Coroners Act, 1996
[Section 26(1)]

Western Australia

RECORD OF INVESTIGATION INTO DEATH

Ref No: 25/15

I, Evelyn Felicia Vicker, Deputy State Coroner, having investigated the death of ***Francis Gerald ROBERTS****, with an Inquest held at Perth Coroners Court, Court 51, CLC building, 501 Hay Street, Perth, on the 24 July 2015 find the identity of the deceased was* ***Francis Gerald ROBERTS*** *and that death occurred on 9 March 2014 at Fremantle Hospital coronary care unit, and was consistent with heart failure in association with cardiomyopathy in the following circumstances:-*

Counsel Appearing :

Sergeant L. Housiaux assisted the Deputy State Coroner

Ms Jane Godfrey (State Solicitors Office) appeared on behalf of the Department of Corrective Services.

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INTRODUCTION

Francis Gerald Roberts (the deceased) was a sentenced prisoner serving an indefinite sentence of life imprisonment with a non-parole period of 13 years for the conviction of murder and concurrent convictions relating to gaining benefits by fraud.

The deceased had been unwell with known heart disease and insulin controlled type two diabetes mellitus prior to his imprisonment on the 28 May 2004. In March 2006 he was transferred to Casuarina Prison (Casuarina) due to his ongoing medical issues and to facilitate family visits. He was significantly non-compliant with medical intervention. On 24 May 2012 he was registered as a Phase I terminally ill prisoner. This was updated to a Phase II terminally ill prisoner on the 21 June 2012 and he remained at Phase II until his death in March of 2014.

The deceased was transferred for the final time from the Casuarina Infirmary to Fremantle Hospital on the 14 February 2014 where he remained under guard until his death on 9 March 2014.

The deceased was 62 years of age.

The provisions of the *Coroners Act 1996* require the death of any prisoner be examined by way of inquest (section 3, section 22(1)(a)) and the coroner conducting the inquest is

required to comment on the supervision, treatment and care of the prisoner, while held in custody, (section 25(3)).

BACKGROUND

The deceased was born on the 7 May 1951 in Scotland and was the youngest of 3 boys in his family. Following his move to Australia at 12 years of age he began to truant from school until he eventually ran away approximately a year later. He obtained work as a chef until his late teens and then worked in a variety of occupations, ranging from taxi driver to fisherman.

The deceased was married twice, with 3 children from his first marriage and 5 children from his second marriage. In addition he had one adopted child.

In 1996 the deceased's brother-in-law was involved in a serious motor vehicle collision which left him with serious injuries and the deceased and his wife became his primary carers. The Public Trustee were the managers of the brother-in-law's MVIT payout and deposited a fortnightly sum into the family bank account to accommodate his board and lodging with the deceased and his wife.

In mid-2001 the deceased argued with his brother-in-law and caused his death. The deceased and his wife then disposed of the body but continued to access the funds held

by Public Trustee on behalf of the now deceased brother-in-law.

The deceased was charged over the death and fraud offences in May of 2004 and was convicted and sentenced to imprisonment.

MEDICAL HISTORY

The deceased suffered type 2 diabetes mellitus, hypertension, ischemic heart disease, atrial fibrillation with a permeant pacemaker insertion, hypercholesterolemia and obesity. There was no record of him ever exhibiting any self-harm or suicidal ideation despite his considerable ill health.

The deceased had also suffered a spinal injury when young and the effects of that appeared to become evident following his obesity, alcoholism, and ischemic heart disease. He was allergic to Penicillin and Elastoplast.

The deceased had suffered from ill health for some considerable time before he entered the prison system at the age of 53. He had needed to have a permanent pacemaker inserted in 1994 due to bouts of paroxysmal atrial fibrillation. In 2001 he was investigated with a myocardial perfusion study following chest pain on exertion. He had a small area of mild reversibility in the inferior wall of his left ventricle, however, there was normal left ventricular

function. It was thought likely he had mild to moderate single vessel disease, involving the right coronary artery territory, which was unlikely to cause difficulties in the short to medium term.

In August of 2002 the deceased was admitted for coronary angioplasty and had a stent inserted in his right coronary artery. The angiogram report from that time detailed a *"moderate 40% stenosis to the left main coronary artery. Left anterior descending diffuse disease*".[1]

In December 2003 he was diagnosed with left vitreous haemorrhage secondary to diabetic retinopathy and background diabetic retinopathy, bilaterally, following a history of reduced vision in his left eye. He was treated conservatively.

The deceased consulted with cardiologists just before his incarceration in May 2004 in relation to his chest pain on exertion.

On his admission to Hakea in May 2004 he was assisted by the Prisoners Counselling Service (PCS) as a first time inmate, facing a serious charge likely to result in a substantial term of imprisonment. He declined to engage with the PCS.

[1] Exhibit 2, tab 32

Due to his numinous medical illnesses information was obtained, with his consent, from his community clinicians and this confirmed he had a history which included ischemic heart disease (with right coronary artery stent 2002) atrial fibrillation with permanent pacemaker, hypercholesterolemia and obesity. His medical management and treatment was then continued under the direction of the prison medical staff in conjunction with his consultants at Fremantle and Royal Perth Hospitals.

The prison records and the deceased's medical file indicated he was often aggressive and demanding with both prison and medical staff. In September and November 2004 he refused all medical and clinical observations in an attempt to control his management. It became a feature of his imprisonment history, he would use non-compliance with medical management in an attempt to manipulate his environments.

On involvement of the mental health nurses (MHN), he was not assessed as having serious self-harm or suicidal intent, but he was considered to be depressed as a result of a number of psychosocial stressors relating to his offending and later judicial proceedings. He eventually agreed to a GTN spray for his angina but continued to refuse any other medical intervention.

In December 2004 the deceased collapsed with chest pain but refused to be transferred to hospital or accept medical treatment, again in protest at security measures in the prison environment. He experienced dizzy spells for which investigations could find no cause. After a period of negotiation his compliance with scheduled hospital appointments and medical management within the prison system appeared to improve.

The deceased's compliance with medical treatment remained erratic although it was clear he was suffering with periods of difficulty with his ischemic heart disease, and diabetes. His refusal of management included refusal to attend for annual health assessment checks.

X-ray and ultrasounds of the deceased's right shoulder following reduced movement in October 2005 indicated subacromial bursitis and impingement. His rotator cuff tendons were not imaged well due to his obesity which was believed to have contributed to his lack of movement. He was treated with right subacromial bursal injections. This was still recorded as troubling him in April 2006 when rheumatology at Royal Perth Hospital (RPH) diagnosed adhesive capsulitis (frozen shoulder) and he was recommended for further steroid injections and physiotherapy.

He was investigated in May 2006 for laser treatment in relation to his retinopathy however the decline was not considered sufficiently severe to warrant intervention.

Monitoring of the deceased's cardiac status continued biannually unless there were episodes which warranted specific investigation. He was not always compliant with review.

His shoulder problem continued and a sebaceous cyst was discovered in the subcutaneous tissues overlying his right shoulder in October 2006. Later review indicated he did not consider he had received any benefit from treatment and he was commenced on analgesic patches along with continued physiotherapy.

His compliance with treatment and management was erratic with the deceased refusing to take medication or attend external consultant review.

He suffered a heart attack in November 2007 but the cardiothoracic surgeons did not deem him suitable for a coronary artery bypass graft at that time. Instead he was to be managed by further stenting. His pacemaker began to malfunction and necessitated a change in December 2007. He continued to receive management for his diabetic control and physiotherapy for his shoulder.

In July 2009 the deceased was in chronic atrial flutter and was being paced by his pacemaker 100% of the time. He was suffering shortness of breath, at rest, and paroxysmal nocturnal dyspnoea. He was medicated for fluid overload due to his heart failure.

Attempts to have the deceased lose weight for his health were unsuccessful and he continued to be managed medically.

By April 2011 the deceased continued to be unwell on exertion and his cardiology review was expedited. Essentially it determined his major problems were due to his poor diabetic control. When advised his preferred method of insulin self-administration was not available in the prison environment, he declined any insulin therapy.

Review of his cardiac problems continued and on 15 May 2012 the deceased was admitted to RPH following 5 days of increasing dyspnoea, chest pain on exertion and peripheral oedema. Following investigations he was referred to the cardiothoracic team for coronary artery bypass grafting.

On 24 May 2012[2] the deceased was listed on the prisons Phase I terminally ill prisoner register (high probability of death) and on 25 May 2012 he underwent 4 off-pump

[2] Exhibit 1, tab 20, attach 11

coronary artery bypass (OPCAB) procedures without complication. He was transferred back to Casuarina on 31 May 2012.

On 9 June 2012 the deceased was admitted to RPH under the care of a cardiologist with increasing shortness of breath on exertion, oedema and right sided chest pain. He was found to have had an exacerbation of his heart failure, made worse by the fluid overload and required treatment with diuretics and antibiotics. He was returned to Casuarina on 13 June 2012.

On 20 June 2012 the deceased was admitted to Fremantle Hospital (FH) with exacerbation of his cardiac failure and pneumonia. He was escalated to the Phase II terminally ill prisoner (death imminent) register[3] on the 21 June 2012. He was admitted for a week and treated with antibiotics before being discharged into the care of cardiology. His symptoms improved.

The deceased improved and was discharged from hospital on 27 June 2012 to the Casuarina infirmary. He refused to remain in the infirmary where he could be monitored by nursing staff and insisted he be returned to his unit[4].

[3] Exhibit 1, tab 20, attach 11
[4] Exhibit 2, tab 32

On the 19 July 2012 the deceased was reviewed by a RPH cardiothoracic surgeon who considered the bypassed grafts to be progressing well.

On 16 August 2012 the deceased collapsed and needed resuscitation for 3 minutes before a return of spontaneous circulation. He was admitted to RPH where he experienced another cardiac arrest which required cardioversion. He was admitted to the coronary care unit (CCU) and diagnosed with tenting of the graft of the left anterior descending artery and inadequate blood supply of the distal right coronary artery territory via the vein graft, with severe stenosis of the distal right coronary artery. He required stenting of the distal right coronary artery stenosis and then was provided with a single chamber implantable cardioverter defibrillator. He was discharged back to prison on the 21 August 2012.

On the 30 August 2012 he was reviewed by endocrinology at RPH and his insulin dose adjusted, although it was noted the deceased seemed to be frustrated by the uncertainty of his cardiac disease and his prognosis.

On the 2 October 2012 the deceased was reviewed at FH by respiratory medicine due to a persisting left sided pleural effusion. This was considered to be secondary to his congestive cardiac failure which appeared to be improving.

In January 2013 the deceased was reviewed by an RPH cardiologist who noted his implanted defibrillator was working normally and that it was correcting his atrial fibrillation well. She noted he had significate left ventricular dysfunction and that he needed to be medically reviewed consistently.

There was never any issue the medical staff in the prison were as involved with the deceased's medical management as he would allow them to be. The deceased was regularly reviewed by external consultants for most of his medical issues, again when he would allow the prison medical staff to refer him or agree to attend his appointments.

In May of 2013 he presented to FH as a result of chest pains, against his background of severe ischemic heart disease and congestive cardiac failure. He was treated with nitrates, frusemide and fluid restriction but continued with poor diabetic control. Even in hospital he refused prescribed medication and it was noted this may be adversely affecting both his diabetic control and heart failure. Eventually he was discharged back to prison on 11 May 2013 with his management having been optimised within the parameters he would allow.

Due to his declining health and his attitude to medical staff he was reviewed in June 2013 by a FH professor of community and geriatric medicine with respect to his

capacity to sign an advanced health care directive. It was understood he did not wish for further cardiopulmonary resuscitation, intubation or ventilation through the intensive care unit although he was happy to leave the defibrillator in place, and be treated if he experienced abnormal heart rhythms. The gerontologist had this to say

"Has advance heart failure whose management is complicated by his poor compliance with treatment"[5]

The deceased and the gerontologist were unable to negotiate a current management plan to deal with his deteriorating heart functions.

Two days later the deceased was admitted to FH and a chest x-ray showed enlargement of his heart, and coronary angiography showed severe triple bypass coronary artery disease, with diffuse disease throughout the right coronary artery. There was severe impairment of left ventricular systolic function and the deceased required aggressive diuresis and fluid restriction.

He was thereafter intermittently re-admitted to FH to cope with his fluid retention.

On the 16 of October 2013 the deceased signed a form refusing treatment against the advice of the attending

[5] Deceased's prison medical file June 2013

medical staff and refused to attend a medical appointment at RPH.

Aside from his hospital attendances the deceased had the opportunity to be reviewed by doctors and nurses on a daily basis in the prison system and this was done when he would allow it to occur. He was reviewed for both his sugar levels and his cardiac issues and received a high level of medical input when he would permit it.

EVENTS LEADING TO DEATH

The deceased was allowed to remain in the multipurpose unit (MPU) as his preferred option while he was relatively compliant with his medical regime. However, on 1 February 2014 following a prison management issue the deceased was transferred to the infirmary. The deceased then threatened to refuse to comply with his medical management unless he was returned to his unit. This was accommodated on the 5 February 2014.

On the 9 February 2014 the deceased collapsed following chest tightness but declined medical intervention by the medical staff and returned to his cell where he was told to rest and was reviewed the following day.

On 14 February 2014, recreation officer, Aaron Hardwick, was on duty in the MPU where the deceased was accommodated in a special protection unit. He was

accessing a computer approximately 4 meters from the deceased's cell when he observed the deceased leaving his cell and collapsing as he went through the doorway. It was approximately 5:40pm and Officer Hardwick's attention was drawn to the deceased because of his collapse. He landed face first on the ground.[6]

Officer Hardwick called a code red and rolled the deceased onto his side where he noticed the deceased was bleeding from his nose and a cut on his face. Officer Hardwick removed his glasses and attempted to speak with the deceased, who was breathing but non communicative. The officer placed the deceased in the recovery position until the medical staff arrived. The deceased was assessed as requiring transfer to an emergency department. His blood pressure was low at 94/55 but his respiratory rate, pulse rate and Glasgow Coma Score (GCS) were all in the normal ranges. He was transferred by ambulance to FH and on route experienced another episode of collapse.

Once in the emergency department the deceased was found to have congestive cardiac failure, a possible heart attack, pneumonia and possible pacemaker dysfunction. His pacemaker when checked was found to be functioning normally, but indicated there had been 3 episodes of ventricular fibrillation on the 14th, for which he had been shocked and reverted back to sinus rhythm. The record

[6] Exhibit 1, tab7

from the pacemaker was consistent with his episodes of collapse that day. He was admitted to cardiology.

There was difficulty correcting his congestive cardiac failure despite treatment with diuretics and strict fluid restrictions. He developed gross oedema and abdominal ascites. He was treated with frusemide and glyceryl trinitrate and, on 3 March 2014, stated he was feeling better. He was certainly less breathless following good diuresis.

On the 5 March 2014 the deceased appeared to suffer a seizure and his pacemaker indicated he had again experienced a ventricular tachycardia/ventricular fibrillation storm which had invoked 8 shocks from the pacemaker. Following an angiogram he was admitted to ICU for intubation and supportive therapy and given antiarrhythmic agents. He continued to receive diuretics and fluid management but experienced electrolyte imbalance and another 3 episodes of ventricular tachycardia/ventricular fibrillation on 6 and 7 March 2014.

The deceased was extubated on the 7 March 2014 due to concerns he would deteriorate due to end stage congestive cardiac failure. He continued to receive treatment but developed respiratory failure with increasingly laboured breathing. On the 8 March 2014 he was transferred to the CCU.

Once in CCU the deceased remained on CPAP and on inspired oxygen, although at lower levels. He stated he felt better as a result of improved fluid control and his observations were satisfactory, but his fluid balance started to diminish. He was sweaty, pale and clammy and continued diuresis was implemented in an effort to control his fluid balance. The deceased had requested his defibrillator be deactivated, but then changed his mind requesting it remain active, and discussions were held about his state of health.

The deceased continued to deteriorate and discussions with his family resulted in a plan he would remain with full medical management but was not for resuscitation if he were to deteriorate further.

The deceased suddenly deteriorated during a sponge bath in the evening of 9 March 2014 when he became pulseless and non-responsive. He was assessed by the cardiologist on the ward who declared him to have died just after 6pm on 9 March 2014.

POST MORTEM EXAMINATION

The post mortem examination of the deceased was carried out on 10 March 2014 by Dr Clive Cooke, Chief Forensic Pathologist, PathWest Medical Centre.

Dr Cooke found the deceased to be overweight with changes of recent medical intervention. The deceased's face was noted to be bruised on the tops of the cheeks which appeared to be healing, however, further examination was withheld due to a request by his family there be no internal post mortem examination.

Following negotiations between a coroner and the deceased's family a partial post mortem examination allowed review of the abdominal and thoracic cavities to establish the likelihood death was as a result of the deceased's know heart conditions.

Following that examination and toxicology, which was consistent with the deceased's prescribed medical care, Dr Cooke noted it was most likely the deceased had died of a sudden disturbance in the normal beating of his heart (cardiac arrhythmia) arising on the basis of significant pre-existing heart disease.

CONCLUSION AS TO THE DEATH OF THE DECEASED

I am satisfied the deceased was a 62 year old sentenced prisoner housed at Casuarina Prison for the majority of his 10 years incarceration following a conviction for murder in May 2004.

The deceased was housed at Casuarina from 2006 due to the availability of medical staff attached to the Casuarina

Prison Infirmary. On admission the deceased had suffered from a range of serious medical issues, not the least of which was his diabetes and cardiac disease.

Throughout his prison term the deceased received input from consultants and specialists relevant to his complex medical problems, including cardiology, rheumatology, endocrinology, and while he had required stents before his incarceration, he required further cardiac intervention during his incarceration.

The deceased was frequently non-compliant with medical review, management and treatment and his heart disease deteriorated with him requiring coronary artery bypass in May 2012. He was a difficult patient both from the perspective of the hospital staff on his admissions, and the prison staff during his incarceration.

His heart disease continued to worsen and he developed cardiac failure as a result of his ischemic cardiomyopathy on a background of diabetes mellitus. He developed recurrent ventricular arrhythmias and despite intensive medical treatment he finally suffered a fatal arrhythmia in hospital while being bathed by nurses on the 9 March 2014.

While the deceased had been assessed for the Royal Prerogative of Mercy (RPOM) it was ultimately declined due to the difficulties of finding an appropriate placement for the

deceased with his many medical conditions in the community. In addition there was the seriousness of his offending and his difficult management.

I find death occurred by way of Natural Causes.

SUPERVISION TREATMENT AND CARE OF THE DECEASED WHILE IN PRISON

The medical documentation relating to the deceased is voluminous, both from the prison perspective and the hospital perspective. He suffered serious health conditions for 10 years prior to his incarceration and was not a well man when incarcerated in May 2004.

On his admission to prison his medical history was assessed and he continued to receive review with respect to his diabetes control, and his cardiac condition which had already necessitated the insertion of a pacemaker.

His pacemaker was assessed and altered when necessary, but the deceased failed to comply with review management and this exacerbated his decline to some extent.

Following serious medical intervention in May 2012 which warranted coronary bypass surgery, despite previous pacemaker and stenting, the deceased was assessed as a Phase I terminally ill patient in May of 2012. Shortly thereafter, due to difficulties with his management, he was

made a terminally ill Phase II patient/prisoner and remained on the terminally ill Phase II list until his death some 20 months later.

Due to difficulties in managing the deceased's medical problems, he affectively controlled his placements within the prison system to suit his preferences. Even then he was only marginally compliant with management to the level necessary to facilitate his continued placement in the MPU.

By February 2014 the deceased was experiencing frequent collapses due to his cardiac failure and the inability of his pacemaker to adequately control the level of ventricular fibrillation.

Following two serious episodes of collapse on 14 February 2014, later discovered from his pacemaker to be in fact three, he was admitted to FH where he remained in either ICU or CCU until his death on the 9 March 2014.

On the day of his death, although deteriorating, the deceased was responsive and conversant with the nurses at FH who were bathing him at the time of his final fatal arrhythmia.

Overall, the deceased was in custody from May 2004 until March 2014 and during that time was transferred to a hospital facility on 76 separate occasions for cardiology,

radiology, diabetic, ophthalmology, rheumatology, surgical, endocrinology and podiatry health. He was hospitalised on 12 occasions as an emergency patient and also attended outpatient appointments and was reviewed by the prisons' medical advisors.

He consistently refused to attend medical appointments and often did not comply with the medical advice he was given when he did attend. As his condition deteriorated so he also refused to be placed in the infirmary at Casuarina, but wished to remain in MPU because he believed he was at threat from other prisoners.

In my view it is apparent the deceased's supervision, treatment and care, while a prisoner was reasonable and appropriate, despite his complex medical management and a resistant demeanour.

E F Vicker
Deputy State Coroner
6 August 2015