OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Peter Shishko**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 1766/06(6)
DELIVERED ON:	16 December 2009
DELIVERED AT:	Brisbane
HEARING DATE:	8 October 2009
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	Coroners: inquest, death in custody, natural causes, sufficiency of medical supervision and response.

REPRESENTATION:

Counsel Assisting:	Mr Mark Le Grand
Department of Community Safety:	Ms Melinda Zerner
The Park Centre for Medical Health:	Mr Mark Sainsbury (Cooper Grace Ward, Lawyers)

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The Coroners Act 2003 provides in s45 that when an inquest is held into a death in care, the coroner's written findings must be given to the family of the person who died; each of the persons or organisations granted leave to appear at the inquest; and to various specified officials with responsibility for the justice system. These are my findings in relation to the death of Peter Shishko. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of State Coroner.

Introduction

Peter Shishko died while on remand and under an involuntary treatment order in an isolation room at The Park Centre for Mental Health at Wacol on 18 June 2006. Mr Shishko was a 47 year old male Caucasian remand prisoner previously accommodated at the Arthur Gorrie Correctional Centre at Wacol.

Because the incident was a "death in care" within the terms of the Act[1] it was reported to the State Coroner for investigation and a possible inquest.

These findings

- confirm the identity of the deceased, the time, place, circumstances and medical cause of Mr Shishko's death;
- consider whether the actions or inactions of any person contributed to his death;
- consider whether the medical treatment afforded to him at The Park Centre for Medical Health (PCMH) was adequate and reasonable; and
- consider whether any changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.

The investigation

Detective Sergeant B A Swift and Plain Clothes Senior Constable Mark Kickbusch attended Mr Shishko's room at the PCMH at about 3.00am. From their observations they could not find anything that suggested an external influence on the causation of Mr Shishko's death.

[1] s8(3) defines "reportable death" to include deaths in care and s7 requires that such deaths be reported to a coroner or to a police officer who, in turn, is required to report to a coroner in writing. Section 27 requires an inquest be held in relation to all deaths in care which raise issues about the deceased person's care.

Sergeant Dennis Ryan of the South Brisbane Scenes of Crime office attended at the scene and in the presence, and at the direction of Detective Sergeant Swift, took a number of photographs of the seclusion room and of the deceased.

Thereafter the investigation languished. When, after numerous requests and directions, Sergeant Swift finally provided a report two years and two months after the death, it was seriously inadequate, containing only scant statements from two witnesses and no analysis of obvious issues such as the quality of the care provided to the patient/prisoner while he was in custody.

I readily appreciate the difficulty police officers may face when attempting to investigate deaths that occur in a medical setting which is why staff of this office are always available to assist with suggestions and the nomination of independent experts. I have seen no evidence in this case that technical challenges caused the unacceptable delay. I conclude Sergeant Swift failed to give the matter appropriate attention. I acknowledge the apology received from the Assistant Commissioner, Metropolitan South, and take heart from his advice that the progress of coronial files in the region shall henceforth be audited and monitored.

The inquest

An inquest was held in Brisbane on 8 October 2009. Mr M Le Grand was appointed as counsel to assist me. Leave to appear was granted to Ms M Zerner for the Department of Community Safety (the successor to the Department of Corrective Services) and Mr M Sainsbury of Cooper Grace Ward, lawyers for The Park Centre for Mental Health.

All of the statements, records of interview, photographs and materials gathered during the investigation were tendered at the inquest. The evidence was reviewed and submissions were made to the Court by counsel assisting. I was satisfied the matters I was required by the Act to make findings on could be established without the need to call oral evidence.

The evidence

I turn now to the evidence. Of course, I cannot summarise all of the information contained in the exhibits but I consider it appropriate to record in these reasons, the evidence which I believe is pertinent and relevant to the findings I have made.

Background to incarceration

On 27 February 2006, Mr Shishko was interviewed and charged by police in relation to the arson and attempted arson of the Elizabeth Street Medical Centre in Acacia Ridge, Queensland on 1 and 14 February 2006 respectively. The police allege that when interviewed Mr Shishko made full admissions to committing the offences. He also faced charges of public nuisance and obstructing police. At the time, Mr Shishko stated to police that he believed he was not going to live long

enough to face trial because he had been diagnosed as morbidly obese with a limited life expectancy.

Mr Shishko appeared in the Richlands Magistrates Court on the date he was charged and was remanded in custody. He was transferred to the Arthur Gorrie Correctional Centre on 3 March 2006. Three months later, on 2 June 2006, he was transferred to The Park Centre for Mental Health in Wacol as a result of mental health issues identified during his incarceration.

Mr Shishko had not previously been charged with any criminal offences but in the early part of 2006, it seems his mental state deteriorated significantly.

Deceased's medical care

Mr Shishko had been suffering from bipolar affective disorder (BPAD) for at least 25 years but apart from two inpatient admissions in the 1980s it was apparently reasonably well controlled. It is notable that his father was also diagnosed with schizophrenia and a sister with BPAD.

He obviously suffered a significant relapse when imprisoned and was transferred to the Park as a result of increasing mania leading to him being too difficult to manage in the general prison setting.

In addition to BPAD, hospital records document Mr Shishko's ailments as including sleep apnoea, hypertension and hypercholesterolemia. At the time of his death his weight was recorded at 165 kg.

The records detail that throughout his admission Mr Shishko was placed in seclusion on numerous occasions due to his aggressive behaviour.

On 15 June 2006, while in seclusion in the Bandicoot medium secure unit, it was noted Mr Shishko's feet and lower limbs were swollen but it seems no investigation of the cause was undertaken.

It is apparent that his treating doctors had some difficulties in designing a pharmacotherapy regime that addressed all his symptoms without significant side effects.

While at The Park, Mr Shishko was prescribed the following medication:

1) Aspirin – 300mg in the morning;

2) Candesarten, an anti-hypotensive – 16mg in the morning;

3) Atorvastatin, for cholesterol – 40mg in the morning;

4) Diazepam, a sedative – 10mg four times daily;

5) Lithium, for the bi-polar disorder – 500mg twice a day;

6) Olazapine, an anti-psychotic – 15mg daily; and

7) Quetiapine, an anti-psychotic – 150mg daily

Circumstances of Death

Shortly before 11.00pm on 17 June 2006 he was again placed in the isolation room in the Bandicoot unit due to antisocial behaviour including elevated mood and acting aggressively. Staff believed that there was an unacceptable risk that he would assault other persons in the unit.

Ms Janeen Fraser, a registered nurse recalls that when she commenced duty at 11.00pm on that day, Mr Shishko was already in the seclusion room.

In accordance with usual practice Mr Shishko was subject to 15 minute visual observations from the commencement of Nurse Fraser's shift. This consisted of the nurse looking through a clear window in the entry door to the seclusion room.

Nurse Fraser recalls making a check of Mr Shishko at 1:45am and noting that he was apparently asleep. She was aware he suffered from a form of sleep apnoea which caused him to have an irregular breathing pattern during sleep. She recalls standing at the observation window and observing Mr Shishko's breathing, watching his chest rise and fall. She could also hear him breathing loudly.

When Nurse Fraser returned to the seclusion room at 2.00am she could not see that he was breathing. The discharge summary prepared soon after the death states that he was found on the floor but this is not mentioned in the nurse's statement.

She called for the assistance of other staff working at that time and entered the seclusion room to check on Mr Shishko's non-responsiveness.

A "Code Blue" was called and cardiopulmonary resuscitation was commenced immediately. Nurse Donald McKee and Nurse Cathy Herron also entered the observation cell with Nurse Fraser. Nurse Manager Charles Clist notified the Queensland Ambulance Service. Ambulance officers arrived at the unit at 2:14am and continued the unsuccessful attempts to resuscitate Mr Shishko.

Mr Shishko was pronounced dead at 3.00am

His relatives were advised and Mr Shishko's eldest half sister, Amelia Campbell, attended the John Tonge Centre and viewed and identified Mr Shishko's body on Sunday 18 June 2006.

The autopsy

An autopsy was undertaken by a forensic pathologist Dr R Williams on 19 June 2006 at the John Tong Centre. Dr Williams noted that the body showed no signs of recent injury although there were signs of recent therapy being two defibrillator pads on the body, one on the right upper chest and another on the left lateral chest. An internal examination noted that there was severe atherosclerosis in the left anterior descending artery and mild atherosclerosis in the right coronary and left circumflex coronary arteries. Dr Williams concluded the main cause of death as coronary atherosclerosis. She based this conclusion on the circumstances surrounding death and the post mortem findings.

Dr Williams said:

> *"This man most likely suffered a fatal abnormal heart rhythm (arrhythmia) induced by impaired blood supply to the heart. Further, sleep apnoea and morbid obesity are considered significant other conditions relevant to death. This is because both these conditions are known to increase the risk of developing fatal arrhythmias."*

Forensic toxicology

An analysis of three specimens of femoral blood was undertaken at the Forensic Toxicology Laboratory of Queensland Health Scientific Services and a certificate issued of the results dated the 18th August 2006 showing:

- Alcohol - Not Detected (less than 10mg/100ml)
- Diazepam - 0.2 mg/kg
- Nordiazepam - 0.2 mg/kg
- Oxazepam - 0.02 mg/kg
- Temazepam - 0.03 mg/kg
- Olanzapine - 0.35 mg/kg
- Quetiapine - 0.2 mg/kg
- Lithium - 4 mg/kg

Dr Williams reviewed the toxicology analysis and wrote:

"Toxicology identified a number of medications in the blood sample Olanzapine, an anti-psychotic agent was present at a concentration above therapeutic range but well below the fatal range. Quetiapine and Lithium, also anti-psychotic agents, were both detected at levels within therapeutic range. Diazepam, an anti-anxiety agent, and Nordiazepam, a metabolite of Diazepam, were identified at concentrations within therapeutic range. Oxazepam, another anti-anxiety agent was detected at a sub-therapeutic level. Temazepam, a sedative/hypnotic medication was present at a sub-therapeutic concentration."

Findings required by s45(2)

Identity of the deceased

The deceased was Peter Shishko, who was born in Brisbane on 25 August 1958.

How he died

Mr Shishko died from natural causes while being detained at a mental health facility pursuant to an involuntary treatment order.

Place of death

Mr Shishko died at The Park Centre for Mental Health at Wacol in Queensland.

Date of death

Mr Shishko died on 18 June 2006

Cause of death

Mr Shishko died of an abnormal heart rhythm (arrhythmia) induced by atherosclerosis while suffering from sleep apnoea, morbid obesity and while heavily sedated with prescribed psychotropic drugs.

Recommendations

Section 46 of the Act authorises a Coroner conducting an inquest to comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

The circumstances of Mr Shishko's death raised a number of concerns which were the subject of further investigation. They were: -

- Whether the cocktail of prescription drugs found in Mr Shishko's blood contributed to his death by suppressing the cardiopulmonary system and by exacerbating the pre-existing medical conditions such as sleep apnoea;

- Whether the swelling of Mr Shishko's feet and lower limbs on 15 June 2006 was appropriately responded to;

- How Mr Shishko came to have Olanzapine at a concentration above therapeutic range in his blood at the time of death; and

- Whether it was appropriate to prescribe several drugs of like effect simultaneously, that is, Olanzapine, Quetiapine and Lithium, all anti-psychotic agents, together with Diazepam, Nordiazepam, Oxazepam, all anti-anxiety agents and Temazepam, a sedative/hypnotic.

As a result, a consultant psychiatrist, Dr J G Reddan was briefed to provide an advice on the appropriateness of the medication regime. She was asked to comment on the possible interactions, contra-indications and physiological effects, in general, and on the cardiac pulmonary system of a person with diagnosed sleep apnoea, in particular.

In summary, Dr Reddan observed and concluded:

- Mr Shishko's morbid obesity greatly complicated the treatment of his medical and psychiatric conditions.

- The doses of psychotropic medication he was administered would not place a reasonably healthy man of his age at marked risk.

- The use of two antipsychotics at the same time is not ideal and should have been avoided.

- Any sedative medication was likely to exacerbate the hypoxic effects of sleep apnoea.

- The use of diazepam as a sedative was not an ideal choice of benzodiazepine in Mr Shishko's case because there was a foreseeable risk its accumulative sedative affects would exacerbate the hypoxic effects of sleep apnoea, leading in turn to him being more likely to develop an arrhythmia in the setting of a diseased heart.

- Mr Shishko's medical conditions were not sufficiently appreciated or attended to: For example:-

    - there is no record of regular blood pressure recording, even weekly, or of any review of his cardiovascular status;
    - when Mr Shishko was noted to have swollen feet and lower legs on 15 June and 16 June 2006, his

cardiovascular system should have been examined, looking for signs of early cardiac failure; and

- it seems he was not provided with a continuous positive airway pressure (CPAP) machine as previously had been recommended.

Dr Reddan concluded:

> *However, as previously stated, Mr Shishko's psychiatric management was not particularly unusual, and the doses of drugs he was given again were not excessive ordinarily for a relatively fit and healthy middle aged man. There is no evidence that the medications administered to Mr Shishko played more than a possible or indirect role in his death. As previously stated, Mr Shishko's medical condition was such that he may well have died suddenly at any time. However the records from The Park indicate that insufficient monitoring of his medical condition was undertaken during the admission and a sign of possible cardiac failure was not sufficiently attended to.*

The Director of Clinical Services of Queensland Health, Dr Terry Stedman candidly accepted the main thrust of Dr Reddan's findings. He wrote:-

> *Overall, Dr Reddan's comments are not unreasonable and I agree that a greater attention to the medical care of a person such as Mr Shishko should be expected in a facility such as this. I also agree that these omissions conceivably played an indirect role in the outcome.*

Dr Stedman also conceded that consideration should have been given to the use of the CPAP machine by Mr Shishko later in his stay at The Park.

However, Dr Stedman disputes that Mr Shishko's swollen feet necessarily related to imminent cardiac failure and suggests that noting the physical signs and taking a history was a "*reasonable exercise of clinical judgment."*

With respect, Dr Stedman is wrong when he suggests the autopsy findings did not suggest these symptoms indicated cardiac failure. The autopsy report noted; *"On 15 June 2006 swelling of his feet and lower limbs was noted. This may be an indication of heart failure."*

The Court was informed The Park has developed a local policy from the "Acute Sedation Guidelines" and recently commenced work using the National Safety Priority on "clinical deterioration" to ensure observation of patients are more closely linked to necessary follow-up actions.

Further, that after completing a root cause analysis further training was given to clinical staff on the management of psychiatric patients with sleep apnoea, including the use of CPAP devices.

Finally the Court was informed that The Park has implemented changes to address the specific systemic failures identified in Dr Reddan's report. The offer was made to brief the Court further on these initiatives but I don't consider I am in a position to critique those reforms and so I did not take up that offer.

As it appears to me that the issues of concern have been addressed by the relevant authorities, there is no need for me to make any further recommendations.

I close this inquest.

Michael Barnes
State Coroner
Brisbane
16 December 2009