IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 006200

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	Coroner David Ryan
Deceased:	Gary Ronald Burgess
Date of birth:	14 August 1962
Date of death:	19 November 2021
Cause of death:	1(a) Massive aspiration in the setting of intubation following complications of severe ileus (cause unknown) 2 Schizophrenia
Place of death:	Frankston Hospital 2 Hastings Road, Frankston, Victoria, 3199
Keywords:	Ileus – bowel obstruction – clozapine

INTRODUCTION

1. On 19 November 2021, Gary Ronald Burgess was 59 years old when he died at Frankston Hospital. Mr Burgess lived in community disability accommodation in Hastings but at the time of his death, he was receiving treatment as an inpatient pursuant to the *Mental Health Act 2014* (**the MHA**).

BACKGROUND

2. Mr Burgess's medical history included a mild intellectual disability, treatment-resistant schizophrenia, diabetes mellitus, gout, benign prostatic hypertrophy, hypertension and dyslipidaemia. His schizophrenia had been treated with clozapine since 1993.[1]

3. On 25 August 2021, Mr Burgess was admitted to the Inpatient Psychiatric Unit (**IPU**) at Frankston Hospital pursuant to a temporary treatment order under the MHA. His admission followed a deterioration of his mental state attributed to the management of his clozapine therapy and the impact of Covid-19 related psychosocial stressors. During his admission, his clozapine dose was re-titrated along with other psychotropic medications and he was discharged back to the community on 4 October 2021.[2]

4. On 8 October 2021, Mr Burgess was again admitted to the IPU at Frankston Hospital after having a further relapse in his medical condition. Further titration of his clozapine dose was undertaken although Mr Burgess was noted to have a poor response to the therapy. He was commenced on lithium[3] and alternative diagnoses (such as delirium and vascular dementia) were considered.

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[1] Peninsula Health medical records, p 111/741
[2] Peninsula Health medical records, p 375/741; p 916/1526.
[3] A mood stabiliser medication primarily used in the treatment of patients with bipolar disorder and major depressive disorder.

THE CORONIAL INVESTIGATION

5. Mr Burgess's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury. The death of a person in care or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes. However, if the coroner considers that a death is due to natural causes, an inquest is not required to be held. In this case, I have determined that it is not necessary to hold an inquest.

6. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

7. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

8. I directed that statements be obtained from clinicians who treated Mr Burgess at the Frankston Hospital. I have also obtained the medical records from the hospital and a report from the forensic pathologist.

9. This finding draws on the totality of the coronial investigation into the death of Mr Burgess. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[4]

[4] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

10. On 3 November 2021, a treatment order under the MHA was made by the Mental Health Tribunal for a period of 26 weeks.[5]

11. On 5 November 2021, Mr Burgess was prescribed laxatives and a bowel chart was commenced, as his treating clinicians noted he had not opened his bowels for at least four days. An abdominal X-ray revealed constipation but no proximal bowel dilatation to suggest bowel obstruction. Mr Burgess subsequently had large bowel actions on 6, 8 and 9 November 2021. His treating clinicians attributed the constipation to Mr Burgess's clozapine therapy.[6]

12. On 9 November 2021, Mr Burgess's mental state declined and he also sustained a witnessed fall, although he did not strike his head or lose consciousness. A medical examination after the fall noted that Mr Burgess's abdomen was soft with possible mild tenderness but he denied experiencing any pain. His medical management included reducing his laxatives due to concerns of lithium toxicity and dehydration given his recent bowel movements.[7]

13. On 13 November 2021, Mr Burgess was noted to have poor oral intake and his abdomen was observed to be distended. He had a large soft bowel action later that evening.[8]

14. On 14 November 2021, Mr Burgess was observed to be incontinent with three very soft bowl actions.[9]

15. On 17 November 2021, Mr Burgess was observed to be eating small amounts of food and drinking fluids. His vital signs remained unremarkable and his abdomen remained distended. With some encouragement, he walked to a lounge chair and watched television for around 45 minutes. He went to the toilet in the afternoon but was noted to be constipated. A mental health nurse notified the medical team about Mr Burgess's distended abdomen, who advised that it had been unchanged since his admission which was also consistent with information provided by Mr Burgess's mother.[10]

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5 Peninsula Health medical records, p 175 & 184/741.
6 Peninsula Health Medical records, p 1029/1526
7 Medical records, p 1027/1526; Statement of Dr Geeta Rudra dated 4 November 2022.
8 Medical records, p 958/1526.
9 Medical records, p 1386/1526.
10 Statement of Dr Bruce Maydom dated 28 October 2022; Medical records, p 946/1526.

16. On 18 November 2021, Mr Burgess remained in bed and the clarity of his communication was diminished. He was reviewed by both the psychiatry and medical teams and his lithium dose was reduced as it was thought to be contributing to his urinary incontinence. His laxatives were increased as it was observed that his bowels had not opened in the last four days.

17. Later that evening, Mr Burgess was observed to have a fever and elevated heart and respiratory rates. He appeared unwell with a grossly distended (non-tender) abdomen with "*tinkling bowel sounds*". The medical team ordered an urgent X-ray for a suspected bowel obstruction.[11]

18. On 19 November 2021 at 4.21pm, a MET call was initiated by nursing staff due to Mr Burgess's elevated heart and respiratory rates. There was no bed available in the Intensive Care Unit (**ICU**) at the time but Mr Burgess was assessed by the ICU registrar who concluded that he had aspirated with a high suspicion that the cause was a bowel obstruction/ileus.[12] His supplemental oxygen was increased and he was administered a dose of morphine but he continued to deteriorate.[13]

19. At around 6.50pm, Mr Burgess was transferred to ICU. He was intubated but his oxygen saturation failed to improve and he continued to vomit large volumes of gastric contents. He subsequently went into cardiac arrest and cardiopulmonary resuscitation was commenced. CPR was discontinued after approximately eight minutes as there was no return of cardiac activity and he suffered profound hypoxia due to massive aspiration. He was declared deceased at 7.40pm.[14]

Identity of the deceased

20. On 19 November 2021, Gary Ronald Burgess, born 14 August 1962, was visually identified by his brother, Peter John Burgess.

21. Identity is not in dispute and requires no further investigation.

[11] Medical records, p 759 & 927/1526.
[12] An ileus is a functional bowel obstruction (as opposed to a mechanical bowel obstruction) due to the absence of peristalsis / bowel motility (muscle contraction for propelling contents of the gastrointestinal tract).
[13] Statement of Dr Kavi Haji dated 25 November 2022.
[14] E-Medical Deposition dated 19 November 2021; Medical records, p 939/1526.

Medical cause of death

22. Forensic Pathologist Dr Yeliena Baber from the Victorian Institute of Forensic Medicine performed an examination and provided a written report of her findings dated 26 November 2021.

23. Dr Baber reviewed a computed tomography (**CT**) scan which showed a grossly distended stomach and part of the small bowel with some ischaemic regions of small bowel. She further noted that the distal large bowel appeared of normal calibre and there was bilateral aspiration pneumonia.

24. Dr Baber clearly observed that Mr Burgess had suffered from a bowel obstruction (mechanical or otherwise) but that the cause of that obstruction was not clear.

25. Toxicological analysis of post-mortem samples identified the presence of a number of drugs, including clozapine,[15] consistent with Mr Burgess's treatment at Frankston hospital.

26. Dr Baber provided an opinion that the medical cause of death was 1 (a) Massive aspiration in the setting of intubation following complications of severe ileus (cause unknown); 2 Schizophrenia.

Review of care

27. Peninsula Health have acknowledged that the circumstances of Mr Burgess's death have highlighted that patients who are subject to clozapine therapy need to be very closely monitored and more information needs to be made available to other medical specialists and staff to ensure they have greater knowledge and understanding of the serious gastrointestinal complications associated with its use.[16]

28. Peninsula Health reported Mr Burgess's case to Safer Care Victoria and a review was conducted which resulted in the following recommendations:

    a) A review and update of the Clozapine Clinical Practice Guideline (**CPG**);

    b) The development of a standardised template for bowel management for all patients prescribed clozapine;

[15] Clozapine is an antipsychotic drug effective for treating the positive and negative symptoms of schizophrenia. It is restricted to patients who do not respond to first-line antipsychotics.
[16] Statement of Dr Geeta Rudra dated 4 November 2022.

c) An update to the clozapine prescribing alert;

d) The development of a CPG for admission to the Psychiatric Assessment and Planning Unit;

e) Investigating the feasibility of associating task automation with medication prescribing (ie. bowel chart commencement when clozapine is prescribed); and

f) A review of the MET call process.

29. I referred this case to the Coroners Prevention Unit (**CPU**) to review the care provided to Mr Burgess during his last admission to the Frankston hospital.[17] It noted that clozapine therapy needs to be monitored routinely as it can lead *to* "*increased frequency of constipation and delayed diagnosis and treatment increase the risk of severe complications of gastrointestinal hypomotility, resulting in intestinal obstruction, faecal impaction, megacolon, paralytic ileus and intestinal ischaemia or infarction*".[18]

30. As at 1 March 2022, the Therapeutic Goods Administration's database of Adverse Event Notification records 1023 clozapine reports with a fatal outcome, including 103 due to gastrointestinal disorders.[19]

31. The CPU considered that the medical management of Mr Burgess was reasonable and that it is unlikely that his death was preventable in the circumstances. Further, they advised that the preventative measures proposed to be implemented by Peninsula Health in relation to the management of patients who are prescribed clozapine are reasonable. However, they noted that although the staff in the IPU at Frankston Hospital were aware of and had documented Mr Burgess's risk of clozapine-induced constipation and associated gastrointestinal disorders, health care professionals in other areas of the hospital may have had a lower level of awareness. This appears to be reflected in the recommendations made by Peninsula Health.

[17] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[18] Clozapine Australian Product Information, p 6. Accessed online 15 June 2022, <https://www.ebs.tga.gov.au/ebs/picmi/picmirepository.nsf/pdf?OpenAgent&id=CP-2018-PI-01813-1&d=20220615172310101>.

[19] Therapeutic Goods Administration, Department of Health, Australian Government, Medicines Safety Update, 22 April 2022, "Clozapine and gastrointestinal hypomotility with severe complications".

32. The CPU agreed with Dr Bruce Maydom, General Medicine Consultant at Peninsula Health, that Mr Burgess's death was likely due to clozapine-induced ileus rather than clozapine-induced constipation, noting that the large bowel did not contain faecal material.

FINDINGS AND CONCLUSION

33. Pursuant to section 67(1) of the Act, I make the following findings:

    a) the identity of the deceased was Gary Ronald Burgess, born 14 August 1962;

    b) the death occurred on 19 November 2021 at Frankston Hospital, 2 Hastings Road, Frankston Victoria, from massive aspiration in the setting of intubation following complications of severe ileus with schizophrenia as a contributing factor; and

    c) the death occurred in the circumstances described above.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations directed to Safer Care Victoria:

(i) review the details of this case and the recommendations made at Peninsula Health, in order to consider whether some / all / additional process improvements in clinical care for patients taking clozapine should be implemented across all acute care health services state-wide;

(ii) consider the utility of developing a guideline focused on education and improved clinical care delivery primarily for non-psychiatric health practitioners for the management of constipation in patients on clozapine (and other antipsychotics), similar to the documents from NSW Health and SA Health (see Attachments A and B).

I convey my sincere condolences to Mr Burgess's family for their loss.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

Pursuant to section 49(2) of the Act, I direct the Registrar of Births, Deaths and Marriages to amend the cause of death to the following "1(a) Massive aspiration in the setting of intubation following complications of severe ileus; 2 Schizophrenia".

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

Aline Burgess, Senior Next of Kin

Peninsula Health, c/o K&L Gates

Safer Care Victoria

Senior Constable Ashley Riley, Coroner's Investigator

Signature:

Coroner David Ryan

Date : 27 April 2023

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.