Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref No: 7/18

I, Evelyn Felicia Vicker, Deputy State Coroner, having investigated the death of **Robert Paul RODDA** *with an Inquest held at Perth Coroners Court, Court 51, Central Law Courts, 501 Hay Street, Perth, on 2 February 2018 find the identity of the deceased was* **Robert Paul RODDA** *and that death occurred on 14 October 2015 at Fiona Stanley Hospital, as the result of Multi-organ Failure following surgical repair of Abdominal Aortic Aneurysm in the following circumstances:-*

Counsel Appearing:

Sergeant L Housiaux assisted the Deputy State Coroner

Mr S Tomasich (State Solicitors Office) appeared on behalf of the Department of Justice (Corrective Services)

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INTRODUCTION

On 14 October 2015 Robert Paul Rodda (the deceased) was a sentenced prisoner located at Fiona Stanley Hospital (FSH) undergoing palliative care following surgery for a ruptured abdominal aortic aneurysm (AAA).

The deceased had a long history with the criminal justice system spanning the majority of his adult life. He also had a very long and complicated medical and mental health history starting in early childhood.

Due to his significant medical history the deceased had been considered for early release under the Royal Prerogative of Mercy (RPOM) provisions in 2010, but this had not been recommended due to his lack of family support in the community and the benefit to his appropriate medical care while incarcerated.

The deceased had been made a terminally ill prisoner in 2012 due to the severity of his cardiac and respiratory disease, and in December 2012 had first been diagnosed with an AAA. Surgery was contraindicated due to the severity of the deceased's other morbidities. Following further review in 2015 it was considered the aneurysm had enlarged to the extent there was a danger of rupture and he was admitted to FSH to evaluate his requirements for surgery.

On 22 September 2015 the indications were his AAA had ruptured and he was taken to theatre for emergency surgery to repair the rupture. The necessary surgery caused the deceased to suffer renal failure requiring permanent dialysis.

On 12 October 2015 the deceased withdrew himself from dialysis and palliative care was commenced. He died in custody at FSH on 14 October 2015.

The deceased was 62 years of age.

The provisions of the *Coroners Act 1996* (WA) 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 that prisoner, while held in custody, (section 25 (3)).

BACKGROUND

The Deceased

The deceased was born on 18 April 1953 in South Australia. He appears to have had a truly traumatic childhood, despite there being two versions of his early years.[1] Regardless of whether he was adopted at 3 years of age following the murder of his biological parents, or physically and emotionally abused by his father, who worked as a prison guard, he was first recorded as having been seen by a

[1] Ex 1, tab 12 & 16

psychiatrist at 9 years of age for mood swings and hyperactivity. That fact suggests serious difficulties for the deceased.

According to prison records he ran away from home when aged 10 and reported he had been raped. He was admitted to a hospital facility in 1967 for 2 ½ years as a result of his behavioural difficulties. He self-reported leaving school at 14, due to his admission to the facility in South Australia, and gave a history of alcohol and cannabis abuse.

On release he was employed as a storeman at Woolworths, but was charged with shop lifting and after that time had no successful periods of employment.

The deceased first came to the attention of the criminal justice system in South Australia in 1971 for false pretences and since that time his offending had continued, although escalating in severity, with convictions reported in NSW, SA and QLD as well as WA. Almost all the deceased's offences were frauds, escalating to armed robberies.

The deceased was first imprisoned in Western Australia in 1977 at Albany Regional Prison and since that time had spent most of his life incarcerated. This led to his becoming institutionalised and he was assessed by his consultant psychiatrists as unable to cope in the community. The various psychiatrists who reviewed him during his adult life gave his mental health diagnoses as personality disorder,

post-traumatic stress disorder (PTSD) and depressive illness.

The deceased claimed to be in a long term supportive relationship at the time of his last incarceration in 2005 with only one other prior significant relationship in his youth.

The deceased had attempted self-harm when in the community and during his times in prison had often been placed on the At Risk Management System (ARMS) or the Support and Monitoring System (SAMS) at his own request due to his stress when interacting with other people. He had been in custody by the time of his death in 2015, since October 2005 and had been eligible for parole since 27 April 2011. Parole had been declined by the Parole Board on the grounds of his risk to the community of reoffending, partly due to his inability to cope when in the community.

Applications for early release by RPOM were made on his behalf in both 2010 and 2012, but were declined because he effectively had no home address in the community where he would receive appropriate care for his many medical issues.[2] When in custody he spent most of his time in the infirmary with periods in the Crisis Care Unit (CCU) due to his severe situational anxiety.[3]

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[2] t 2.2.18, p6-7, Ex 2, tab 14, 15
[3] Ex 2, tab A

Medical History

The deceased was a long term smoker and suffered with ischaemic heart disease from a young age with numerous heart attacks requiring angioplasties and stent insertions. He had chronic obstructive pulmonary disease (COPD), hypertension, bronchiectasis, rheumatoid arthritis resulting in pulmonary erosive nodules, osteoporosis, type II diabetes mellitus, anaemia, kidney disease, to name a few prior to his later diagnosis of AAA.

He had required medical procedures from the age of 3 months for pyloric stenosis, appendectomy when age 9, undescended testis at age 12, varicose veins in 1985, a ganglion in 2001 with transurethral resection of his prostate in 2013.

It would be fair to say the deceased attended Royal Perth Hospital (RPH) for various specialist reviews with respect to his numerous co-morbidities almost monthly and sometimes more frequently from 2010 onward.

He was first diagnosed with a AAA in December 2012 when an incidental scan reviewed in RPH Vascular Clinic disclosed a 5.5 centimetre aneurysm. This was further investigated by way of a CT angiogram and the deceased continued to have admissions to RPH for urinary tract infections requiring IV antibiotics and investigation of pre-synoptical episodes disclosing a normal EEG. The deceased's AAA was reviewed in July 2013 when it seemed

relatively stable and it was decided the deceased would continue to be managed conservatively due to his other complex medical conditions.

2015

By 2015 the deceased was already recognised as being terminally ill due specifically to the interaction of his more serious ailments involving cardiac disease, respiratory disease, rheumatoid arthritis and various gastric issues.

In February 2015 the deceased was reviewed in the RPH respiratory department for his pulmonary nodules which at that stage were stable. He was again reviewed in March for a nose bleed which required cauterizing before release.

From 13-20 March 2015 the deceased was again admitted to RPH, this time with blood in his vomit and stools after another nose bleed. An urgent colonoscopy and gastroscopy were undertaken which showed diverticular disease and he was treated with antibiotics. While in the ward the deceased developed chest pains with rising troponin levels and was found to have significant coronary artery disease of his proximal and mid left anterior descending artery. It was heavily calcified and could only be treated with dual antiplatelet therapy because of his difficulty with blood thinners, such as Warfarin, and his risk of stroke.[4]

[4] Ex 2, tab A

In April 2015 the deceased was admitted to FSH vascular clinic for review of his AAA and it was noted it had increased in size. It was considered it would probably be necessary for operative intervention to prevent rupture and he required assessment as to his suitability for the necessary surgery.[5]

Later in April he was returned to RPH to assess his anaesthetic risk in the case of surgery. This was followed up in June 2015 at the urology clinic via video-link, where his medication for amitriptyline was increased.

In July 2015 the deceased was reviewed in RPH respiratory clinic as a result of his increasing shortness of breath. From RPH he was reviewed and admitted to FSH following five days of coughing up blood and sputum. CT scan showed bilateral upper and lower zone rheumatoid nodules, bulbous emphysema and bronchiectasis. He had an ultrasound guided lung biopsy on 27 July 2015 and was treated with antibiotics and discharged back to the Casuarina infirmary in 28 July 2015.

On 19 August 2015 he again returned to the FSH Respiratory Clinic for review and this time was diagnosed with a left sided nodular plural thickening felt to be plural inflammation related to his pulmonary nodules.

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[5] Ex 1, tab 10

On 17-18 August 2015 the deceased was admitted to FSH with left sided chest pain following a thoracic CT angiogram (CTA) to further evaluate a thoracic aortic aneurysm. The CTA revealed a pneumothorax and no treatment was required for the thoracic aortic aneurysm.

21 SEPTEMBER 2015

On 21 September 2015 the deceased was on route to RPH for a scheduled cardiology appointment with a SERCO escort when he complained of chest pains and the ambulance was diverted to FSH.[6]

While in hospital on 22 September 2015 the deceased developed sudden hypotension and significant drop in his haemoglobin levels which was suggestive of a bleeding AAA. An urgent open repair of his ruptured AAA was required which was now 9 centimetres in size. During surgery aortic clamping was required for a long period of time. This resulted in the deceased suffering renal failure which required permanent ongoing dialysis.

On 25 September 2015 the deceased developed rapid atrial fibrillation (AF), elevated troponin levels and ST elevation in the anterolateral leads of his ECG, indicative of cardiac ischaemia. He was diagnosed with acute pulmonary oedema and an infective exacerbation of bronchiectasis. He did not tolerate the dialysis and two medical emergency

[6] Ex 2, tab 1

team (MET) calls occurred over night with respiratory distress.

The deceased found the dialysis extremely taxing and on 12 October 2015 asked he be voluntarily withdrawn from dialysis. There was no family with whom to consult and his acknowledged senior next of kin, a retired prison pastor, visited him on 13 October 2015 in FSH for the last time. Ms Millin reported the deceased as being accepting of his fate by that time and she heard he then died the following day. Ms Millin considered the deceased had received "*excellent care for his extensive health issues*" during his time in prison.[7]

The deceased's restraints were removed on 13 October 2015[8] when palliative care commenced and he died on 14 October 2015 in the mid-evening.[9]

POST MORTEM EXAMINATION

The post mortem examination of the deceased was carried out by Dr Gerard Cadden, Forensic Pathologist of the PathWest Laboratory of Medicine of WA on 20 October 2015.

At post mortem examination Dr Cadden noted the recent surgical repair of the deceased's AAA and noted the clinical history indicating there had been vascular injury to a renal vessel during the course of the surgery.[10]

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[7] Ex 1, tab 9
[8] Ex 2, tab 17 & 18
[9] Ex 2, tab 1
[10] Ex 1, tab 6

Severe longstanding lung disease was evident with severe distortion of both lungs and an appearance suggestive of a chronic inflammatory process with infections in the past. The vessels supplying the heart showed severe disease and previous stent insertion was apparent. There was excessive scarring of the heart in keeping with severe heart disease. There was extensive generalised atherosclerosis with multifocal atherosclerosis and multifocal myocardial scarring. There was localised infarction of the left kidney and the right kidney gave appearances in keeping with the history of agenesis.

Neuropathology confirmed small old strokes in the right putamen and right frontal lobes, with no other abnormalities detected.[11]

Toxicology revealed multiple medications at therapeutic levels consistent with the deceased's extensive medical care.[12]

At the conclusion of the post mortem investigations Dr Cadden concluded the deceased had died as a result of multi-organ failure following surgical repair of abdominal aortic aneurysm, and noted the deceased's severe ischaemic heart disease and severe chronic pulmonary disease were contributing underlying considerations when looking at the ultimate cause of death.

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[11] Ex 1, tab 7
[12] Ex 1, tab 8

MANNER AND CAUSE OF DEATH

I am satisfied the deceased was a 62 year old sentenced prisoner who had suffered both physical and mental difficulties for most of his life. I have no doubt his traumatic youth resulted in his criminal offending, mostly related to fraud and robberies.

The deceased's medical care while in custody was extensive for his numerous co-morbidities. The West Australian Prison Medical file is contained in 23 volumes of progress notes and specialist reviews in tertiary metropolitan hospitals.

The deceased's severe ischaemic heart disease and atherosclerosis resulted in a diagnosed AAA. This was managed conservatively due to his numerous related and non-related co-morbidities which contraindicated surgical intervention at an earlier time. It was a naturally occurring condition and ruptured while surgical intervention was being assessed. Surgery was a life saving measure to repair the rupture on 22 September 2015. In emergency conditions prolonged clamping of the aorta was unavoidable. The surgery did save the deceased's life, but caused renal failure.

To deal with the renal failure the deceased required ongoing dialysis for life. It was the deceased's choice to withdraw himself from that management.

I am satisfied the deceased requested palliative care only and the withdrawing of dialysis inevitably led to multi-organ failure and death. This was the deceased's choice and in view of the fact the surgery had been necessary due to his naturally occurring condition I consider his death to be the result of natural causes.

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, from both the prison perspective and the various hospitals involved. He had suffered serious health conditions for his entire life and received intensive medical intervention for all his serious morbidities during the times he was incarcerated.

It is unfortunate the deceased had such a tragic life which resulted in the majority of his adult life being spent in custody. However, I am satisfied that had the deceased, with that medical and mental health history, been at large in the community he would not have been in a position to care for himself as he was cared for in custody.

The deceased received ongoing care at the consultant level for all of his serious conditions and continued to receive management of his diabetes, his cardiac condition and his serious respiratory disease whenever he was in custody.

It was recognised as early as 2010 his illnesses were likely to result in his death from natural causes and his release into the community was considered, but rejected on the grounds he would have no community support, which was clearly the case, and his difficulties were being adequately managed in prison. I would go further and say his difficulties were only managed in prison and that the deceased, due to his institutionalisation, would have been unable to manage his medical conditions at large in the community. While he had the support of Ms Millin, she was his only support and not in a position to care for him as did the infirmary at Casuarina with its frequent access to the necessary tertiary medical facilities.

It was during the course of one of the deceased's reviews for his other medical problems he experienced chest pain and was diverted to FSH to deal with his chest pain. It was discovered his known aortic aneurysm had ruptured and it was necessary he received emergency intervention before he died as a direct result of the rupture. That surgery involved a prolonged procedure with clamping of his aorta which led to a lack of adequate perfusion to his kidneys. The resulting renal failure could only be dealt with by way of dialysis, which the deceased voluntarily declined.

I find in all the circumstances of this case the deceased's supervision, treatment and care was appropriate and clearly

better than he would have been able to manage in the community at large.

E F Vicker
Deputy State Coroner
2 May 2018