injury. JP had lengthy history of self-harm when acutely unwell. This included overdoses, self-mutilation, and injections of ink into his veins, injections of faeces into his testicles

requiring their surgical removal, neck lacerations and insertion/inhalation of foreign objects.

Preadmission

10. JP had been discharged from the IPU on 24 October 2017 and was engaged with and supported by community mental health team and Jesuit Services. JP failed to attend for his scheduled depot injection on 31 October 2017. Unsuccessful attempts were made to engage with JP and community support staff expressed their concerns his mental state had deteriorated. On 2 November 2017 JP's current community treatment order (CTO) under Mental Health Act 2014 (Vic) was varied to an inpatient treatment order (ITO). With co-ordination provided by OACER, JP was transported by Ambulance Victoria and Victoria Police to the Northern Hospital emergency department, where he was directly admitted to the IPU.

Admission to IPU

11. JP was admitted to the IPU on 2 November 2017 in response to a deterioration in his mental state associated with increased substance use. This included auditory and tactile hallucinations, paranoid delusions and JP had decreased insight and judgement. JP was admitted as a compulsory patient under the *Mental Health Act 2014* (Vic) and was subject to an ITO and nursed in the IPU intensive care area (ICA) because he was agitated, aggressive and disorganised.

12. A consultant psychiatrist reviewed JP on 3, 17 and 19 November 2017, and 6 December 2017. The clinical risk assessment and management initial assessment (CRAAM) was completed by the consultant psychiatrist on 3 November 2017. There are documented daily reviews by psychiatric registrars during JP's stay in the ICA including revised risk assessments on 2, 6, 7, 8, 9, 13, 17, 18, 19 and 20 November 2017, with escorted leave approved by a psychiatric registrar on 13 November 2017. Medical staff reviews became appropriately less frequent after JP's transfer to the low dependency unit (LDU). There is evidence of medical officer reviews at regular periods and frequently in response to JP's physical health issues and requests for medication changes and repeated mental state examinations by IPU staff.

13. On 6 November 2017 JP complained of abdominal pain and rectal bleeding. An x-ray revealed JP had an 8.2cm nail in his bowel, which he had inserted. JP refused treatment stating it would dissolve. JP required restraint and the nail was successfully removed under anaesthetic on 10 November 2017.

14. JP was prescribed a combination of medications, including paliperidone, chlorpromazine, clonazepam, and methadone. JP was also prescribed sodium valproate however he was noted to be non-adherent. JP had access to analgesia and had input into the combination of medications, which appear to be within prescribing guidelines.

15. JP's behaviours when acutely unwell included verbal and physical aggression toward staff and some co-patients. There are documented instances when the staff felt unsafe when JP was highly agitated, but even when JP's mental state was assessed as improved he had frequent verbally offensive and abusive outbursts to staff, especially female staff members.

16. Following several trial periods, JP was transferred permanently from the ICA to the LDU until 20 November 2017. On this date, he was given permission by his psychiatric registrar to have escorted leave to seek accommodation. The revised CRAAM risk assessment form noted escorted leave approved by the psychiatric registrar on 13 November 2017, a medical officer on 17 November 2017 and an intern on 6 December 2017. Over the ensuring weeks, JP had episodes of escorted leave with staff members and most were uneventful. Documented consultant psychiatrist approval occurred on 6 December 2017.

17. Discharge planning was comprehensive and included case conferences with multiple agencies, referral to the high-risk panel and the development of a plan to support JP, initially in the Austin Health SECU program, and longer-term to establish and support him in the community.

18. On 16 December 2017 JP was settled and underwent uneventful escorted leave. At 4.30pm, on 17 December 2017, his IPU nurse took him on escorted leave, returning about 4.30pm. Whilst on leave, JP went to a toilet (his nurse remained outside the toilet door). At 8.00pm JP approached his nurse requesting further leave. Upon explaining it was too late in the day, whereupon JP became upset and voiced suicidal

ideation. His nurse attempted to explore his suicidal ideation, however JP became hostile and irritable. His nurse increased her observation frequency to every 15 minutes. At 8.45pm JP entered the dining room, groaned in pain and disclosed he had injected faecal matter into his vein. A syringe was located in his room which it is assumed he sourced from the sharps container in the toilet while he was on escorted leave.

19. JP was assisted back to his bed, wrapped in a blanket for comfort and administered 1 gram of Paracetamol for pain. At the request of the unit manager, his nurse notified the on-call Psychiatry Registrar, who in turn notified and fully appraised the Senior Psychiatry Registrar.

20. Nursing staff conducted initial observations of vital signs at 8.55pm. At the second nursing observations at about 9.15pm, an increase in heart rate led to the initiation of a MET call. Nursing staff attended JP's bedroom to assist with the MET call, by reassuring JP and encouraging his co-operation. A Medical Registrar of the Northern Hospital was in attendance and took a sample of JP's blood for analysis.

21. JP was transferred and admitted to The Northern Hospital ED with the assistance of a wheelchair.

Medical Management Overview

22. Upon transfer to the ED following initiation of a MET call, medical staff were informed JP had disclosed he had injected faeces into his arm.

23. He was commenced on antibiotics. It was planned that he would be given 3 different antibiotics, namely ceftriaxone, ampicillin and metronidazole, however there were major problems obtaining and maintaining intravenous access and JP subsequently refused further IV access. He was therefore commenced on the oral antibiotic moxifloxacin, on the advice of infectious diseases specialists.

24. Whilst in the ward JP had multiple MET calls for low blood pressure, fever and altered conscious state. On one occasion his depressed conscious state with pin-point pupils and slow respiratory rate responded dramatically to the administration of naloxone and it was speculated that this was due to opiate use, although it was not

known how it was obtained. There was an unproven suspicion that he had been hoarding his methadone.

25. JP's blood cultures subsequently grew bacterial consistent with faecal bacteria.

26. At a MET call an IV was re-inserted and JP was given intravenous antibiotics, which, on the advice of the infectious diseases unit, was changed to meropenem. The IV subsequently failed and JP returned to oral antibiotics. Due to JP's highly aggressive behaviour a special attendant was allocated, however he was unable to be present after 9.30 pm due to JP's agitation, absconding and aggressive behaviour.

27. Whilst in ICU JP's observations were mildly abnormal but did not require specific supportive therapy. He was sufficiently stable for ICU to plan for his discharge on the morning of 19 December.

28. Sadly at 6.05am, JP was found deceased in his bed.

29. JP's death was reported to the coroner. A post-mortem examination undertaken by Dr Paul Bedford gave the cause of death as:

1(a) septicaemia following a self-administered intravenous injection of faeces.

Dr Bedford made a number of Comments, including:

a. The mechanism of death in septicaemia includes cardiovascular collapse due to hypertension, multi-organ failure, and systemic inflammatory response syndrome.

b. JP also had severe focal single vessel coronary artery atherosclerosis, with up to 80% luminal occlusion. This was sufficient to have caused death in **isolation by inducing an acute coronary syndrome, which includes sudden** cardiac death and acute myocardial infarction. The mechanism of death in these cases is lethal arrhythmia. It is possible that the presence of severe ischaemic heart disease has interacted with the effects of sepsis, and in particular prolonged hypotension and tachycardia have the potential to compromise myocardial oxygenation.

30. Following JP's death, a joint internal review of Northern Health and North Western Area Mental Health was conducted, the conclusions of which are as follows:

- NorthWestern Mental Health improve the clarity of requirements for regular consultant psychiatrist review of all inpatients by writing a procedure and that compliance is audited as part of regular file audits

- NorthWestern Mental Health decided to include these changes in the existing Assessment and Review policy/procedure

- NorthWestern Mental Health decided each patient in the mental health acute psychiatric unit was to be reviewed twice a week

- July 2018 the policy was submitted to the NorthWestern Area Mental Health Continuous Improvement Committee, which did not approve the changes, requested further review and the inclusion of the expected consultant psychiatrist review timeframes

- NorthWestern Mental Health expected these changes to have been made within three months.

31. The internal review made the following recommendation:

    - Improve the clarity of the requirement for regular consultant review of all inpatients by writing a procedure and including on the regular audit of files.

32. I am advised that Dr David Fenn, the Acting Director of Clinical Governance of NorthWestern consulted with the Clinical Directors of NWMH and surveyed the consultant psychiatrists and obtained agreement that consumers in the inpatient units would receive a minimum of 2 reviews by a consultant psychiatrist each week where feasible. He amended the relevant Procedure and presented it to the NWMH Clinical Risk Management Committee for endorsement. This committee recommended a number of changes, which were incorporated, and the procedure has now been approved and posted on the Melbourne Health electronic i-policy system. Consultants at the Northern Area Inpatient Units have been informed regularly of this requirement by the Director of Clinical Services. An audit is planned in the New Year.

33. Recruitment to consultant staffing of the units has remained challenging, but was completed in October 2018, and the units are now operating at their recommended complement. The complement for Psychiatrist has been increased by 0.6 EFT at a

total cost of circa $180,000, raising the total complement of psychiatrists to 4.2 EFT (including 0.2 EFT Lead Consultant time) across the units.

34. In addition, the operational management of the units has been restructured and improved allowing for the employment of a Nurse Unit manager for each 25 bed unit. It is expected that these appointments will continue to drive significant improvements in clinical practice.

35. In addition to the specific recommendation, Northern Area Mental Health Service has undertaken other significant improvements in the inpatient units. These include restructuring the management and operation of the units, and new guidelines for clinical escalation. These guidelines have been developed for the Continuing Community Care Unit, the Community Mental Health Teams and the Inpatient Unit.

Conclusion following review of Mental Health treatment

36. The medical records document a co-ordinated, comprehensive and responsive approach to providing care to JP with a high level of communication with JP and between the health services, their departments and the community agencies. JP presented with complex issues, a serious mental illness with complex symptomology, substance dependency and the complications of aggression, disorganisation, disinhibited and antisocial behaviours.

37. The care provided was recovery focused and involved consultation with Aboriginal Health Services to the degree JP allowed. There is consistent evidence of timely referral by the IPU to specialist services for advice and specialist care.

38. I am satisfied the response of his nurse to JP expressing suicidal ideation in the hours prior to staff being told he had injected himself was appropriate and was consistent with the previously effective responses throughout his current and earlier admissions, on the occasions JP expressed suicidal ideation. His nurse appropriately attempted to explore with JP what he was experiencing and when he responded with hostility, the observation frequency was increased.

39. The investigation has identified that the frequency of review by a consultant psychiatrist for JP in the 11 days prior to his transfer to Northern Hospital was

suboptimal, which supports the finding of the Northern Hospital and NorthWestern Mental Health internal review.

40. Nevertheless, it is unlikely greater frequency of review by a consultant psychiatrist would have changed the outcome because JP had been relatively settled, was considered to be at baseline, had uneventful escorted leave previously and on the day prior, suggesting leave arrangements would not have been changed.

Conclusion following review of Medical treatment

41. JP posed a complex and difficult management problem that required some compromise regarding the administration of oral versus IV antibiotics. Following CPU review, I am satisfied that to insist upon IV antibiotics would have required the insertion of a central venous line with associated risks and most certainly significant long-term restraint to prevent JP's interference. It is likely that the antibiotic regime employed was effective, as JP's condition was not deteriorating. His sudden death was unexpected and not in keeping with severe sepsis.

42. I consider no further coronial investigation into JP's medical management is required.

FINDINGS

43. Having considered all the evidence, in the circumstances described above:

44. I find that JP born on 21 January, died on 19 December 2017 at Northern Hospital of septicaemia following a self-administered intravenous injection of faeces.

45. I express my sincere condolences to JP's family.

46. Pursuant to Section 73 (1) of the Coroner Act 2008, I order that this finding be published on the internet.

47. I direct that a copy of this finding to the following:

(a) Next of Kin

(b) Northern Health

(c) Dr Neil Coventry – Office of the Chief Psychiatrist

(d) Other registered interested parties

(e) Coronial Investigator

Signature:

MR JOHN OLLE

CORONER

Date: 7 February 2019