CORONERS ACT, 2003

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 25th day of November 2015 and the 17th day of November 2017, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Geoffrey Lachlan Hogarth Frederick.

The said Court finds that Geoffrey Lachlan Hogarth Frederick aged 60 years, late of Glenside Campus, 226 Fullarton Road, Eastwood, South Australia died at the Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 28th day of May 2013 as a result of end stage renal failure. The said Court finds that the circumstances of his death were as follows:

1. Introduction, cause of death and reason for Inquest

1.1. Geoffrey Lachlan Hogarth Frederick was 60 years of age when he died of natural causes in the Royal Adelaide Hospital (the RAH) on 28 May 2013. At the time of his death he was subject to a Level 3 inpatient treatment order that had been imposed by the Guardianship Board pursuant to the Mental Health Act 2009. His place of detention at the time of his death was the RAH. Mr Frederick's death was therefore a death in custody as defined by the Coroners Act 2003. Accordingly, a mandatory Inquest into the cause and circumstances of his death was required by law. These are the findings of that Inquest.

1.2. Mr Frederick's cause of death was established by way of a pathology review undertaken by Dr Iain McIntyre of Forensic Science South Australia. The review was conducted having regard to Mr Frederick's recent and longitudinal medical history. Dr McIntyre concluded that the cause of Mr Frederick's death was end stage renal failure. I find that to have been the cause of his death.

2. Background and the events leading to Mr Frederick's death

2.1. In 1972 at age 19 Mr Frederick was diagnosed with schizophrenia. At about age 30 he was diagnosed with glomerulonephritis which is defined as any group of kidney diseases involving the glomeruli, usually thought to be result of antibody, antigen reactions that localise in the kidneys because of their filtering functions. Acute nephritis is marked by blood in the urine and fluid and urea retention. Children eventually recover completely but adults are more likely to progress to chronic nephritis and eventual kidney failure. Mr Frederick did develop chronic kidney failure.

2.2. In the period leading up to Mr Frederick's death, he had been receiving twice weekly dialysis in respect of his renal failure. Thrice weekly had been the recommended frequency of dialysis, but Mr Frederick had resisted this. Dialysis is a life preserving and indeed life saving measure without which a patient would die. It is generally administered via a surgically created fistula. This method of administration was not utilised in Mr Frederick's case because he would pick at the fistula and cause it to bleed. So in his case it was administered via a central line. In the period before Mr Frederick's death there were a number of occasions on which the permacath was dislodged, the suspicion being that Mr Frederick himself deliberately pulled it out. Radiological advice was that it would not be possible to reinsert it. From mid May 2013 onwards Mr Frederick did not receive dialysis and he died on 28 May. The only issue of substance in this Inquest was whether the cessation of his dialysis had been appropriate.

2.3. I should here say something about Mr Frederick's history. In 1993, while Mr Frederick was acutely psychotic, he killed his mother. He was ultimately found not guilty of murder by reason of insanity. He was admitted to James Nash House from 1993 to 1999. He was then transferred to a closed ward at Glenside from 1999 to 2001. In 2001 he was moved to an open ward at Glenside and he remained resident there until 2011.

2.4. In 2005 Mr Frederick was diagnosed with thin glomeruli membrane disease with interstitial scarring. He had end-stage renal failure which was required to be maintained with dialysis from that point forward.

2.5. In 2010 an application was made to the Guardianship Board for guardianship of Mr Frederick. The application was made because he refused to cooperate with medical

treatment as a result of his impaired mental capacity. On 4 June 2010 an application was submitted by Robyn Downing, a Glenside social worker. Ms Downing submitted that Mr Frederick had no family or friends to assist him or to assist services in trying to help him and that he suffered from chronic schizophrenia, chronic renal failure and hypertension. Ms Downing also submitted that Mr Frederick had limited social skills and had a limited capacity to look after himself. It was also submitted that his chronic schizophrenia and associated illness meant that he had little or no ability to understand his renal condition, the treatment that this condition required and the reason he required treatment.

2.6. On 30 June 2010 guardianship of Mr Frederick was granted to the Public Advocate. Other concomitant orders were made. Appropriate services including dialysis were provided to Mr Frederick. He was provided with supported accommodation.

2.7. Mr Frederick's final admission to hospital commenced in January 2013. This admission would culminate in Mr Frederick's death on 28 May 2013. The clinical course of this admission is described in the statements of Dr Kym Bannister[1] who was the Medical Co-Director of the Central Northern Adelaide Renal and Transplant Service and Dr Jonathan Symon[2] who is a consultant psychiatrist. As well, certain aspects of Mr Frederick's guardianship are explained in the statement of Ms Popi Amanatidis[3] who was Mr Frederick's appointed guardian.

2.8. In his statement Dr Bannister explains Mr Frederick's long admission between 21 January 2013 and 28 May 2013 and the critical parts of Mr Frederick's management. Dr Bannister refers to Mr Frederick pulling out the permacath that resulted in massive bleeding, a cardiac arrest and then intensive care admission. The line was reinserted with great difficulty and the radiologist involved felt that it would not be possible to replace another central line if it was dislodged again. As a result, Dr Bannister wrote to the Public Advocate indicating that if the patient did pull the line out again, or if there were complications with the line, it would be very difficult to continue dialysis and in view of the patient's inpatient situation and quality of life that consideration should be

[1] Exhibit C6
[2] Exhibit C5
[3] Exhibit C7a

given to cessation of dialysis altogether. A response from the Public Advocate in early May 2013 agreed with that strategy. The statement of Ms Amanatidis confirms this approach. During the latter part of Mr Frederick's admission he did in fact again pull out his permacath and as a result of the decision that had been made in respect of further dialysis, dialysis was ceased on 10 May 2013. This inevitably resulted in his final demise.

2.9. The statement of Ms Amanatidis explains the course of events leading up to Mr Frederick's death. On 18 March 2013 she received a phone call from Dr Lawlor, a neuropsychiatrist from the RAH, informing her that Mr Frederick was still in hospital and was still unwell. Dr Lawlor stated that Mr Frederick required the insertion of a new catheter because he had removed the previous catheter that had been put in place on 26 February 2013. Dr Lawlor requested that the Office of the Public Advocate have a discussion with Mr Frederick and the RAH staff about whether or not it was of value to continue reinserting catheters for Mr Frederick's dialysis. Dr Lawlor noted that Mr Frederick was currently leaving his dialysis treatment before it had been completed.

2.10. On 19 March 2013 Ms Amanatidis received a phone call from Dr Taylor at the RAH informing her that Mr Frederick was going to have a new catheter inserted. As Mr Frederick's guardian she consented to that procedure. On 20 March 2013 Dr Carroll, a nephrologist from the RAH, informed Ms Amanatidis that Mr Frederick had not had another catheter inserted because he had stated that he would pull the lines out. Dr Bannister also called Ms Amanatidis and repeated that Mr Frederick had refused to have another catheter inserted and stated that he would pull it out if reinserted. He said that Mr Frederick was no longer dialysable, basing this on the functionality of the dialysis and whether it would achieve any quality of life. Dr Bannister observed that Mr Frederick had been in the RAH for about eight weeks and opined that he did not fit the guidelines for treatment. Ms Amanatidis told Dr Bannister that she believed at that point that Mr Frederick needed to continue dialysis treatment. Ms Amanatidis asserts that other members of the Office of the Public Advocate staff, including the Public Advocate himself, had concluded that it was appropriate for Mr Frederick to continue treatment.

2.11. Over the ensuing days there was further discourse between the Office of the Public Advocate and the RAH clinicians about the question of reinsertion of the catheter. Dr Taylor told Ms Amanatidis that he could reinsert the catheter but would require anaesthetic support. Concerns were expressed about the sustainability of the procedure and the possibility that Mr Frederick would pull the catheter out in a public place, bleed heavily and die. A conversation between Ms Amanatidis and Mr Frederick at the RAH involved Mr Frederick saying that he wanted reinsertion of the catheter.

2.12. The reinsertion procedure took place on 22 March 2013. During this procedure Mr Frederick bled so heavily that it led to a cardiac arrest from which he was resuscitated.

2.13. On 27 March 2013 Ms Amanatidis gave a direction as Mr Frederick's guardian that he would be not for resuscitation. On the same day the Guardianship Board granted the Level 3 Inpatient Treatment Order for a period of 6 months.

2.14. In April 2013 there was further discourse regarding suspected cancer in respect of which Mr Frederick refused investigation and stated that he wanted to die. In the event this was not investigated. There were other medical complications arising during the course of this month. In addition, on 26 April 2013 correspondence between the RAH and the Office of the Public Advocate outlined that the insertion of Mr Frederick's catheter in March 2013 had been problematic and had involved subsequent complications. By then Mr Frederick had been moved back to the psychiatric ward. The problems faced by the proceduralist when trying to insert the catheter were discussed, as was the likelihood that the catheter would become infected. Due to the extreme technical difficulties that had been involved in the reinsertion of the catheter it was the consensus view of all nephrologists in the Renal Unit of the RAH that no further line should be attempted. It was their considered view the treatment of Mr Frederick was largely futile and that his quality of life was minimal. The letter sought agreement from the Office of the Public Advocate that in the event of line sepsis that the line be withdrawn, that Mr Frederick be given the appropriate antibiotics and that no further dialysis take place.

2.15. In late April 2013 there was some discussion with psychiatric staff concerning arrangements for Mr Frederick to be discharged from the RAH. In the beginning of May 2013 there was some further discussion about that issue.

2.16. On 13 May 2013 Ms Amanatidis received a phone call from a Dr Tillett, a renal specialist from the RAH, advising that on 10 May 2013 Mr Frederick was seen holding his line as he was lying in his bed and that it was believed that he had pulled it out midway through dialysis. On the other hand, Mr Frederick had said that he stood up and it '*just happened*'. Mr Frederick was advised that the line would not be reinserted. On the same date Dr Lawlor explained to Ms Amanatidis that he had spoken with Mr Frederick about the line removal and had advised him of the complexities of the situation insofar as he had experienced a cardiac arrest during the previous insertion. He had explained that the lack of a line would now mean that no further dialysis would be undertaken. Dr Lawlor enquired as to the Public Advocate's current view regarding treatment. A decision was made within the Office of the Public Advocate to accept the advice of Mr Frederick's renal team.

2.17. On 14 May 2013 Ms Amanatidis wrote to Dr Lawlor indicating that as the guardian for Mr Frederick's health care she would consent to any care or treatment consistent with palliative care. She later clarified by email that she would not enforce dialysis. Consequently Dr Lawlor sent an email that date to all interested entities advising that the Public Advocate would not enforce replacement of the catheter and that there was consent to a palliative approach to Mr Frederick's ongoing treatment. It was said in this email:

> 'This is in line with Geoff's own view that replacement of the catheter may represent a significant risk to life.'

Thereafter Mr Frederick was palliated and he died on 28 May 2013.

3. Conclusions

3.1. Mr Frederick's detention pursuant to the Mental Health Act 2009 did not in any way contribute to his death. Nor did any other order of the Guardianship Board. On the contrary, it is plain that Mr Frederick's death would have occurred much earlier but for the intervention of clinicians at the RAH.

3.2. I was satisfied that Mr Frederick's dialysis was discontinued for sound reasons. The view was taken that reinsertion of the catheter in mid May 2013 would have been associated with such difficulty that it would not have been appropriate. This is particularly so when regard is had to the fact that at the previous insertion Mr Frederick had experienced a cardiac arrest as a result of the consequent blood loss. Mr Frederick was also a very sick man.

3.3. There are no recommendations to be made in this matter.

Key Words: Death in Custody; Natural Causes

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 17th day of November, 2017.

Deputy State Coroner