IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 005176

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	Peter Charles White, Coroner
Deceased:	Danny Wayne Feschuk
Date of birth:	23 June 1970
Date of death:	31 October 2016
Cause of death:	Cardiomegaly in the setting of hypoventilation syndrome in an obese man with schizophrenia
Place of death:	Werribee

I, PETER CHARLES WHITE, Coroner,

having investigated the death of DANNY WAYNE FESCHUK

without holding an inquest:

find that the identity of the deceased was DANNY WAYNE FESCHUK

born on 23 June 1970

and that the death occurred on 31 October 2016

at Werribee Mercy Hospital Psychiatric Unit, 300 Princes Highway, Werribee, Victoria 3030

from:

I (a) CARDIOMEGALY IN THE SETTING OF HYPOVENTILLATION SYNDROME IN AN OBESE MAN WITH SCHIZOPHRENIA

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Mr Feschuk was a 46-year old single, disability support pensioner who ordinarily lived alone in public housing in Maidstone. He had a medical history that included an acquired brain injury, cervical injury with spinal fusion following a fall resulting in unsteady gait, recurrent falls and mobilisation by wheelchair, chronic pain, previous intravenous drug and other substance use, hepatitis C, heavy smoking, chronic obstructive pulmonary disease [COPD], acute on chronic type 2 respiratory failure,[1] and hypoventilation syndrome with a baseline oxygen saturation level of 80% and sleep aponea.

2. Mr Feschuk also had an extensive psychiatric history, with more than 50 admissions over 30 years. He had been diagnosed with schizophrenia and antisocial personality disorder, characterised by poor impulse control and other behavioural issues that complicated his management. He was well known to Mercy Mental Health Service and had been managed in the community for several periods. However, for the three years prior to his death, he had been managed as a voluntary patient with antipsychotic medication by his general practitioner [GP].

3. In February 2016, Mr Feschuk was living alone in a 'quite dysfunctional neighbourhood'[2] with his finances managed by State Trustees. His mental health had deteriorated due to non-compliance with his medications, and because of deterioration of his physical health and self-neglect. His GP facilitated his admission to the Ursula Frayne Psychiatric [UFP] inpatient unit in Footscray where he remained, barring several admissions to the medical ward for management, until his transfer to the Werribee Mercy Psychiatric Inpatient Unit [WMPIU] on 27 September 2016. The transfer to WMPIU occurred to facilitate management of his medical

[1] Respiratory failure (low oxygen levels) with a high carbon dioxide level (hypercapnia).
[2] Coronial brief of evidence, Statement of Dr Indika Jayathilake.

co-morbidities given the proximity of medical wards, especially given that he was considered unsuitable for independent living at home due to functional decline.

4. Mr Feschuk was admitted to WMPIU as an involuntary patient subject to an inpatient treatment order under the *Mental Health Act* 2014. His mental state was stable and without psychotic symptoms, having improved with the reintroduction of his medications at UFP. He remained demanding at times and easily frustrated, however, this was attributed to his acquired brain injury rather than schizophrenia. He was particularly prone to frustration and agitation on those occasions he was not allowed to go outside to the hospital grounds unaccompanied by staff in order to smoke.

5. During his WMPIU admission, Medical Emergency Team [MET] calls occurred on multiple occasions due to Mr Feschuk experiencing respiratory distress, low oxygen saturations and hypoxia. Between 1 and 7 and 16 and 17 October 2016 Mr Feschuk was transferred to the medical ward via the emergency department [ED] for management of pneumonia and acute respiratory symptoms and hypoxia following MET calls.

6. On 17 October 2016, a medical decision was made by clinicians to make Mr Feschuk not for resuscitation [NFR]. Upon his return to WMPIU that day, his treating psychiatrist, Dr Indika Jayathilake, cancelled Mr Feschuk's unaccompanied hospital ground leave to smoke due to his increased medical and falls risks in consultation with the Acting Unit Manager and Clinical Director.

7. On 21 October 2016, a meeting occurred between Mr Feschuk's family, including his legal guardian and sister Heleena O'Sullivan, and representatives of the medical, psychiatric and nursing teams (and managers) involved in Mr Feschuk's care. Among the issues discussed were the factors contributing to Mr Feschuk's rapidly deteriorating lung function, his resuscitation status and his high level nursing care needs post-discharge.[3]

8. On 23 October 2016, a MET call occurred when Mr Feschuk experienced respiratory distress and hypoxia. He was again transferred to the medical ward and was treated for acute pulmonary oedema and an exacerbation of COPD. Mr Feschuk's medical and psychiatric teams discussed the most appropriate setting for his ongoing management until an appropriate discharge destination could be established and secured.

9. On 28 October 2016, the medical team was of the view that Mr Feschuck was medically stable and could be managed on the psychiatric ward. However, he remained on the medical ward.

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[3] Coronial brief of evidence, Statement of Dr Indika Jayathilake.

10. On the afternoon of 31 October 2016, a meeting occurred between Mr Feschuk's family, and representatives of the medical, psychiatric, social work and nursing teams to determine the most appropriate setting – medical or psychiatric – for his management prior to discharge. The medical team indicated that Mr Feschuk's condition was stable from an 'intervention perspective'[4] and that he was not suitable for palliative care as he could live for several months at his current level of function. Management of his behaviour on the medical ward, one-to-one psychiatric nursing notwithstanding, was of concern.[5] For their part, the psychiatric team were concerned that Mr Feschuk's baseline nursing and medical care needs were difficult to meet at WMPIU. Social workers were to continue to explore appropriate discharge destinations. By the conclusion of the meeting, the arrangement was that Mr Feschuk would remain on the medical ward.

11. However, at about 5pm the same day, Mr Feschuk was transferred back to WMPIU, with ongoing one-to-one psychiatric nursing.[6] Handover from the medical team recommended regular vital sign observation (but not oxygen saturation measurement),[7] with instructions for a MET call if Mr Feschuk's Glasgow Coma Score[8] was below 13 and he was cyanotic, with oxygen saturation below 80 per cent.[9] The medical team determined that Mr Feschuk no longer required supplementary oxygen.[10]

12. At about 6.15pm, Mr Feschuk was medically examined in WMPIU, at which time his vital observations were unremarkable and he was not cyanotic.

13. Around 6.30pm, Mr Feschuk was agitated and uncooperative because he was not permitted to smoke a cigarette. He was prescribed and encouraged to accept nicotine replacement therapy.

14. At about 8.20pm, a Code Blue was called when Mr Feschuk's nurse observed him in respiratory distress. The Code Blue team assessed Mr Feschuk and commenced cardio-pulmonary resuscitation, however, once the NFR order was located, efforts to revive him were ceased. Mr Feschuk was pronounced deceased at 8.33pm on 31 October 2016.

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[4] That is, according to the statement of (psychiatrist) Dr Anindya Banerjee, that no new surgery or investigations or interventions were planned.
[5] Coronial Brief of Evidence, Statement of Dr Dean Stevenson.
[6] Dr Banerjee queried this development (given it was at odds with the outcome of the family meeting) and was informed by Dr Stevenson, the Director of Mercy Mental Health, that the medical team had determined that as he was medically stable, Mr Feschuk should be transferred to the psychiatric unit. On the basis that he was originally transferred from WMPIU to the medical ward, Mercy Mental Health ought to accept his return.
[7] Given Mr Feschuk's low baseline oxygen saturation, levels were to be measured only if he became symptomatic (with signs of hypoxia).
[8] An objective measure of consciousness.
[9] Coronial Brief of evidence, Statement of Dr Emma Tulloch.
[10] Supplementary oxygen was administered only cautiously as Mr Feschuk was a 'carbon monoxide retainer' such that high oxygen saturations (achieved through supplementary oxygen) would reduce his respiratory drive and he would become drowsy due to increased CO_2.

15. At my request, a coronial brief of evidence was prepared by First Constable Simon Bowen of Werribee Police.

16. Forensic pathologist, Dr Melissa Baker of the Victorian Institute of Forensic Medicine, reviewed the circumstances of the death as reported by police to the coroner, post-mortem computer assisted tomography [PMCT] scans of the whole body and performed an autopsy. Among Dr Baker's anatomical findings were cardiomegaly[11] with biventricular hypertrophy, pulmonary oedema and congestion, COPD, moderate single vessel coronary artery atherosclerosis, chronic hepatitis and obesity (BMI 35.58kg/m^2).[12]

17. Routine post-mortem toxicology detected oxycodone,[13] oxazepam,[14] haloperidol,[15] quetiapine[16] and olanzapine[17] at low levels, a therapeutic dose of methadone and its metabolite,[18] and a trace of paracetamol. All of the drugs detected except paracetamol, have some central nervous system depressant effect that is additive with the concurrent use of such drugs.

18. Dr Baker attributed Mr Feschuk's death to natural causes, namely, cardiomegaly in the setting of hypoventilation syndrome in an obese man with schizophrenia.

19. The pathologist noted that Mr Feschuk's clinical diagnoses of COPD secondary to heavy smoking, chronic type 2 respiratory failure and hypoventilation syndrome[19] but that her post-mortem examination revealed changes of COPD, not indicative of severe disease.

20. Dr Baker noted that cardiomegaly, often caused by hypertension, may also be seen with ischaemic heart disease and obesity, while hypertension itself has many underlying causes such as COPD, sleep apnoea, use of amphetamines or may be idiopathic. Cardiomegaly is associated with increased myocardial oxygen demand, arrhythmias and sudden death.

21. It was also noted that sudden death has been reported in schizophrenics due to schizophrenia alone and is thought to be a result of instability of the autonomic nervous system. In addition, atypical antipsychotics can lead to prolongation of the QT interval and predispose to fatal

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[11] An enlarged heart, that is a heart weight above that expected for a man of Mr Feschuk's height and weight.
[12] Body Mass Index or BMI is a measure of body fat based on a person's weight in kilograms (kg) divided by his or her height in meters squared. A BMI under 18.5 is considered underweight, a BMI between 18.5 and 24.9 is regarded as a healthy weight, while a BMI of 25.0 to 29.9 is classified as overweight and a BMI of over 30, obese.
[13] A semi-synthetic opiate narcotic analgesic.
[14] A benzodiazepine.
[15] An antipsychotic medication.
[16] An antipsychotic medication.
[17] An antipsychotic medication.
[18] A synthetic narcotic analgesic.
[19] Hypoventilation syndrome – insufficient ventilation leading to hypercapnia) is caused by several disorders including central alveolar hypoventilation (secondary to an underlying neurological disease), obesity hypoventilation syndrome (secondary to obesity and sleep disorder) and COPD – any of which may account for Mr Feschuk's condition.

cardiac arrhythmias. Mr Feschuk was prescribed atypical antipsychotics olanzapine and quetiapine.

22. Accordingly, Dr Baker advised that the mechanism of Mr Feschuk's death was likely to have been a cardiac arrhythmia in the context of an enlarged heart which is potentially electrically unstable, in the setting of chronic hypoxia and hypercapnia, the underlying cause of which is multifactorial.[20]

23. I find that Mr Feschuk, late of Basquet Street, Maidstone, died at Werribee Mercy psychiatric inpatient unit in Werribee on 31 October 2016 of natural causes, namely, cardiomegaly in the setting of hypoventilation syndrome in an obese man with schizophrenia. The available evidence does not support a finding that any want of clinical management or care on the part of Mr Feschuk's Mercy Health clinicians or nursing staff caused or contributed to his death.

I direct that a copy of this finding be provided to the following:

The Feschuk family, c/- S. Tomyn & Co.

Mercy Health, c/- Michael Regos, DLA Piper Australia

Mr Simon Cooke, Mercy Hospitals Victoria Ltd

Office of the Chief Psychiatrist

FC S. Bowen, Werribee Police

Signature:

PETER CHARLES WHITE
CORONER
Date: 15/5/2018

Coroners Court of Victoria

[20] Coronial brief of evidence, Report of Dr Melissa Baker.