Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 34/16

I, Sarah Helen Linton, Coroner, having investigated the death of ***Troy Allan ROGINSON*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth*** *on* ***19 September 2016*** *find that the identity of the deceased person was* ***Troy Allan ROGINSON*** *and that death occurred on* ***22 April 2014*** *at* ***Royal Perth Hospital*** *as a result of* ***head injury in a man with chronic liver disease*** *in the following circumstances:*

Counsel Appearing:

Sgt L Housiaux assisting the Coroner.
Mr G Stockton (State Solicitor's Office) appearing on behalf of the Department of Corrective Services.

TABLE OF CONTENTS

INTRODUCTION

1. Troy Allan Roginson (the deceased) died on 22 April 2014 at Royal Perth Hospital. At the time of his death the deceased was a sentenced prisoner.

2. As the deceased was a prisoner under the *Prisons Act 1981* (WA) at the time of his death, he was a 'person held in care' under section 3 of the *Coroners Act 1996* (WA). In such circumstances, a coronial inquest is mandatory.[1]

3. I held an inquest at the Perth Coroner's Court on 19 September 2016.

4. The documentary evidence included two comprehensive reports of the death prepared independently by the Western Australia Police and by the Department of Corrective Services (the Department).[2] The authors of both reports were also called as witnesses at the inquest.

5. The inquest focused primarily on the circumstances surrounding the death, as it was a sudden and catastrophic event involving an assault by another sentenced prisoner.

BACKGROUND

6. The deceased was born on 15 November 1978 in Queensland and was an only child. He was raised by his mother and had a dysfunctional childhood. As a teenager he appears to have led a fairly independent life with little adult supervision. He began consuming alcohol at the age of 13 years and by the age of 14 years he was using amphetamines. His drug use then escalated to heroin. He left school in Year 10 and never held a position of employment.

7. The deceased was first convicted of an offence when he was thirteen years of age and as an adult the deceased was an entrenched recidivist offender who served numerous terms of imprisonment. The only gaps in his offending occurred whilst he was in custody. The offending consisted predominantly of property related offending to support his substance abuse. In more recent times the deceased had breached parole a number of times by reoffending, which affected the likelihood of being released on parole again.

---

[1] Section 22(1) (a) *Coroners Act*.
[2] Exhibits 1 and 2.

8. The deceased had attempted drug rehabilitation through the naltrexone program, the methadone program and other substance abuse programs but always relapsed into drug use.

9. He never married and had no children. He had been in one significant long-term relationship but his partner sadly died of a drug overdose in 2000. When the deceased was not in prison he usually lived with his mother in Perth.

10. In October 2003 the deceased was diagnosed with hepatitis C as a consequence of his intravenous drug use. He was ambivalent about treatment and although he was referred to the Hepatology Clinic at Royal Perth Hospital he did not consistently engage with them. Through the course of his hepatitis C he developed cirrhosis of the liver, which was diagnosed in 2010. A complication of his cirrhosis was thrombocytopenia (low platelet count), which is characterised by delayed clotting of the blood.[3]

LAST TERM OF IMPRISONMENT

11. At the time of his death the deceased was a minimum security prisoner serving a total of four years' imprisonment for convictions of burglary, possession of stolen or unlawfully obtained property and numerous other related offences. He had been admitted back to prison on 16 July 2011. He had an earliest date of release of 18 July 2015 and an earliest eligibility date for parole of 17 July 2013.

12. The deceased served parts of his sentence at Hakea Prison and Acacia Prison before he was transferred to Wooroloo Prison Farm (Wooroloo) on 11 December 2012, where he remained as a minimum security prisoner until the events leading to his death. He was not released on parole although his circumstances were reviewed by the Prisoner's Review Board, most recently on 21 November 2013. Parole was denied for various reasons, including past poor performance on supervision, and the deceased was reportedly accepting of this decision.[4]

13. While in prison the deceased was able to access the methadone programme and also participated in a number of cognitive skills and drug programs. Blood tests in 2012 showed ongoing abnormal liver function and in January 2013 blood tests showed a low platelet count as a result of his chronic liver disease. On 8 May 2013 he tested positively for hepatitis C again and showed continued signs of chronic liver disease. He was not a candidate

[3] Exhibit 1, Tab 19.
[4] Exhibit 2, Directed Review, p. 8.

for Interferon treatment as he still required drug rehabilitation and pharmacological intervention.[5]

14. The deceased was subject to regular reviews by nursing staff at Wooroloo to monitor his methadone use and treatment side effects. He also received dental treatment in prison.[6]

15. The deceased's prison records show satisfactory prison behaviour while at Wooroloo with nil loss of privileges. He was described by Unit staff as polite and courteous and a good worker who was pleasant and respectful to staff and prisoners. He maintained weekly telephone contact with his mother and a friend and received occasional mail.[7]

EVENTS ON 21 APRIL 2014

16. During the afternoon of Monday, 21 April 2014 the deceased approached another inmate, Robert Garlett, who was seated in the dining area. Mr Garlett was sitting with another prisoner, Darren Polak. The deceased told Mr Garlett that he was sitting at the deceased's table and he was not to sit there again. The deceased then walked away and sat somewhere else and had his meal.[8]

17. Mr Garlett was angry and offended at the way he had been spoken to by the deceased, so at the completion of his meal he went looking for the deceased in the company of Mr Polak. They located the deceased a short time later. He had just taken out some rubbish and was near the bins outside Unit 4. Mr Polak spoke to the deceased and then Mr Garlett punched the deceased forcefully once to the chin with his right fist, causing the deceased to fall backwards and strike his head on a concrete path. The deceased immediately began convulsing, at which time Mr Polak apparently called for help and then Mr Polak and Mr Garlett ran away.[9] Other prisoners were alerted to the deceased's plight and came to assist him.

18. Officer Suzanne Taylor was taking her meal break in the Unit 4 office when she was interrupted by a prisoner banging loudly on the Unit Door. She responded by rushing out onto the Unit veranda, where she observed the deceased lying flat on his back, with blood on his face, on the concrete ramp outside the office. He appeared to be having a seizure and was unconscious. Officer

[5] Exhibit 2, Directed Review, p. 5 and Tab 19.
[6] Exhibit 2, Directed Review, p. 6.
[7] Exhibit 2, Directed Review, p. 8.
[8] Exhibit 1, Tab 2.
[9] Exhibit 1, Tab 2.

Taylor immediately initiated a Code Red medical emergency before commencing first aid.[10]

19. In response to the emergency call, assistance was provided by other prison officers in the vicinity. An ambulance was also requested as a priority at approximately 5.07 pm.[11]

20. No medical staff were on duty at Wooroloo at the time, as nurses are only rostered on for day shifts at Wooroloo, and the only nurse rostered for that day (being a public holiday) had ceased duty for the day approximately thirty minutes before the incident.[12] However, all of the prison officers are trained in CPR and senior first aid, so they were able to provide suitable emergency medicine while waiting for the ambulance officers to arrive.[13] The prison officers applied a dressing to the deceased's head wound to control the bleeding and the deceased was placed into the recovery position with oxygen administered as he was breathing but unconscious.[14]

21. An ambulance arrived at Wooroloo at 5.27 pm. He was assessed by ambulance staff at 5.30 pm and given a Glasgow Coma Scale (GCS) score of 3 out of 15. His eyes were closed, he did not speak but only moaned once or twice, and he had no control over his arms. His pupils were noted to be sluggish. The deceased was taken by ambulance to Swan District Hospital Emergency Department.[15]

22. The deceased arrived at Swan District Hospital at 6.07 pm and was triaged as a Category 1. He was seen by a senior registrar, Dr Philip Brooks, who noted the deceased had spontaneous respirations and oxygen saturations of 100% on room air. His initial GCS score given by the nursing staff was 11 but Dr Brooks gave him a GCS of 14 on his assessment. At that time the deceased was moving all of his limbs and his pupils were equal and reactive to light. He had noted lacerations to his chin and base of his skull but no clinical signs of a base of skull fracture. However, a CT scan of his head and cervical spine showed extensive skull fracture. Dr Brooks discussed the deceased's case with the neurosurgical team at Royal Perth Hospital and transfer was arranged.[16]

23. Prior to the transfer Dr Brooks was called to see the deceased by nursing staff as his conscious state had reduced and his GCS

[10] Exhibit 2, Directed Review.
[11] Exhibit 1, Tab 11.
[12] T 13; Exhibit 2, Directed Review, p. 8.
[13] T 10.
[14] Exhibit 2, Directed Review, p. 3.
[15] Exhibit 1, Tab 11.
[16] Exhibit 1, Tab 12.

was now 12. At 9.00 pm Dr Brooks arranged a review by Dr David de Vos, an Emergency Physician, who found that the deceased's GCS was 12 and assessed that the deceased did not require intubation but did need transfer to the neurosurgical unit. At 9.03 pm the deceased was taken by ambulance to Royal Perth Hospital for specialist neurosurgical care.[17]

24. The deceased was admitted to the Intensive Care Unit at Royal Perth Hospital. The deceased's GCS at Royal Perth Hospital was noted to be fluctuating between 5 and 12 and he was combative. He required endotracheal intubation, sedation and ventilation. A further CT scan showed multifocal haemorrhages in the frontal lobes with evidence of traumatic subarachnoid blood in the subarachnoid spaces as well as in the middle cranial fossa. He was seen by the neurosurgical service who assessed his traumatic brain injury as non-survivable and palliative measures were implemented.[18] The deceased's mother was notified by police.

25. He was clinically determined to be brain dead at 10.13 pm on 22 April 2014. He was separated from medical ventilation and intravenous support and cardiac output ceased late on the afternoon of 23 April 2014.[19]

26. Following his death a reflection service was held at Wooroloo, which was attended by several hundred prisoners and staff.

CAUSE OF DEATH

27. A post mortem examination was performed on 28 April 2014 by Dr Jodi White, a Forensic Pathologist. The examination showed evident fracturing of the skull with an associated traumatic brain injury and soft tissue injury to the scalp soft tissues. Gross neuropathology confirmed a traumatic brain injury.[20]

28. The deceased's liver was markedly cirrhotic and the spleen enlarged. The deceased was confirmed as being hepatitis C positive. The cause of the cirrhosis was most likely due to the hepatitis C and cirrhosis can cause an enlarged spleen. The deceased's liver disease may have resulted in an increased amount of bleeding occurring after the deceased sustained his head injury.[21]

[17] Exhibit 1, Tab 12.
[18] Exhibit 1, Tab 13.
[19] Exhibit 1, Tab 13.
[20] Exhibit 1, Tab 6.
[21] Exhibit 1, Tab 6.

29. Toxicological analysis of ante mortem bloods showed methadone and tetrahydrocannabinol consistent with recent use.[22]

30. At the conclusion of the examination Dr White formed the opinion that the cause of death was head injury in a man with chronic liver disease.[23] I accept and adopt the conclusion of Dr White as to the cause of death.

MANNER OF DEATH

31. There was no CCTV footage of the incident as the prison units at Wooroloo are heritage protected, as well as being surrounded by heritage protected trees, which prevent cameras being affixed in the relevant area and the perimeter cameras do not have vision of the area.[24] However, a police investigation identified two persons of interest, being Mr Polak and Mr Garlett.

32. On 23 April 2014 Mr Garlett was arrested by police as a suspect for the unlawful assault of the deceased, causing his death. Mr Garlett participated in an electronic record of interview, where he made full admissions to assaulting the deceased, resulting in his death. He was charged that same day with unlawful assault causing the death of the deceased, pursuant to s 281 of the *Criminal Code.*

33. On 5 February 2015 Mr Garlett entered a plea of guilty to the charge in the Perth Magistrates Court and was remanded to the District Court for sentencing. On 25 June 2015 Mr Garlett was sentenced by Bowden DCJ to 2 years and 8 months' imprisonment, which commenced on 10 August 2014.[25]

34. I find that the manner of death was unlawful homicide.

QUALITY OF SUPERVISION, TREATMENT AND CARE

35. Under s 25(3) of the *Coroners Act 1996*, where a death investigated by a coroner is of a person held in care, the coroner must comment on the quality of the supervision, treatment and care of the person while in that care.

36. A medical review of the deceased's care while in prison generally shows he was given assistance to manage his drug addiction and

[22] Exhibit 1, Tabs 6 and 7.
[23] Exhibit 1, Tab 6.
[24] T 11 – 12; Exhibit 2, Tab 20.
[25] Exhibit 1, Tab 2 and Tab 18.

appropriate options to treat his hepatitis C and manage his liver disease.[26]

37. As to his medical treatment on the day of the incident, Detective Sergeant Mathew Atkinson from Major Crime Squad investigated the deceased's death and found no suggestion that there was any delay in prison staff providing first aid or requesting an ambulance.[27]

38. The medical care provided at both Swan District Hospital and Royal Perth Hospital was similarly of a high standard.[28]

39. As to supervision generally, Mr Richard Mudford, who reviewed the death in custody on behalf of the Department, advised that the circumstances of the deceased's death were extremely unusual, in that it was considered to be the first recorded serious assault by one prisoner of another in Wooroloo.[29] Mr Mudford explained that as a minimum security prison the prisoners housed at Wooroloo have been assessed to be of good behaviour and stable and they are anticipating release soon, so they usually do not present a management issue.[30] As Wooroloo is also a more pleasurable environment than a maximum security prison, this also usually encourages good behaviour on behalf of the prisoners housed there in order to avoid being returned to a maximum security prison.[31] After his arrest for the assault of the deceased, Garlett was returned to a maximum security prison.[32]

40. In these circumstances, I am satisfied that there was nothing that the Department did or failed to do that contributed to the deceased's death.

CONCLUSION

41. The deceased was a 35 year old man who had spent much of his adult life in prison. He was not prone to violence and did not generally present as a management problem. At the time of his death he was a minimum security prisoner in Wooroloo and was reported to be polite, courteous and respectful of others.

42. On the day of his death the deceased had a verbal altercation with some younger prisoners who had only recently arrived at Wooroloo. The argument was over a minor matter of seating

[26] Exhibit 1, Tab 19.
[27] T 7.
[28] T 7.
[29] T 12.
[30] T 12 – 13.
[31] T 13.
[32] T 13,

arrangements in the dining area. It should have started and finished in the dining area, but the two younger men chose to pursue the deceased from the dining area and confronted him near his unit. One of them punched the deceased and, as they often do, the single punch had immediate and fatal consequences. The deceased fell backwards, struck his head on concrete and sustained a traumatic brain injury that resulted in his death.

43. Due to the recent public efforts of champion boxer Danny Green, what Mr Garlett did to the deceased is no longer called a 'king hit' but now is more appropriately known as a 'coward's punch.' The public message that is sought to be conveyed is that a single thoughtless act done in anger can have devastating and irreversible consequences, so young people should think twice before resorting to violence. It is to be hoped that, two years on from the needless death of the deceased, that message is now being heard and heeded more often.

S H Linton
Coroner
29 September 2016