
FINDINGS of Coroner Simon Cooper following the holding of an inquest under the *Coroners Act* 1995 (Tas) into the death in care of:

Frederick Rocky Bowden

Record of Investigation into Death (With Inquest)

Coroners Act 1995

Coroners Rules 2006

Rule 11

I, Simon Cooper, Coroner, having investigated the death of Frederick Rocky Bowden

Hearing Dates

With an Inquest held at Hobart on 20 September 2018

Appearances

E Avery – Counsel Assisting the Coroner

Introduction

1. On 12 April 2015 Frederick Rocky Bowden, aged 59, died in the Roy Fagan Centre (RFC) Kalang Avenue, Lenah Valley. At the time of his death Mr Bowden was the subject of a treatment order made by the Mental Health Tribunal under the *Mental Health Act 2013*.
2. Mr Bowden's death is subject to the *Coroners Act 1995* (the "Act"). The Act provides that an inquest must be held where a death occurs in Tasmania and the deceased person was, immediately before their death, a person held in care.
3. Section 3 of the Act provides a person is in care if that person was a person detained or liable to be detained in an approved hospital within the meaning of the [Mental Health Act 2013](#), or in a secure mental health unit or another place while in the custody of the controlling authority of a secure mental health unit, within the meaning of that Act. As a consequence, an inquest in relation to Mr Bowden's death was mandatory. In most other jurisdictions in Australia, an inquest is also mandatory in such circumstances.

4. The ambit of any coronial investigation is defined by the *Act*. Relevantly, section 28 provides:

"(1) A coroner investigating a death must find, if possible –

(a) the identity of the deceased; and

(b) how death occurred; and

(c) the cause of death; and

(d) when and where death occurred; and

(e) the particulars needed to register the death under the [*Births, Deaths and Marriages Registration Act 1999*](#).

(f)

(2) A coroner must, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate.

(3) A coroner may comment on any matter connected with the death including public health or safety or the administration of justice.

(4) A coroner must not include in a finding or comment any statement that a person is or may be guilty of an offence.

(5) If a coroner holds an inquest into the death of a person who died whilst that person was a person held in custody or a person held in care or whilst that person was escaping or attempting to escape from prison, a secure mental health unit, a detention centre or police custody, the coroner must report on the care, supervision or treatment of that person while that person was a person held in custody or a person held in care."

5. Section 28(5) of the *Act* imposes an obligation to report on the care, supervision or treatment of Mr Bowden in this case. The rationale for such a requirement is the public policy reason to ensure that the death of every

person who is detained against their will in any state-run institution by reason of an order of a court, tribunal, or the executive is carefully, independently and transparently examined. In Waller's *Coronial Law and Practice in New South Wales* (third edition) at page 28 it is said that:

“Society, having effected the arrest and incarcerations of persons who have seriously breached its laws, owes a duty to those persons, of ensuring that their punishment is restricted to this loss of liberty and is not exacerbated by ill treatment or privation while awaiting trial or serving their sentences. The rationale is that by making mandatory a full and public inquiry into deaths in prisons and police cells the government provides a positive incentive to custodians to treat their prisoners in a humane fashion and satisfies the community that deaths in such places are properly investigated.”

Mr Bowden's Background

6. Born Frederick Rocky Bowden, but known to some members of his family as Kerry Frederick Bowden¹, Mr Bowden had a troubled upbringing and a difficult life. He had an extensive criminal history dating back to the early 1970s. He served a number of terms of imprisonment. Whilst in prison in the late 1980s, Mr Bowden was formally diagnosed as suffering from schizophrenia.
7. Thereafter, he was treated with medication. After release, Mr Bowden lived with a brother and was supported by a mental health worker and an advocate.
8. His very poor mental health meant he had a number of admissions as an inpatient for treatment. Some of those admissions were involuntary, i.e. as the result of an order under the applicable mental health legislation, which compelled him to be hospitalised and to undertake a particular course of treatment against his will.
9. Mr Bowden never married and had no children.

¹ Affidavit of Tina Mayne Exhibit B9.

Circumstances of Death

10. For the last few years of his life Mr Bowden was treated with, *inter alia*, clozapine, an antipsychotic medication reserved for the most serious cases of schizophrenia and similar illnesses. The drug appears to have been reasonably effective in the management of the worst of his symptoms.
11. However, his physical health deteriorated markedly over the last few months of his life.
12. On 19 March 2015, Mr Bowden was admitted to the Royal Hobart Hospital and found to be suffering from severe renal failure. Renal dialysis was considered but, given the nature of Mr Bowden's schizophrenic symptomology, was not a course able to be pursued.
13. On 31 March 2015, an emergency Guardianship Order was made for 28 days appointing the Public Guardian to be Mr Bowden's guardian.²
14. A decision was made to palliatively care for Mr Bowden after this date. He was initially housed at the Millbrook Rise Mental Health Facility and, when his condition worsened, transferred to RFC on 10 April 2015. Two days later, at 10.40am and in the presence of two staff members, Mr Bowden died.
15. The fact of Mr Bowden's death was reported to the Coroner's Office and investigated under the *Act*. Nothing suspicious about his death was identified. An autopsy was carried out on his body by the State Forensic Pathologist Dr Christopher Hamilton Lawrence MB BS, FRCPA, who also reviewed his medical records. He found no signs of violence or injury on Mr Bowden's body.
16. Dr Lawrence expressed the opinion in an affidavit tendered at the inquest³, that the cause of Mr Bowden's death was aspiration pneumonia and end stage renal failure, due to obstructive uropathy and cardiac fibrosis. I accept Dr Lawrence's opinion.

² Exhibit B17a.

³ Exhibit B6.

17. The possibility that Mr Bowden's renal failure may have been due to a suspected overdose of clozapine was investigated. The evidence suggests, and I am satisfied, that if there was an overdose, it was accidental and consisted of just one extra tablet. Dr Anthony J Bell MD FRACP FCICM medical advisor to the Coroner's Office and a specialist in the treatment of renal disease, reviewed this issue and Mr Bowden's medical treatment generally. He provided a report, which was tendered at the inquest.⁴
18. Dr Bell said that if there had been an overdose of clozapine, it was in no way related to Mr Bowden's development of renal impairment. Dr Bell expressed the opinion that Mr Bowden's renal failure was caused by benign prostate hypertrophy, which in turn caused an obstruction of his urine outflow. Dr Bell said Mr Bowden's condition was diagnosed and treated appropriately, that his medical management was of a good standard, and that the teamwork between Mr Bowden's various practitioners was 'excellent'. I accept Dr Bell's opinion.

Formal Findings

19. On the basis of the evidence at the inquest I find, pursuant to Section 28(1) of the *Coroners Act* 1995, that:
- a. The identity of the deceased is Frederick Rocky Bowden, also known as Kerry Frederick Bowden;
 - b. Mr Bowden died in the circumstances set out in this finding;
 - c. The cause of Mr Bowden's death was aspiration pneumonia and end stage renal failure; and
 - d. Mr Bowden died on 12 April 2015 at the Roy Fagan Centre, Kalang Avenue, Lenah Valley, Tasmania.

Comments, recommendations and report on care, supervision or treatment

20. I am affirmatively satisfied on the basis of the evidence at the inquest that the

⁴ Exhibit B8.

care and supervision of Mr Bowden was of an acceptable standard and in no way caused or contributed to his death.

21. The circumstances of Mr Bowden's death is not such as to require me to make any comments or recommendations pursuant to section 28 of the *Coroners Act* 1995.

Dated 19 October 2018

Simon Cooper
Coroner