CORONERS ACT, 1975 AS AMENDED

SOUTH *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 21st and 22nd days of July 2004 and the 6th day of August 2004, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Jeffrey Ronald Fredericks.

I, the said Coroner, find that Jeffrey Ronald Fredericks aged 41 years, late of the Adelaide Remand Centre, Currie Street, Adelaide, South Australia died at the Adelaide Remand Centre, Adelaide, South Australia on the 4th day of May 2001 as a result of haemorrhage due to incised wounds to left and right cubital fossae.

1. Reason for inquest

1.1. On Tuesday 1 May 2001 Jeffrey Ronald Fredericks was arrested near Balaklava on warrants, one for rape, unlawful detention and threatening life, and the other for breach of home detention bail.

1.2. After the arrest, Mr Fredericks was conveyed to Nuriootpa Police Station, where he was charged. He appeared in Tanunda Magistrates Court later that day and was remanded in custody to the next day. On 2 May 2001, he was remanded in custody until 14 May 2001 (the warrant is Exhibit C19d).

1.3. Accordingly, at the time of his death on 4 May 2001, Mr Fredericks was 'detained in custody pursuant to an Act or law of the State' within the meaning of Section 12(1)(da) of the Coroners Act 1975, and an Inquest into his death was therefore mandatory by virtue of Section 14(1a) of the said Act.

2. Introduction

2.1. At 10pm on Friday 4 May 2001, Jeffrey Ronald Fredericks contacted the Control Room from his cell in the Adelaide Remand Centre ('ARC') using the intercom system, calling for help. He told Correctional Services Officer Paul Roberts that he had cut himself.

2.2. Correctional Services Officers Clive Lancaster, Peter Stanton and Peter Crompton attended at Mr Fredericks' cell at 10:03pm. Lancaster saw through the viewing panel that he had wounds to both arms and there was a large amount of blood in the area.

2.3. The correctional services officers obtained surgical gloves and towels and then entered the cell. Mr Fredericks resisted their attempts to stop the bleeding.

2.4. Registered Nurses Richard Cann and Werner Sturm arrived at the cell at 10:04pm and 10:05pm respectively. Mr Fredericks was carried, using a blanket as a stretcher, down the stairs, and then by wheelchair to the Infirmary.

2.5. Upon arrival in the Infirmary, Mr Fredericks was in cardio-respiratory arrest. RN Cann undertook emergency treatment measures until the arrival of an ambulance at 10:15pm. Ambulance officers then undertook advanced life support.

2.6. Mr Fredericks was conveyed to the Royal Adelaide Hospital, arriving at 10:52pm where further emergency measures were undertaken, but these proved futile. Mr Fredericks' life was pronounced extinct by Dr John Wearne at 10:57pm (see Exhibit C3a).

3. Cause of death

3.1. A post-mortem examination of the body of the deceased was performed by Dr John D Gilbert, Forensic Pathologist, on 5 May 2001. Dr Gilbert concluded that the cause of death was 'haemorrhage due to incised wounds to left and right cubital fossae'. He commented:

> '1. Death was due to haemorrhage resulting from incised wounds to each cubital fossa. The incised wounds were superficial but in each case the medial cubital vein was almost completely transected. Blood loss from each would probably have consisted of a brisk trickle and it would have taken quite some time, up to an hour, for life-threatening blood loss to occur.

Based on the amount of blood at the scene, it appears that the deceased had remained in his cell for some time after incising his arms before summoning assistance. Clearly he was still conscious at that point and was reportedly still responding to simple commands on arrival in the ARC Infirmary. Thereafter his condition steadily deteriorated despite vigorous resuscitation efforts by ARC staff and subsequently by SAAS paramedics. He was still displaying an idioventricular rhythm when assessed by SAAS officers. By the time of his arrival at the Royal Adelaide Hospital he was essentially dead displaying early post mortem lividity with fixed pupils and life was certified extinct 5 minutes later.

2. Analysis of a specimen of blood obtained at autopsy reportedly showed a blood alcohol concentration of nil. Lignocaine was present in the blood consistent with administration during resuscitation. No other common drugs were identified.
3. There were no injuries or other markings on the body to indicate the involvement of another person in the death.
4. No natural disease that could have caused or contributed to the death was identified at autopsy.'

(Exhibit C4a, p6)

3.2. An initial toxicological analysis of Mr Fredericks' blood found none of the common drugs, or alcohol. Re-examination at the request of Counsel Assisting produced the following results:

'1. Although an initial sensitive but broad screen indicated the possible presence of a tricyclic antidepressant in the blood, further more specific testing could not confirm this.

If the deceased was a rapid or average metabolizer of dothiepin, then the level of dothiepin in the blood at the time of death from a single 75mg dose ingested 7 hours earlier, may have been below the limit of detection of the analytical method.

2. A trace level of ibuprofen was presumptively identified in the blood. The level is consistent for a rapid metabolizer for the dosage pattern that is believed to have taken place.'

(Exhibit C5b)

3.3. I accept Dr Gilbert's opinion, and find that the cause of death was as he described.

4. Background

4.1. Jeffrey Ronald Fredericks was born on 11 September 1959. He was one of three children. He grew up in Port Augusta.

4.2. Mr Fredericks' mother states that her son was a 'scallywag' as he grew up. He spent his 21st birthday in gaol.

4.3. Mr Fredericks' offender history report discloses that he had been in trouble with the criminal justice system since 1972, when he first appeared before the Port Lincoln Children's Court charged with break, enter and larceny. He was a regular Children's Court offender until 1978 when he was sentenced to imprisonment for a series of similar offences.

4.4. From 1978 onwards, Mr Fredericks regularly appeared in the District Court charged with breaking offences and drug offences. Apart from some drink/driving behaviour in the mid 1990s, Mr Fredericks remained out of serious trouble (apart for traffic offences) from 1981 until 2001 when the trouble with his former defacto wife began to appear in the courts.

4.5. As to Mr Fredericks' relationship with is former defacto wife, his mother said:

> 'Their relationship became very difficult and a lot of arguing was going on over drugs. Jeffrey was a drug user and when he smoked cannabis he was fine but (if) he used other drugs such as amphetamine and ecstasy he became a difficult person.
>
> Jeffrey was selling 'speed' in Adelaide and he had a 'round'. He used to tell me that he would take the speed to stay awake so he could complete his round. At this time his relationship began to deteriorate more and more due to the lack (of) perceived communication. He also told me about Easter time 2001 that he was carrying a gun whilst at Adelaide.'
>
> (Exhibit C46a, p3)

4.6. Mr Fredericks' former defacto wife alleged that on 6 October 2000 he physically assaulted her and then had sexual intercourse with her without her consent. She reported the matter to the police, but she subsequently gave an intimation to the police to take no further action. After speaking to a counsellor, she changed her mind again, and a report was submitted. Perhaps unsurprisingly, it seems that Mr Fredericks was never arrested on that charge.

4.7. After that incident, Mr Fredericks' former defacto wife and two children fled to Victoria. He traced them, and they returned to South Australia on 9 January 2001 in order to reconcile.

4.8. Notwithstanding the apparent reconciliation, Mr Fredericks' former defacto wife alleged that on 10 January 2001 he assaulted her by punching her repeatedly. She alleged that he slapped their 10 year-old daughter across the face when she tried to intervene, causing her nose to bleed.

4.9. It was also alleged that on 11 January 2001, Mr Fredericks threatened to 'pop' his former defacto wife while he was in possession of a loaded pistol, and also threatened to kill a detective who was investigating the rape allegations.

4.10. Mr Fredericks was arrested on 15 January 2001. He was conveyed to the Port Adelaide Police Station. Detective Senior Constable Dietman said that he spoke little after his arrest, and he showed no sign of depression or irrationality.

4.11. After being charged and appearing before the Port Adelaide Magistrates Court, Mr Fredericks was initially remanded in custody, but later released on 'home detention'. His former defacto wife had taken the children and moved interstate.

4.12. Mr Fredericks breached the conditions of his 'home detention' and failed to appear in court on 16 March 2001. A warrant was issued for his arrest.

4.13. On 26 March 2001 Detective Senior Constable Dietman spoke to Mr Fredericks on the telephone, during which Mr Fredericks said that he wanted to 'end it all' and that he felt like 'slitting his throat'.

4.14. A later telephone conversation between the two men took place on 27 April 2001, during which Mr Fredericks told Detective Dietman that he had stopped using drugs, and wished to sort out the charges against him and get on with his life.

4.15. Mr Fredericks was eventually arrested at his house at Whitwarta, near Balaklava, at about 7:30am on 1 May 2001. He was taken to the Nuriootpa Police Station where he was charged. It was noted at that time that he did not appear despondent or irrational or disturbed or otherwise at risk (see Exhibit C43d). See also the statements of Senior Constable Alsop (Exhibit C43a), Constable Keynes (Exhibit C44a), and Detective Senior Constable Carruthers (Exhibit C45a).

4.16. In contrast to the observations of the police officers, however, Mr Fredericks told his mother during a telephone conversation that day (she said it was 3 May 2001, but it came from Nuriootpa Police Station so it must have been 1 May 2001) that he was going to meet his mate Neville. Neville was his best friend who had committed suicide several months earlier.

4.17. Mrs Fredericks did not report her son's comments to anyone in authority. She said:

> 'I just thought it was talk and I didn't think he'd do it.'
> (Exhibit C46a, p2)

4.18. Mr Fredericks appeared in the Tanunda Magistrates Court on 1 May 2001 and was remanded in custody until 14 May 2001.

4.19. Admission to the Adelaide Remand Centre

Mr Fredericks arrived at the ARC on 2 May 2001. After a number of formalities were attended to, he was interviewed by Correctional Services Officer Darren Stock. He identified asthma as his only health condition. He denied any history of psychiatric illness or self-harming behaviour. The 'Specific Needs Assessment' did not produce any information of concern.

4.20. Mr Stock also completed a 'Prison Stress Screening Form' ('PSSF') which is part of the Case Management File (Exhibit C22i). The following answers are significant:

'Interview

Q4	About how often do you expect to receive visits from family, partner, or close friends?	(Rarely)/ never ☑
Q7	Are you concerned about losing someone important to you, either through the break-up of a relationship or friendship, or through illness?	(Yes,) very much ☑
Q8	Do you have family problems	Yes ☑
Q9	Are you worried about your own health or wellbeing	(Yes,) very much ☑
Q11	Have you been assessed or treated in a psychiatric hospital or James Nash House?	No ☑
Q12	Have you been diagnosed as having a psychiatric disorder?	No ☑
Q14	Have you used drugs regularly to relax or block out problems in the last month?	Yes ☑
Q18	**Have you ever tried to commit suicide or intentionally hurt yourself?**	**No ☑**
Q20	** Have you thought about committing suicide since you were arrested or imprisoned?	(Yes) Maybe ☑
Q21	** Do you feel like harming yourself	No ☑
Q22	** **Sometimes people feel that those close to them would be better off if you were dead. Have you felt like that recently?**	**(Yes,) Maybe ☑**
Q23	Do you have things to look forward to or does the future seem hopeless?	(Seems Hopeless) or not sure ☑

4.21. As a result of this assessment, Mr Fredericks scored 11. The form states:

> 'Consider as at risk if:
> 1 Score is greater than 8; or
> 2 Any of the asterisked (**) / shaded items are positive (Yes or Maybe); or
> 3 Regardless of the score, the interviewing officer feels a further opinion is warranted.'

Mr Stock noted that Mr Fredericks was 'referred to Nurse Brenda'.

4.22. Following the interview with Mr Stock, Mr Fredericks was given the 'second issue' of property (the first was prison clothing). The second issue included a disposable razor (see Exhibit C19a, pp3-4).

4.23. Medical evaluation

Mr Fredericks was interviewed and assessed by Registered Nurse Brenda Walker at about 8:20pm that evening. RN Walker said that he was the last of 6 or 7 new inmates. In her statement, RN Walker recalled the following:

> 'I was made aware by prison officer Darren Stock that Fredericks had recorded an '11' on the prisoner admission stress screening. On this night I made reference to this stress screening while I was speaking to Fredericks. This is a standard practise if the prisoner scores high. I have also had this stress screening form produced to me by Newitt. This stress screening form is contained in the prisoner Case Management File for Fredericks, which has also been marked 'PLN-JRF 9'.
>
> I spoke to Fredericks for about fifteen minutes. During this time Fredericks was initially guarded and evasive when answering questions. I mainly focussed on whether or not he had any thoughts of self harm. He presented to me as being evasive when answering these questions. He didn't exactly say 'yes' and he didn't exactly say 'no' to my questioning of self harm issues. Fredericks had answered 'yes' to some of the self harm questions of the screening form.
>
> From reference to my notes I can recall that when asked directly whether he had thoughts of self harm, I have recorded his direct quote response as;
>
> He said, 'The answer to that should be no, otherwise you will lock me up'
>
> When I asked Fredericks again of self harm he replied that 'yes and no' to him having thoughts of self harm. I questioned him further and I asked him if he had a plan, to which he replied 'No'.
>
> He also presented as being a bit flat in his affect, and he appeared to be depressed. Due to these matters, and the fact that he couldn't give me a firm guarantee that he would not self harm, I decided to have Fredericks placed into Unit 7 for the night. Unit 7 is an observation unit. Fredericks opened up a little towards the end of the interview but for his own safety I decided that he should spend the night in Unit 7. Fredericks did state to me that he did have family problems. I recommended that Fredericks should be under camera surveillance in Unit 7. This fact is recorded in my hand written notes.

> Ordinarily Fredericks would have spent the night in the prison infirmary, however as the infirmary was full on this night, then Unit 7 was the next best option.'
>
> (Exhibit C47a, pp2-3)

On the evidence, this was a very sensible precaution in the circumstances.

4.24. Unit 7 is known as a 'Special Management Area' and has electronic surveillance. Prisoners who have been assessed as 'at risk' are not permitted to retain safety razors.

4.25. Mr Fredericks was placed in Unit 7 at 9:15pm on 2 May 2001.

4.26. In accordance with standard procedure, Mr Fredericks was examined and assessed by the Medical Officer, Dr Boguslaw Karpinski. The movement log indicates that the consultation commenced at 9:28am and concluded at 9:35am (Exhibit C19e).

4.27. Referring to his notes in the clinical record (Exhibit C22f), Dr Karpinski explained his findings on examination:

> 'Above noted.
> Feeling much better today
> Denies self-harm/suicidal thoughts
> Asthmatic - on Ventolin
> Also c/o headaches due to recent MBA/Head injury → forehead scar ++
> Also: would like to restart Prothiaden as he found it helpful last time
> H/S ✓ Chest ✓ Abdo ✓ CNS ✓ no deficit M/S ✓
> → - Prothiaden 75-150
> - Brufen (?) PRN (food)
> - Ventolin issued for PRN use'
>
> (T53 and Exhibit C22f)

4.28. As a result of Dr Karpinski's assessment that he was not 'at risk', Mr Fredericks was admitted to Unit 1 at ARC at about 9:45am on 3 May 2001. Correctional Services Officer Heather Freeman said she spoke to him on a number of occasions during the day and he seemed 'fine' (Exhibit C16a, p2).

4.29. Mr Fredericks received his prescribed medication at 4pm on 3 May 2001. The prisoners were 'locked down' at 4:30pm and the night passed uneventfully, as did the daylight hours of 4 May 2001. Mr Fredericks received his medication again at 4pm.

4.30. After lockdown on 4 May 2001, foot patrols took place at 6:10pm and 8pm (I agree with Counsel Assisting, Ms Hodder, that Stanton's time is an error. Stanton's entry in the patrol log [Exhibit C22b] is 2055, whereas the patrol log [Exhibit C22h] and the

medical record [Exhibit C22f] both record 8pm). Stanton and Crompton said that on each occasion the prisoner was sighted and no problems were identified (see Exhibit 8a, p2).

4.31. RN Richard Cann said that he saw Mr Fredericks at both medication rounds, at 4pm and 8pm and he recalled nothing remarkable about his demeanour (Exhibit C10, p2).

4.32. Emergency call

At about 10pm Roberts received a call via the intercom system from Cell 24, Unit 1, Mr Fredericks' cell. The caller said:

> 'Help me, help me … I need help, I've cut myself.'
>
> (Exhibit C15a, pp2-3)

Roberts immediately advised the Shift Manager, Lancaster.

4.33. Lancaster, Crompton and Stanton immediately went to the cell. Lancaster said:

> 'I looked in through the perspex section of the door and I could see a large amount of blood on the floor, and I saw a male person who I now know as prisoner Fredericks, lying on the floor of the cell. Fredericks was not flat out on the floor, but rather he was half propping himself up off of the floor. I think that he had his back against the bed. At no time was Fredericks standing or moving about his cell.'
>
> (Exhibit C9a, p3)

4.34. Stanton called the Infirmary for medical assistance. Lancaster and Crompton donned surgical gloves and entered the cell. Lancaster said:

> 'At opening the door, the prisoner was still lying on the floor and conscious.
>
> Crompton and I entered. Fredericks was saying words to the effect of 'I want my puffer, I want my puffer'. I noticed that he was short of breath, and incoherent. He was kind of rambling on about wanting his puffer and he was moaning. I asked Fredericks where he had cut himself, as it was not immediately obvious. I could see that he was covered in blood, the blood was quite thick on the floor. There was so much blood on the floor that I recall it was quite slippery. The blood was also all over his body. At this time Fredericks was only wearing a pair of jocks, no other clothes. I still could not see from where he was bleeding, so I grabbed a towel, or a blanket, I can not remember specifically which one, and I wiped the towel/blanket over his body to clear some of the blood off of him. It was then that I found that he had some cut marks on the inside of both of his left and right arms. The cut marks were only both small, blood was not gushing out, but the blood that was coming out was a deep red colour. The cuts were only about 1.5 centimetres long, and they were both on the inside of his elbow. They were more of a hole rather than a slice.'
>
> (Exhibit C9a, p4)

4.35. RN Cann arrived at the cell soon afterwards. He quickly realised that an ambulance was needed. One of the correctional services officers made the call.

4.36. RN Cann's recollection of events is different to that of Lancaster. He said that when he arrived, the three correctional services officers were standing outside the cell telling Mr Fredericks to pass out the blade (Exhibit C10a, p3). Lancaster denied this (Exhibit C9a, p4). Cann also thought Mr Fredericks was still standing up (Exhibit C10, p3) whereas Lancaster said he was lying down (supra). Stanton agreed (Exhibit C8a, p4).

4.37. I do not think that anything turns on these discrepancies. It was an emergency situation and memories are bound to differ.

4.38. An investigation by Messrs Smedley and Johnson of the Department for Correctional Services revealed that the incident was not video-recorded in accordance with the Standard Operating Procedure No 6. The correctional services officers responsible argued that this was treated as a medical emergency rather than a custodial one. I agree with the criticism of this failure, since the factual dispute I have just described need not exist.

4.39. However, I also agree with Messrs Smedley and Johnson that this failure did not 'adversely impact on the incident', although such failures could have serious consequences in other circumstances.

4.40. Since it cannot be argued that this failure had a causative effect on Mr Fredericks' death, it cannot form the basis of a recommendation pursuant to Section 25(2) of the Coroners Act, 1975.

4.41. <u>Resuscitation attempts</u>

RN Cann said that once the cell was opened, the correctional services officers entered and held Mr Fredericks down using reasonable force. He said:

> 'By this time it was apparent that Fredericks was quite weak, he had lost a lot of blood. I think that it was only two guards that took him to the ground. I recall that they were wearing gloves. Fredericks did struggle when they took him to the ground but again he was very weak and easily over powered.
>
> Once on the ground inside of the cell Fredericks was held down. He was flailing his arms about and he had to be restrained from doing so. The cell was covered in blood on the floor, it was very very slippery and I recall that I could not hold my footing. I quickly

> examined Fredericks and I found two wounds. They were located on his left and right cubital fossa. Both of Fredericks wounds had stopped bleeding. A blanket was then put under Fredericks. The blanket came from inside of Fredericks' room. Whilst pressure was applied to his wounds, he was dragged from his cell and out on to the mezzanine floor.'
>
> (Exhibit C10a, pp4-5)

Stanton noted that Mr Fredericks was removed from Unit 1 at 10pm.

4.42. A blanket with a man at each corner was used to lift Mr Fredericks down the stairs, and he was then conveyed by wheelchair, while maintaining pressure on his wounds, and holding his legs up to maintain blood pressure. RN Cann said:

> 'Once we arrived at the infirmary, Fredericks was wheeled straight into the treatment room and he was taken off of the wheel chair and placed on the floor. Again, a Trendelenburg position was maintained as his legs were elevated on a chair. Present in the treatment room was Tania Cann and Werner Sturm. I reassessed Fredericks' conscious state. He was still conscious but he had deteriorated. I can't recall if it was either Tania or Werner, but one of them gave Fredericks oxygen. I applied a tourniquet to his right arm and I was about to insert a cannula when he went into respiratory arrest. I then took over maintaining Fredericks' airway, I used a Laederal bag. Werner was checking the pulse and I think that I sent Tania off to get the emergency box from Unit 1 as I had left it there when we moved Fredericks. Shortly after respiratory arrest he went into full cardiac arrest. CPR was then commenced, I maintained the airway and Werner applied compressions. CPR was maintained until the ambulance paramedics arrived. I believe that we continued the CPR for about five or so minutes. The ambulance arrived fairly quickly.'
>
> (Exhibit C10a, pp5-6)

4.43. SA Ambulance Service Officers Ferguson and Currie received a call to the ARC at 10:06pm. They arrived at 10:12pm and took several minutes to reach the Infirmary. Ferguson inserted an intravenous line and administered saline. Mr Fredericks vomited so his airway was suctioned and he was intubated. Adrenaline was administered intravenously.

4.44. Despite these efforts, Mr Fredericks failed to improve. In fact his condition continued to deteriorate clinically as he developed tachycardia and ventricular fibrillation. Ferguson considered his chances of survival to be 'extremely thin' but the decision was made to continue aggressive resuscitation and transfer him to the Royal Adelaide Hospital.

4.45. Mr Fredericks arrived at the Royal Adelaide Hospital at 10:52pm. The doctors continued cardio-pulmonary resuscitation but after a short time it was decided that further effort was futile. Dr John Wearne said:

> 'I noted that he had early lividity on his back and due to the prolonged time of CPR and absent signs of life and evidence of lividity any further resuscitation was ceased. I pronounced life extinct at 10:57pm.'
>
> (Exhibit C3a, p2)

5. Issues arising at inquest

5.1. Was Mr Fredericks' death intentionally self-inflicted?

There is no doubt that Mr Fredericks' injuries were self-inflicted. His actions in removing the blade from the disposable razor and making small, precise wounds in his cubital fossae (inside elbows) seem deliberate and not impulsive.

5.2. I have already referred to Dr Gilbert's comment that the wounds would have resulted in a 'brisk trickle' of blood which would have continued for up to a hour before it became life-threatening. Dr Parker, whose evidence I will discuss shortly, agreed (T103). It therefore seems that Mr Fredericks refrained from calling for help until his condition was critical.

5.3. If, as I accept, the last patrol occurred at about 8pm, there were two hours within which Mr Fredericks could have sought assistance.

5.4. Dr Karpinski commented that he thought Mr Fredericks' actions were impulsive. He said:

> 'I understand that Fredericks actually requested help once he had inflicted the self harm suggesting that he didn't want to die. In my experience, many self harm acts in the prison setting are not a suicidal act, but rather a way of dealing with anger and frustration.'
>
> (Exhibit C48, pp4-5)

5.5. The notes Mr Fredericks wrote to his former defacto wife and children convey sadness and remorse for his previous behaviour. Certainly, those notes, and the notes to his mother and sister, evince an intention to die. Other notes also display anger and make allegations that a man had stolen a large amount of Mr Fredericks' property.

5.6. Although the evidence may indicate that anger and impulsiveness may have played a part, my conclusion is that Mr Fredericks had been contemplating suicide for some time, that he confessed his thoughts to his mother, and, to a lesser extent, to RN Walker, but that he had regained control of his thoughts by the time he saw Dr Karpinski.

5.7. Mr Fredericks waited a considerable time, up to an hour, after he cut himself before he called for help. Whether he panicked when the symptoms began to appear, or whether he was delirious by then, cannot be known. In my opinion, until this very late change of mind, Mr Fredericks intended to take his own life.

5.8. Emergency treatment

I received a report from Dr Helen Parker who in an Emergency Physician at Western Hospital, Footscray, Melbourne, and a Forensic Physician at the Victorian Institute for Forensic Medicine.

5.9. Dr Parker took into account that when the correctional services officers attended at Mr Fredericks' cell, their actions needed to include donning protective equipment, assessing the location of the weapon, and ascertaining the source and severity of the bleeding, and then restraining the non-compliant inmate who may have been delirious from hypoxia. These tasks were achieved in a difficult setting involving large quantities of blood.

5.10. The fact that the ambulance was called within 6 or 7 minutes from the time of Mr Fredericks' initial call indicates that it was made at the earliest appropriate time (Exhibit C49, p9).

5.11. The actions of the nurse and the correctional services officers in carrying Mr Fredericks down the stairs in a blanket, and then keeping his legs elevated in the wheelchair was 'commendable'.

5.12. RN Cann's efforts, with assistance from the other nurses, in the Infirmary came in for particular commendation. Dr Parker said:

> 'It is important at this point to emphasize two important points:
>
> - The clinical scenario that confronted the nurses and correctional officers is one that I believe would be exceedingly rare in a correctional facility.

- This scenario would have posed a significant treatment challenge even to a team of emergency specialists in a fully equipped resuscitation area of a tertiary hospital.

Particularly bearing these in mind, the three nurses appear to have provided timely and sound advanced resuscitation efforts, in a difficult environment, with no immediate medical back-up. Their actions clearly reflect previous critical care training and experience.'

(Exhibit C49, p11)

Indeed she described their efforts as 'quite remarkable', and doubted whether doctors in an Emergency Department in a hospital could have done any better (T98).

5.13. As to the efforts of the paramedics, Dr Parker said that the treatment administered was appropriate, taking into account that cardiac arrest from exsanguination carries a very high mortality rate (Exhibit C49, p12).

5.14. Finally, Dr Parker commented that Mr Fredericks was effectively deceased on arrival at the Royal Adelaide Hospital, and so the decision taken there to cease resuscitation efforts was appropriate (Exhibit C49, p12).

5.15. Dr Parker explained that after substantial bleeding occurs, a phenomenon known as haemorrhagic shock occurs. She said:

'Shock is defined as a state in which the tissues of the body have an inadequate blood supply and the cells lack sufficient oxygen to survive. Shock is a continuum with the following phases:

- a **compensated phase**, where the body is able to preserve blood pressure and flow to vital organs
- a **decompensated phase**, where there is inadequate blood flow to vital organs

and

- **irreversible shock**, where, even if blood pressure is restored by the use of drugs and fluids, irreversible damage has occurred at the cell level and death will ensue.

It is not possible to detect clinically at which point irreversible shock occurs, thus it is important to recognize and treat shock as early as possible.

Haemorrhagic shock occurs from blood loss. The average blood volume in an adult is 70ml/kg body weight, thus in an average male the total blood volume is ~ 6 litres. When haemorrhage occurs, a complex series of compensatory mechanisms become activated with the overall effect of attempting to maintain blood flow to the vital organs. Thus for example, blood is diverted away from the skin causing it to appear pale and cool. The healthy person will tolerate a loss of up to 10% of their blood volume with little more than a slight rise in their pulse rate to compensate for this loss. The blood pressure is generally maintained until a blood loss of about 30% of the total blood volume, and at this point the pulse will also be rapid, the skin pale and cool, and an alteration in

> conscious state is often seen. Thus, low blood pressure is a late sign in haemorrhagic shock and indicates either a massive haemorrhage, a state of decompensated shock or indeed a combination of the two.'
>
> (Exhibit C49, p13)

5.16. Dr Parker concluded that by the time Mr Fredericks was found by the correctional services officers and the nurse, he was in a state of decompensated shock, which rapidly deteriorated to a point, which can not be identified, when it became irreversible (Exhibit C49, p15).

5.17. Assessment of suicide risk

It is apparent that the PSSF identified Mr Fredericks as being at risk. Professor R G Goldney, Professor of Psychiatry at the University of Adelaide, said:

> 'A risk screening instrument had clearly delineated him to be at risk, not only in the sense that he scored sufficiently in the overall points or the instrument, but he also scored positively on two of three questions, any one of which would have placed him in a risk category.'
>
> (Exhibit C21a, p6)

5.18. Having been thus identified, Mr Fredericks was equivocal and ambivalent when he spoke to RN Walker. To her credit, she pressed him about his suicidal thoughts, and then very appropriately took the cautious approach and referred him to Unit 7.

5.19. Dr Karpinski knew than RN Walker had taken that course the night before, although he did not have a copy of the PSSF with him. For some inexplicable reason, the form was returned to Corrections staff and a copy was not retained for the clinical record. I have been informed that this system has now changed.

5.20. Dr Karpinski thought that Mr Fredericks was having a 'situational crisis' when he saw RN Walker, and that, like many other inmates, this had passed. He said in his statement:

> 'In my experience, a majority of a persons who are brought to the ARC go through a situational crisis due to the stressful nature of imprisonment. Most prisoners would settle within 24 hours to a few days as they resolve the crisis situation. In this case, this is what I perceived to be happening. I was definitely surprised to hear that Fredericks had taken his own life as I was of the opinion that the crisis would be resolved within a short space of time as he adjusted to the situation. He was admitted to the ARC in January under very similar circumstances and during this time he successfully dealt with very similar issues. The fact that Fredericks actually requested medication to assist him cope

> was a positive indicator. I believe that Fredericks' action of taking his own life was an impulsive act.'
>
> (Exhibit C48, p4)

5.21. Dr Karpinski described the consultation as 'fairly lengthy' (Exhibit C48, p3). In fact, it lasted from 7 to 10 minutes, depending on whether an entry in the log is a '5' or an '8'. During that time, Dr Karpinski not only assessed Mr Fredericks' mental health and suicide risk, he also discussed his asthma, his recent motorcycle accident, and the prescription of Prothiaden. He listened to his heart and chest, and examined his abdomen, central nervous system and musculo-skeletal system.

5.22. Professor Goldney said in his report that even 10 to 15 minutes:

> '… is not an adequate time in which to gain rapport with a person and elicit sufficient information upon which one can base a sound clinical judgment in regard to a person's safety and the need for treatment.'
>
> (Exhibit C21, p7)

Dr Karpinski agreed (T61). In fact, the consultation was 7 to 10 minutes, and only a small proportion of that was spent assessing Mr Fredericks' mental state.

5.23. Professor Goldney was also critical of the fact that Dr Karpinski had prescribed Prothiaden, an antidepressant medication, without documenting 'specific emotional symptoms for which it was prescribed' (Exhibit C21, p6). Dr Karpinski had not made a diagnosis of depression. His only ground for prescribing Prothiaden was that Mr Fredericks 'found it helpful last time'.

5.24. Dr Parker also pointed out that Dr Karpinski made no arrangements for a follow-up appointment. This would have been appropriate since antidepressant medication was being prescribed (T86). She said that it was not sufficient to rely on the observations of nursing staff, or the prisoner self-reporting, in order to detect ongoing problems.

5.25. Dr Karpinski also accepted that criticism, and cited his lack of time. He said:

> 'I totally agree with his statement, I have no qualms about it whatsoever. Nevertheless, I have significant time restraints and basically time that I have to make a note is time between one prisoner leaves and other one enters my office and as much as I would like to document it and as much as I am aware of a need to document it properly, I think I physically have no time to do it.' (T61)

5.26. Dr Karpinski acknowledged that he could have made more time if necessary, although this would have been at the expense of other patients (T63). He said that this had never happened (T76). He could also have referred Mr Fredericks to a psychiatrist (although Mr Fredericks' death occurred before he would have been seen).

5.27. Dr Karpinski said that he would have regarded Mr Fredericks as being at risk if he had known that he had answered 'yes' to questions 20 and 22 on the PSSF. However, Dr Karpinski said that he still would have faced a difficult decision because he might have lost Mr Fredericks' 'trust' if he had sent him back to Unit 7, which was considered a punishment unit (T56).

5.28. Dr Karpinski also acknowledged that he knew that Mr Fredericks was 'telling me what he wanted to tell me' in order to get to a 'normal' unit (T56). He said:

> 'When I saw him on the following morning I did question him about all these statements he made the night before. Very often these statements are made out of anger, out of frustration, and they do indicate that there is a problem but they don't really indicate the severity of it. So when I saw him on the following day I did explore all this, I did ask him all these questions and my impression at the time was that of yes, he was angry, he was frustrated, he had thoughts of self-harm, but organised, he had thought about it as he did on a previous admission, he settled, he felt better, and he requested medication, and my impression was that his crisis situation was resolving and he was no longer suicidal.' (T66)

5.29. I am not convinced that Dr Karpinski did question Mr Fredericks about the statements he made the night before. He made no note of having done so, and he would not have had time. In my view, Dr Karpinski did not look far beyond Mr Fredericks' statement that he was 'feeling much better today, denies self-harm or suicidal thoughts'.

5.30. Professor Goldney concluded:

> 'Second, it is evident that although the screening instrument picked up the potential risk of Mr Fredericks, the subsequent assessment, or at the very least the documentation of that assessment, was manifestly inadequate. Thus routine documentation of symptoms associated with depression was not made, and there is no recording of potential stressors in Mr Fredericks' life. Until such enquiry and documentation are made it seems to me to be inappropriate to transfer a person from an area of close observation. Indeed, to do so appears to undermine the purpose of having a screening instrument, as I presume that the purpose of such an instrument is to detect those persons who require more detailed examination. That does not appear to have occurred, unless in fact it occurred, but was not documented.
>
> The conclusion to be drawn from this should not necessarily be that the suicide of Mr Fredericks could have been prevented. However, in my view it is more probable than

> not that had a more detailed assessment of Mr Fredericks being undertaken then, in all likelihood, additional information would have emerged which may have alerted Dr Karpinski to adopt a more rigorous observational management of Mr Fredericks.
>
> I acknowledge that one cannot be certain about this. Thus it is possible that even had a full assessment been undertaken in time, Mr Fredericks could have maintained his denial of suicidal ideation.'
>
> (Exhibit C21a, pp7-8)

5.31. I accept Professor Goldney's conclusions. There is no way to know whether the outcome would have been different if Mr Fredericks had been adequately assessed. However, there is a chance that it may have, and this was lost.

6. Recommendations

6.1. Where a prisoner has been assessed as being 'at risk' of suicide, it seems to me that a full assessment of his mental state should occur before he is released into the general prison population.

6.2. Dr Karpinski's consultation with Mr Fredericks lasted for 7 to 10 minutes, during which an assessment of both his physical and mental health occurred. Both Dr Karpinski and Professor Goldney thought that this was insufficient.

6.3. It is not clear to me that the limitations on Dr Karpinski's time were the result of systemic limitations. Dr Karpinski said that he could have made more time available, although this had never happened. It may be that Dr Karpinski has adjusted his clinical practice to fit the available time, which is most undesirable (see his evidence at T77-T78). I note that Messrs Smedley and Johnson, authors of the Department for Correctional Services report into the incident, also expressed concerns about the adequacy of the time taken (see Exhibit C20a, p9).

6.4. I therefore recommend, pursuant to Section 25(2) of the Coroners Act, 1975 that the Director, Forensic Health Service, in consultation with the Chief Executive Officer, Department for Correctional Services:

- Examine the time available to clinicians to ensure that there is sufficient time to carry out an appropriate mental state examination before a prisoner is assessed as not being at risk of self-harm;

- Consider whether a special arrangement needs to be put in place when a prisoner is being considered for transfer out of an area set aside for surveillance of 'at risk' prisoners so that an adequate assessment of a prisoner's mental health takes place before a decision is made.

Key Words: Death in Custody; Suicide Risk - Assessment Of; Haemorrhagic Shock

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 6th day of August, 2004.

Coroner

Inquest Number 28/2004 (1069/2001)