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 11th day of June and the 22nd day of December 2020, by the Coroner's Court of the said State, constituted of Brian Malcolm Nitschke, Deputy State Coroner, into the death of Emanuel Mavridis.

The said Court finds that Emanuel Mavridis aged 64 years, late of 24 Kanbara Street, Flinders Park, South Australia died at the Royal Adelaide Hospital, Port Road, Adelaide, South Australia on the 23rd day of September 2018 as a result of heart failure scondary to alcohol related liver disease, coronary obstructive pulmonary disease and ischaemic/alcoholic cardiomyopathy. The said Court finds that the circumstances of his death were as follows:

1. Introduction and cause of death

1.1. Emanuel Mavridis was born on 21 August 1954 and died on 23 September 2018 at the Royal Adelaide Hospital (RAH). He was 64 years of age.

1.2. Mr Yanni Mavridis, the son of Emanuel Mavridis, formally identified the body of his father.[1]

1.3. Dr Sami Termanini, ICU Registrar at the RAH, completed a '*Death Report to Coroner - Medical Practitioner's Deposition*' on 23 September 2018 following Mr Mavridis' death. In that report, he provided his opinion as to the cause of Mr Mavridis' death as natural causes, secondary to alcohol related liver disease, coronary obstructive pulmonary disease and ischaemic/alcoholic cardiomyopathy. Dr Genevieve Gabb,

[1] Exhibit C1

senior staff specialist in general medicine, opined that Mr Mavridis died as a result of heart failure[2]. The opinions of Dr Termanini and Dr Gabb lead me to find, and I do so find, the cause of Mr Mavridis' death to have been heart failure, secondary to alcohol related liver disease, coronary obstructive pulmonary disease and ischaemic/alcoholic cardiomyopathy.

2. Reason for inquest

2.1. Mr Mavridis had been placed on a Level 1 Inpatient Treatment Order (ITO) by Dr Parisha Bisram at 10:10pm on 18 September 2018 at the RAH. This order was made pursuant to section 21 of the Mental Health Act 2009. The ITO was confirmed by Dr Jonathan Symon, a Psychiatrist, on 20 September 2018 at 12:45pm.[3]

2.2. As the death occurred whilst Mr Mavridis was detained under an ITO, his death is regarded as a death in custody.[4] As such, this is a mandatory inquest pursuant to section 21(1)(a) of the Coroners Act 2003.

2.3. I pause here to note that the ITO was not confirmed within the stipulated 24-hour period. Dr Symon did however complete his review as soon as practicable thereafter and I have no concerns in relation to the delay.

3. Background and medical history

3.1. Mr Mavridis was a divorced father of two. He lived alone in his home at Flinders Park with regular assistance from Domiciliary Care and home visits from his family and friends. He had three sisters, who cared for him diligently in the five years prior to his passing.

3.2. Mr Mavridis' general practitioner of 40 years, Dr James Psaltis, disclosed a history including cardiac and lung issues against a background of smoking and alcohol use.[5] A mass had been found on Mr Mavridis' lung in 2016, but he refused medical investigation. Mr Mavridis would consistently refuse to comply with requests to see specialists and would not attend appointments.

[2] Exhibit C3
[3] Exhibit C6a
[4] Of course, he was not 'in custody' in the sense that he had committed any wrong doing. He was required to remain in a hospital for his own safety and to allow treatment
[5] Exhibit C6

3.3. Mr Mavridis had frequent hospital admissions in the two years prior to his death for various reasons, including pneumonia.

4. Mr Mavridis' admission to the Royal Adelaide Hospital

4.1. Mr Mavridis presented to the RAH in the early afternoon of 12 September 2018. He had called family to let them know he was at home and unwell. Mr Mavridis' family members attended at his home and called an ambulance. Ambulance notes indicate that, upon their arrival, Mr Mavridis was sitting on a lounge chair and was drowsy and, at times, confused.[6] He was transported by ambulance to the RAH where he was admitted. He was noted to be hypotensive[7] and suffering from metabolic acidosis[8] and to have a fluctuating GCS.[9] Due to his low blood pressure Mr Mavridis was admitted to the Intensive Care Unit.

4.2. Dr Genevieve Gabb reviewed Mr Mavridis on 13 September 2018 and noted a history of cardiac disease, airways disease and some alcohol and self-care issues. There were at this stage concerns about his liver function.[10]

4.3. By 17 September 2018 Mr Mavridis' immediate cardiac health and his blood pressure had improved somewhat and plans were made to move him to a ward.

4.4. On 18 September 2018, Mr Mavridis stated that he wished to discharge himself from hospital. This was against medical advice. He was still very unwell and considered medically not fit for discharge. Considering Mr Mavridis' stated intention to discharge himself, notwithstanding medical advice to the contrary, that he was very unwell, that he required ongoing treatment for his own protection from physical harm and was considered to have an impaired decision-making capacity, he was placed on a Level 1 ITO.

4.5. On 19 September 2018, Mr Mavridis was moved to a ward. A review was conducted and a working diagnosis was made of significant illness and hepatic encephalopathy.[11] Treatment for his illness (including for the hepatic encephalopathy) and a psychiatric review were arranged for Mr Mavridis.

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[6] Exhibit C6
[7] Low blood pressure
[8] A condition in which too much acid accumulates in the body
[9] Glasgow Coma Scale
[10] Exhibit C3
[11] A disturbance of thinking relating to liver disease

4.6. On 20 September 2018 Dr Jonathan Symon, Psychiatrist, reviewed Mr Mavridis and confirmed the ITO. This ITO was then due to expire on 25 September 2018.

4.7. On 21 September 2018 Mr Mavridis' respiratory function deteriorated. He had hypoxia and an increased requirement for oxygen. Because of his deterioration, Mr Mavridis was returned to the Intensive Care Unit at about 12:30pm on 22 September 2018. Investigation by way of an echocardiogram indicated severe cardiac dysfunction.

4.8. On the morning of 23 September 2018 Mr Mavridis remained alert and responsive. At 7:30am Registered Nurse Karen Davies removed Mr Mavridis' CPAP mask, but left his nasal specs[12] in place. Approximately 15 minutes later Ms Davies noticed his oxygen numbers were depleting.[13] Mr Mavridis' CPAP mask was put back on. Mr Mavridis stopped breathing, his blood pressure plummeted, and he had no pulse.

4.9. Mr Mavridis was declared deceased at 9:30am by Dr Sam Termanini.

5. Coronial investigation

5.1. Detective Brevet Sergeant Joshua Quinn from the Western Adelaide Criminal Investigation Branch of SAPOL investigated the death in custody of Mr Mavridis and prepared a comprehensive report for the State Coroner.[14]

5.2. Detective Quinn noted no issues of concern following his investigation.

6. Submissions by the family

6.1. Mr Mavridis was survived by his three sisters: Ms Semma Antoniou, Ms Sofie (Fofe) Parrella, Ms Helen Mavridis. Each of them attended at the inquest hearings and each of them made submissions to the Court on 25 June 2020.

6.2. They told the Court that Mr Mavridis came from a very close-knit family. He came to Australia with his parents at a very young age. Mr Mavridis had to break off his formal education at primary school level and go out to work because of a work accident suffered by his father. He supported the family while the father was hospitalised and

[12] Nasal specs (cannula) deliver supplemental oxygen or increased airflow to a patient
[13] Exhibit C2
[14] Exhibit C6

thereafter. He was a hard worker. They said that he sacrificed a lot of his own life for others. They said that even after the passing of their parents, they remained a close-knit and supportive family. They said that the sudden death of his mother, the breakdown of his marriage and subsequent estrangement with his sons coincided with him beginning to drink heavily. They said he '*took up drinking probably 5 years ago but I would say that he drank heavily in the last 2 years*'. They described Mr Mavridis as a '*gentleman*' and someone who had the utmost respect for the law.

6.3. It is clear that each of his sisters was close to their brother and did their utmost to look after and care for him, especially in the latter years of his life.

6.4. In submissions to the Court, Mr Mavridis' sister expressed a number of concerns.

6.5. They were concerned that Mr Mavridis had been made and continued to be the subject of an Inpatient Treatment Order at the time of his death.

6.5.1. Mr Mavridis' sisters said that because of his limited formal education, when he spoke, his 'words were a bit jumbled. He kind of talked a little bit in riddles, but that was Emanuel, that's how we knew Emanuel, that's how Emanuel was'. It was suggested by them that because of this, in his interactions with medical staff, he may have appeared to be more impaired than was objectively the case.

6.5.2. However, there is ample evidence before the Court that by at least 18 September 2018, Mr Mavridis was suffering a disturbance of thinking related to his liver disease and by at least 20 September 2018 delirium, most likely brought about by his liver disease.

6.5.3. The evidence is that after an examination at 10pm on 18 September 2018, Dr Parisha Bisram, a medical practitioner, made the determination that such an order was necessary to protect Mr Mavridis from physical harm including deterioration of his condition and that there was no less restrictive means to ensure appropriate treatment for his illness. I note that the hospital notes record that, while at least some of his sisters were present, the serious risks to his health of his self-discharging against advice were attempted to be explained to Mr Mavridis. These included concerns that without monitoring and replacement of his electrolytes as required he might suffer fatal cardiac arrest.

Also, that at that stage he would be likely to be very unsteady on his feet and at risk of falls with the risk of severe injury to the brain or other parts of his body. The notes record that he was unable to provide feedback on the medical advice given and he stated that he wished to go to home. The evidence before me does not support a conclusion that the issue of an ITO at this stage was inappropriate. Indeed, the evidence supports a finding that the issuing of the ITO was appropriate in the circumstances.

6.5.4. The ITO was confirmed by a psychiatrist, Dr Jonathan Symon, after an examination of Mr Mavridis on 20 September 2018 at 12:45pm. The medical notes support that Dr Symons concluded that, at that stage, Mr Mavridis suffered from cognitive impairment and a fluctuating mental state with a provisional diagnosis of delirium secondary to hepatic encephalopathy. Further that in this condition he was a risk to himself as he required inpatient medical care and his insight and judgement as to that need were impaired. The evidence before me does not support a conclusion that the decision to confirm the ITO was inappropriate. On the contrary, the evidence supports a finding that the confirmation of the ITO was appropriate in the circumstances.

6.6. His sisters expressed a concern that no attempt was made to resuscitate Mr Mavridis.

6.6.1. The evidence is that, as of at least 22 September 2018, Mr Mavridis was suffering from an acute deterioration of several chronic and serious underlying medical conditions.[15] The opinion of medical practitioners responsible for his care was that his prognosis for recovery was extremely poor.

6.6.2. The evidence is that on that day, Dr Neuts, ICU Registrar, discussed the severity of Mr Mavridis' illness with two of his sisters. The hospital notes, signed by Dr Neuts, record a family meeting at 4:20pm on that day. The hospital notes record:

> 'Explained that current treatment is a full medical management of acute deterioration. Underlying conditions (liver, heart). Is unlikely to recover. In this view, including ongoing ETOH use, we believe that escalating of care (intubation + ventilation, dialysis) is a life-prolonging treatment and not in Emanuel's best interests.

[15] I note that in relation to Mr Mavridis' cardiac condition, an echocardiogram performed on that day revealed an ejection fraction from his left ventricle of 15-20%

> Sisters did understand severity of illness - but would like 'Everything' done for Emanuel. They don't understand how he could deteriorate so quickly and want him to come back home.'

6.6.3. It was clearly the view of Dr Neuts that, because of his medical conditions, Mr Mavridis was in the end stages of his life and no treatment could reverse this. It was clearly the view of Dr Neuts that if cardiopulmonary resuscitation (CPR) were required it would merely be to prolong his life in a moribund state without any real prospect of recovery. He expressed his view that CPR not be performed.

6.6.4. Later that day, the view and recommendation of Dr Neuts was reviewed by Dr Sharley, ICU Consultant. Dr Sharley agreed with those views and the recommendation that CPR not be performed. Dr Sharley consulted with Dr Gabb who agreed with the views and recommendation. A document titled 'resuscitation alert' which sets out that Mr Mavridis was not to be given CPR was completed and signed by Dr Neuts and countersigned by Dr Sharley and placed on the case notes.

6.6.5. I find that it was a result of this directive that no CPR was performed upon Mr Mavridis.

6.6.6. I note that the sisters present at the family discussion with Dr Neuts wished '*everything*' be done for their brother. I specifically note that in submissions each of the sisters said that they did not then agree with the decision not to resuscitate their brother and would not have agreed. The evidence supports the conclusion that the sisters present at the family discussion did not agree with the decision not to resuscitate their brother and I accept that their reasons for doing so arose from a deep sense of respect and affection for their brother.

6.6.7. A medical practitioner is under no duty to use, or continue to use, life sustaining measures in treating a patient if the effect of doing so would be merely to prolong life in a moribund state without any real prospect of recovery. This is so, whether the patient or others closely connected with the patient requested that such measures be used or continue to be used.[16]

[16] Section 17 Consent to Medical Treatment and Palliative Care Act 1995

6.6.8. There is no evidence to cast any doubt upon the lawfulness and appropriateness of the decision taken by medical practitioners treating Mr Mavridis.

6.7. His sisters were concerned that very shortly before his death a nurse had removed the CPAP (Continuous Positive Airway Pressure therapy) mask from Mr Mavridis.

6.7.1. Dr Gabb reviewed the removal of the CPAP mask by Ms Davies and concluded it was ‘very appropriate nursing care’. She stated:

> 'I have been asked to explain why Nurse DAVIES removed the CPAP (Continuous positive airway pressure therapy) mask from the deceased prior to his death. It wasn't just oxygen that the deceased was receiving from the mask, rather it was BiPAP (Bi-level Positive Airway Pressure). BiPAP is non-invasive ventilation with two levels of pressure. BiPAP is a mask strapped really tight to one's face and causes oxygen to be forced in. While it is not intolerably uncomfortable, it is something that people don't necessarily endure very well, particularly people who haven't had it before which was the case with the deceased. My opinion is that it was very appropriate for the Nurse to remove the BiPAP mask from the deceased, particularly in the ICU setting as was in this instance. It is very, very appropriate nursing care. When the BiPAP was removed the deceased was still being monitored.'

Dr Gabb went on to say:

> 'I don't know if a link can be made between the removal of the BiPAP and the deceased's death. Had the BiPAP not been removed, the deceased may well have died at a similar time. The BiPAP is not a long-term treatment for cardiac failure which was fundamentally the cause of death.'[17]

6.7.2. The evidence before me does not support a conclusion that it was inappropriate for Ms Davies to remove the CPAP mask as she did. Indeed, the evidence supports the conclusion that it was appropriate nursing care.

7. Conclusions

7.1. I find that Mr Mavridis died on 23 September 2018 at the Royal Adelaide Hospital whilst detained under an Inpatient Treatment Order for his own care and protection. I find that order to have been lawful.

7.2. I find that Mr Mavridis received an appropriate level of care and treatment during his admission to the Royal Adelaide Hospital. I further find that no definitive link can be

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[17] Exhibit C3, page 6

made in relation to the timing of his death and the removal of the CPAP mask. Mr Mavridis was still receiving oxygen at that time through his nasal cannula.

7.3. I make no recommendations to make in relation to the death of Mr Mavridis.

Key Words: Death in Custody; Natural Causes; Inpatient Treatment Order

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 22nd day of December, 2020.

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Deputy State Coroner

Inquest Number 60/2020 (1811/2018)