**JURISDICTION** : CORONER'S COURT OF WESTERN AUSTRALIA

**ACT** : CORONERS ACT 1996

**CORONER** : Rosalinda Vincenza Clorinda Fogliani, State Coroner

**HEARD** : 18 AUGUST 2021

**DELIVERED** : 4 FEBRUARY 2022

**FILE NO/S** : CORC 554 of 2018

**DECEASED** : ROMAN, ROBERT WILLIAM

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*Catchwords:*

Nil

*Legislation:*

Nil

**Counsel Appearing:**

Sergeant A Becker assisted the State Coroner

Ms A Barter and Mr J Higgins (Aboriginal Legal Service of WA) appeared on behalf of the family

Mr M McIlwaine (State Solicitor's Office) appeared on behalf of the Department of Justice and the South Metropolitan Health Service

**Case(s) referred to in decision(s):**

Nil

*Coroners Act 1996*
(Section 26(1))

# RECORD OF INVESTIGATION INTO DEATH

*I, Rosalinda Vincenza Clorinda Fogliani, State Coroner, having investigated the death of* ***Robert William ROMAN*** *with an inquest held at Perth Coroner's Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 18 August 2021, find that the identity of the deceased person was* ***Robert William ROMAN*** *and that death occurred on 10 May 2018 at Rockingham General Hospital from a subdural haematoma in a man with diabetes mellitus and chronic kidney disease (requiring dialysis) in the following circumstances:*

## Table of Contents

**INTRODUCTION** .......... **3**
**THE DECEASED** .......... **4**
**DIALYSIS TREATMENT** .......... **6**
**MEDICAL TREATMENT AND CARE IN CUSTODY** .......... **6**
**EVENTS LEADING TO DEATH** .......... **10**
*Deterioration at Fresenius dialysis unit* .......... 11
*Resuscitation efforts* .......... 12
**CAUSE AND MANNER OF DEATH** .......... **13**
**INFORMATION TO THE FAMILY** .......... **14**
**OMISSION REGARDING PLACEMENT ON TERMINALLY ILL LIST** . **17**
**COMMENTS ON SUPERVISION, TREATMENT AND CARE** .......... **18**
*Family concerns about changes in dialysis treatment* .......... 20
*Were there warning signs for subdural haematoma?* .......... 21
**IMPROVEMENTS** .......... **24**
**CONCLUSION** .......... **25**

## INTRODUCTION

**1.** Robert William Roman (Mr Roman) was 55 years old when he died on 10 May 2018 at Rockingham General Hospital from a brain bleed. At the time of his death, he was serving a sentence of imprisonment at Casuarina Prison. He had an extensive past medical history that included type 2 diabetes, end stage renal failure, ischaemic heart disease and chronic obstructive pulmonary disease.

**2.** On 10 May 2018, immediately before his death Mr Roman had been undergoing his regular dialysis treatment for end stage renal failure at the Fresenius Dialysis Clinic in Rockingham, having been taken there from Casuarina Prison by the custodial officers for this purpose.

**3.** During his afternoon dialysis session, Mr Roman became progressively unwell and unexpectedly collapsed. He was taken by ambulance to Rockingham General Hospital where a CT scan showed a right subdural haematoma (brain bleed). Unfortunately, he was not able to be revived, and he died later that night.

**4.** By reason of s 16 of the *Prisons Act 1981* (WA), as a sentenced prisoner, Mr Roman was in the custody of the Chief Executive Officer of the Department of Justice. Therefore, he was a "*person held in care*" within the meaning of s 3 of the *Coroners Act 1996* (WA) (Coroners Act). His death was reported to the coroner as required and an inquest was mandated under s 22(1)(a) of the Coroners Act.

**5.** I held an inquest into Mr Roman's death on 18 August 2021, and heard evidence from Mr Roman's treating Nephrologist, the Director of Medical Services, Department of Justice, and the Senior Review Officer, Performance, Assurance and Risk, Department of Justice. I received 5 exhibits into evidence, comprising 65 tabs.

**6.** My primary function under s 25(1) of the Coroners Act is to find how Mr Roman's death occurred, and the cause of his death. Section 25(5) of the Coroners Act prohibits me from framing a finding or comment in such a way as to appear to determine any question of civil liability or to suggest that any person is guilty of an offence.

**7.** As Mr Roman was a person held in care, pursuant to s 25(3) of the Coroners Act, in this finding I must comment on the quality of his supervision, treatment and care. This obligation reflects the community's concern about the treatment of those who are deprived of their liberty.

**8.** The focus of the inquest was on the care provided to Mr Roman.

**9.** My findings appear below.

## THE DECEASED

**10.** Mr Roman was born on 23 October 1962 in Alice Springs. He was the second oldest of eight siblings. Mr Roman's parents separated when he was still quite young, and this impacted greatly upon him. As a young person, over periods of time he resided with his maternal relatives who looked after him.[1]

**11.** Mr Roman had family connections with the Arrernte (Alice Springs) and the Larrakia (Darwin) people from the Northern Territory. He also had family connections with the Alyawarra and Luritja language groups from Central Australia.[2]

**12.** Mr Roman was a keen sportsman and played in the Central Australian Football League, winning an award for best and fairest. He also played soccer, basketball and darts. He was community oriented and generous with his time, passing on his skills and knowledge in sport.[3]

**13.** Mr Roman completed his schooling in Alice Springs up until Year 11 and followed that with some employment in that region, in a trainee capacity. He subsequently moved to Western Australia for a period, before returning to his homelands.[4]

**14.** Throughout his life he gained employment through the Community Development Employment Program. He was employed in a range of occupations, that included working as a bus driver (for 10 years) for an

[1] Exhibit 19.
[2] Ibid.
[3] Ibid.
[4] Exhibit 2, tab A.

Aboriginal Medical Centre and working as a fleet manager for the Batchelor Institute of Indigenous Tertiary Education.[5]

**15.** Mr Roman had four children and twelve grandchildren. He devoted himself to their care and progression in life. He was equally supportive of his mother and older family members in pursuing their aim to develop their family homeland in the area around the Atitjere Community, north west of Alice Springs. He was instrumental in assisting with these developments to help his family reconnect back to culture.[6]

**16.** Through hard work and strongminded persistence, Mr Roman and his family were able to secure four houses for their homeland, together with connection to facilities, including power, a bore, telephone line and septic system. Mr Roman was allocated one of the four houses and was awaiting formal handover when criminal proceedings were initiated, resulting in his return to Perth to face criminal charges in respect of offences committed in this jurisdiction.[7]

**17.** Mr Roman had several significant co-morbidities. In 2014 he had retired from work due to his declining health. He had developed type 2 diabetes. It was at about this stage that he was diagnosed with end stage renal failure, and he was commenced on haemodialysis. He required this treatment on an ongoing basis for the rest of his life. It is likely that his end stage renal failure was secondary to his type 2 diabetes.[8]

**18.** Mr Roman had ischaemic heart disease, that required coronary artery bypass surgery in April 2016. He was admitted to Fiona Stanley Hospital for this surgery for approximately 14 days. His condition was further complicated by his chronic obstructive pulmonary disease (COPD).

**19.** Mr Roman was deeply loved by his family and they regret that he died away from his country. His family members raised concerns about his dialysis treatment at Perth, and the differences between his dialysis treatment in the Northern Territory. The issues surrounding his dialysis treatment were explored at the inquest.

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[5] Ibid.
[6] Exhibit 19.
[7] Ibid.
[8] Exhibit 1, tab 13; Exhibit 2, tab A.

## DIALYSIS TREATMENT

**20.** In the case of end stage renal failure, when kidneys are no longer properly removing toxins and excess fluid from the body, the fluid builds up and can cause a range of problems, including swelling, shortness of breath and weight gain. Mr Roman was treated for this condition by means of haemodialysis, also referred to as dialysis.

**21.** This is where the blood is drawn from the patient's body and passed through a dialysis machine. The dialysis process refers to the filtering of the patient's blood through a cartridge in the machine to remove toxins and excess fluid, following which the purified blood comes back into the patient's body. The procedure for Mr Roman took approximately four and a half hours and was performed three times a week.[9]

**22.** Through this removal of excess fluid, the patient may get down to their "*dry weight*." The dry weight is ordinarily the lowest weight a patient can safely reach after dialysis, without developing symptoms of low blood pressure (which can occur when too much fluid is removed). Calibrating an appropriate dry weight for an individual patient requires expertise, and sometimes it takes several sessions to successfully identify it.[10]

**23.** My comments regarding Mr Roman's dialysis treatment appear below.

## MEDICAL TREATMENT AND CARE IN CUSTODY

**24.** Mr Roman was sentenced in the Perth District Court on 2 September 2016 to a term of seven years' imprisonment, in respect of two serious offences. His sentence was backdated to 27 August 2016 to reflect previous periods on remand. His earliest eligibility date for release to parole would have been 26 August 2021. His appeal against the length of his sentence was dismissed on 11 November 2016.[11]

[9] ts 17.
[10] Ibid.
[11] Exhibit 2, tab A.

**25.** Mr Roman had two prison placements:

**a)** his intake at Hakea Prison: 2 September 2016 to 30 September 2016 (28 days); and

**b)** his admission to Casuarina Prison: 30 September 2016 to 10 May 2018 (587 days).[12]

**26.** When Mr Roman was taken into custody at Hakea Prison, in accordance with the existing procedures, he underwent a full medical assessment. There was an initial nursing assessment on 2 September 2016, followed by a doctor's assessment on 5 September 2016. The doctor noted a pre-existing medical history that included type 2 diabetes, end stage renal failure, ischaemic heart disease with anterior myocardial infarction, a coronary bypass graft and COPD. His conditions were exacerbated by his chronic smoking, and he was frequently encouraged by clinicians to cease.[13]

**27.** An ECG was performed, and atrial fibrillation was noted during the assessment. Mr Roman's medications were reviewed by the attending doctor and scripted. A plan was made for his ongoing medical care, which included the continuation of his renal dialysis three times a week.[14]

**28.** Prior to his incarceration, Mr Roman had been undergoing renal dialysis at Fiona Stanley Hospital three times each week, though records show that he had missed several dialysis sessions. In August 2016, Mr Roman had been admitted to Fiona Stanley Hospital with complications from missing dialysis for two months. If patients miss their dialysis sessions, they risk developing a life-threatening electrolyte imbalance and fluid overload. This can lead to an accumulation of fluid in the lungs (pulmonary oedema).[15]

**29.** Throughout his time at Hakea Prison, Mr Roman had regular medical reviews and he was conveyed by custodial officers to Fiona Stanley Hospital for his scheduled dialysis sessions three times a week. He was assessed as suitable for a medium security rating.[16]

[12] Ibid.
[13] Exhibit 2, tab 17; ts 7.
[14] Ibid.
[15] Exhibit 2, tab 17; ts 9.
[16] Exhibit 2, tabs A and 17.

**30.** On 30 September 2016 Mr Roman was transferred to Casuarina Prison, where he resided in the infirmary, with twice daily nursing assessments. The day after his admission Mr Roman refused to attend his scheduled dialysis session at Fiona Stanley Hospital and signed a waiver form. Records reflect that while he subsequently also refused to attend dialysis on isolated instances, with encouragement over time he became more compliant and would generally attend his scheduled sessions. His dialysis sessions were then transferred to Midland Hospital.[17]

**31.** Mr Roman was regarded as compliant with instructions from custodial officers and was seen to interact appropriately with the other prisoners. When he was able to work, which he did for a time as an infirmary worker, he was described as having a good work ethic.[18]

**32.** During the early period of his imprisonment at Casuarina Prison, Mr Roman complained about shortness of breath, and he was administered oxygen as required. He was known to have COPD and on occasion he developed an infective exacerbation of COPD, for which he was treated. He was medicated and provided with Ventolin, and his oxygen levels were monitored. He had high blood pressure and was checked for possible congestive heart failure. He was advised to cease smoking, but at that stage he was unable to manage this.[19]

**33.** On occasion, Mr Roman cited his ongoing shortness of breath as the reason for his refusal to attend dialysis.

**34.** Mr Roman's health needs were complex and in early December 2016 he was admitted to Royal Perth Hospital for a few days and diagnosed with acute pulmonary oedema and an exacerbation of COPD. He was treated and when his condition improved, he was returned to Casuarina Prison. During this admission to Royal Perth Hospital, he had dialysis and at this stage his dry weight was approximately 71.4 kilograms.[20]

**35.** Shortly afterwards in December 2016, Mr Roman was admitted to Fiona Stanley Hospital for a few days with fluid overload secondary to end stage

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[17] Ibid.
[18] Exhibit 2, tab A.
[19] Exhibit 2, Tabs A and 17.
[20] Exhibit 2, tab 17.

renal failure, an exacerbation of congestive cardiac failure and exacerbation of COPD. His pulmonary oedema was treated, and he had dialysis while in Fiona Stanley Hospital.[21]

**36.** Following discharge from Fiona Stanley Hospital Mr Roman was returned to Casuarina Prison, and his dialysis sessions were transferred to Fresenius, a satellite unit under the auspices of the Fiona Stanley Hospital Nephrology (Renal) Department, which provides maintenance haemodialysis to patients with end stage renal disease. The satellite units are operated on behalf of the government of Western Australia by private providers. They are nurse-led clinics for stable patients. Patients who become unstable during dialysis are referred to the nearest public hospital or to Fiona Stanley Hospital for further management. Each satellite unit has a visiting Nephrologist for clinical governance.[22]

**37.** In mid-December 2016 Mr Roman was again admitted to Fiona Stanley Hospital for a few days with an acute exacerbation of his COPD and acute pulmonary oedema secondary to fluid overload. He underwent urgent dialysis, resulting in a reduction in his dry weight to approximately 63 kilograms. He was encouraged to cease smoking. An admission to Fiona Stanley Hospital under similar circumstances occurred at the end of 2016 for a few days. After this admission, his condition appears to have stabilised.[23]

**38.** In early 2017, Mr Roman was referred by the Casuarina Prison Medical Officer to the specialist Dr Jagadish Jamboti, Consultant Nephrologist, Fiona Stanley Fremantle Hospitals Group. Dr Jamboti visited Fresenius weekly and conducted a clinic to supervise his patients' dialysis treatment. Dr Jamboti saw Mr Roman at Fresenius in January, May, August and November 2017 and in February 2018, and corresponded with the Casuarina Prison Medical Officer regarding his treatment. During this time Mr Roman underwent stable dialysis sessions three times weekly. He had been scheduled for his three-monthly review with Dr Jamboti, which would have taken place on 21 May 2018.[24]

[21] Ibid.
[22] Exhibit 1, tab 13; Exhibit 2, tab 17; ts 9 to 10.
[23] Ibid.
[24] Exhibit 1, tab 13; ts 10.

**39.** Each dialysis session over this period was approximately four and a half hours, with between two and a half to three litres of fluid removed. In the early part of 2017, Mr Roman had been moved to a self-care unit and was noted to be independent in his activities of daily living. Throughout 2017 and early 2018 Mr Roman continued to receive regular clinical reviews at Casuarina Prison, with medical reviews being done monthly and nursing reviews being done weekly. He ceased complaining of shortness of breath. His blood pressure and weight varied, and clinicians continued to encourage him to cease smoking. He was prescribed a range of medications for his conditions, including medications to lower his blood pressure and cholesterol, and to manage his ischaemic heart disease.[25]

**40.** In the latter part of 2017, Mr Roman's dry weight had increased to approximately 82 kilograms, and the ultrafiltration goal, namely the amount of fluid they planned to take off during dialysis, was approximately two and a half to three litres. In approximately November 2017 Mr Roman successfully ceased smoking. He was engaged in work as a prison cleaner. He looked well and his blood pressure was well controlled. He was compliant with his medications and attended his dialysis sessions. There were no significant medical concerns noted in his records for this period, up until the events leading to his death.[26]

## EVENTS LEADING TO DEATH

**41.** On 5 and 8 May 2018 Mr Roman attended his usual dialysis sessions at the Fresenius dialysis unit as scheduled. These sessions proceeded without problems. On 9 May 2018 he had a nursing assessment at Casuarina Prison, and the observations of his vital signs were within normal limits. He weighed 85 kilograms. There were no records of reported trauma or falls, and this becomes relevant in the context of understanding the events on 10 May 2018, as it is now known that he died as a result of a brain bleed.[27]

[25] Exhibit 2, tab 17.
[26] Ibid.
[27] Exhibit 2, tab 17.

***Deterioration at Fresenius dialysis unit***

**42.** On 10 May 2018 Mr Roman attended his appointment at the Fresenius dialysis unit as scheduled. Before the session he was observed to be in good spirits. His pre-dialysis weight was recorded as 86.7 kilograms, which was broadly consistent with his pre-dialysis weight recorded over the previous few weeks. His pre-dialysis blood pressure and pulse were in the normal range. Essentially, he was clinically stable prior to the commencement of his dialysis on 10 May 2018.[28]

**43.** Mr Roman's dialysis commenced at approximately 12.10 pm on 10 May 2018, with a planned duration of four and a half hours and an ultrafiltration (fluid removal) target of 2.7 litres. This session proceeded without any problems until just before 3.00 pm when Mr Roman complained of a headache and requested paracetamol. He was given paracetamol at 3.00 pm.

**44.** There was no apparent improvement in the headache after 30 minutes, and Mr Roman's blood pressure dropped. In response, the ultrafiltration target was reduced from 2.7 litres to 2.3 litres, a bolus of 150 millilitres of normal saline was administered and he was encouraged to drink the remainder of his water (approximately 100 millilitres).[29]

**45.** This was done in case the headache had been brought on by removal of fluid at an excessive rate. Mr Roman's blood pressure improved, but after a further 30 minutes there was no improvement in his headache, and he requested to come off dialysis. Dialysis was ceased and the dialysis needles were removed from his arm.[30]

**46.** Mr Roman continued to complain of a headache and at approximately 4.25 pm he asked to be seen by a doctor. There was no doctor on site and nursing staff advised Mr Roman and the attending custodial officers that they would arrange for him to be taken to Rockingham Hospital for medical review. Shortly afterwards, quite suddenly Mr Roman's level of consciousness deteriorated, and an ambulance was called.[31]

[28] Exhibit 2, tabs A and 17.
[29] Exhibit 2, tab 15; ts 19.
[30] Ibid.
[31] Exhibit 2, tab 17.

**47.** The information passed on to Rockingham General Hospital was that a brain bleed was suspected, due to the loss of consciousness after the headache.[32]

### *Resuscitation efforts*

**48.** Records reflect that St John Ambulance received a call at 4.35 pm on 10 May 2018, and that they departed promptly under Priority 1 conditions, arriving at Fresenius dialysis unit at 4.41 pm. Paramedics found Mr Roman slumped on the chair, in a sitting position, with an oxygen mask. Paramedics began to support his airway and as his level of consciousness continued to decrease, they inserted an oropharyngeal airway and took him to Rockingham General Hospital, arriving at the Emergency Department at 5.09 pm.[33]

**49.** In the Emergency Department he was found to have a Glasgow Coma Scale of 4. He was comprehensively assessed for injuries and none were found. An urgent head CT scan was ordered, and this showed a large right subdural haematoma measuring 25 millimetres in maximal depth, resulting in both subfalcine and transtentorial herniation, and 24 millimetre of midline shift to the left. Essentially, he was found to have an area of bleeding around the brain, under the tough tissue that covers the brain, called the "*dura*". It has been referred to in this finding as a brain bleed.[34]

**50.** There was significant intracranial bleeding, resulting in raised intracranial pressure. After consultations between the Emergency Consultants and the Neurosurgical Registrar, it was agreed that Mr Roman had an extremely poor prognosis and was likely to die. There was no prospect of active surgical treatment improving his clinical outcome. Palliative and comfort measures were given, and Mr Roman died at Rockingham General Hospital 7.45 pm on 10 May 2018.[35]

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[32] ts 16.
[33] Exhibit 1, tabs 10 and 11.
[34] Exhibit 1, tab 11.
[35] Exhibit 1, tabs 7 and 11.

## CAUSE AND MANNER OF DEATH

**51.** The forensic pathologist Dr Judith McCreath made a post mortem examination on the body of Mr Roman at the State Mortuary on 21 May 2018. Post mortem examination on that date showed bleeding on the brain with pressure changes in the brain, narrowing of vessels supplying blood to the heart, enlargement of the heart, evidence of previous bypass surgery to the heart, scarring within the heart, changes in the kidneys consistent with chronic kidney disease and excess fluid in the lungs. The forensic pathologist ordered further testing.[36]

**52.** On 2 June 2018 the results of the neuropathological examination became available. This examination showed a large acute right subdural haematoma with midline shift to the left and transtentorial herniation, and a supracallosal left subdural haematoma. Essentially the neuropathological examination confirmed bleeding over the surface of the brain with associated pressure effect on the brain.[37]

**53.** On 2 June 2018 toxicological analysis became available and this showed the presence of medications consistent with those prescribed to Mr Roman.[38]

**54.** On 10 May 2019, the results of further examinations became available and were considered by the forensic pathologist. Microscopic examination of tissue showed scarring in the heart, chronic lung disease, scarring in the liver and chronic kidney disease.[39]

**55.** After the receipt of all the examination results, on 10 May 2019 the forensic pathologist formed an opinion on the cause of death. I accept and adopt the forensic pathologist's opinion and **I find that the cause of the deceased's death was subdural haematoma in a man with diabetes mellitus and chronic kidney disease (requiring dialysis)**.

**56.** The neuropathologist commented that non-traumatic (spontaneous) acute subdural haematomas have been described in patients undergoing haemodialysis. It is reported that subdural haematomas have a higher

[36] Exhibit 1, tab 7.
[37] Exhibit 1, tabs 7 and 8.
[38] Exhibit 1, tab 9.
[39] Exhibit 1, tab 7.

incidence in haemodialysis patients than in the general population. The forensic pathologist, whilst noting that most subdural haematomas are traumatic in aetiology, agreed with the neuropathologist's comments.[40]

**57.** I have taken account of the expert opinions, the totality of the deceased's underlying health conditions, his blood thinning medications, and the fact that there was no evidence of any traumatic injury (and specifically none to his head).

**58. I find that the manner of the deceased's death is by way of natural causes**.

## INFORMATION TO THE FAMILY

**59.** During his imprisonment, Mr Roman maintained daily contact with his family through telephone calls, and he received regular social visits from his family. Mr Roman's family expressed concern about not being informed of his clinical deterioration on 10 May 2018, and that a number of them received information after he had died. This aspect was explored at the inquest.[41]

**60.** Mr Roman's clinical deterioration would have been discernible to the custodial officers when he suddenly lost consciousness at the Fresenius dialysis unit, and possibly slightly earlier, at approximately 4.30 pm. At the inquest, Ms Toni Palmer, Senior Review Officer, Performance Assurance and Risk, Department of Justice, was asked about when she would expect steps to have commenced to inform the family.[42]

**61.** Ms Palmer's expectation was that a telephone call should have been made at around the time Mr Roman was asking for the dialysis to stop, to say that things are changing. In practice such a telephone call would be made by the custodial officers to the operations centre, which would in turn convey that information to the prison, for passing on to the next of kin. In Ms Palmer's opinion, it would not have been necessary to await the decision to call an

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[40] Exhibit 1, tabs 7 and 8.
[41] Exhibit 2, tab A.
[42] ts 41.

ambulance. In her view, quite properly, families should be advised as quickly as possible.[43]

**62.** Mr Roman presented at the Emergency Department of Rockingham General Hospital at 5.09 pm on 10 May 2018. As he was a prisoner at the time of his emergency presentation, Rockingham General Hospital had no recorded details of his next of kin. When the results of his head CT scan became available, the Emergency Consultant Dr Tom Bo Sing Lee requested that Mr Roman's family be notified as soon as possible.[44]

**63.** Records reflect that at 5.24 pm on 10 May 2018, the treating doctors advised the custodial officers that Mr Roman's prognosis was very poor. At 5.45 pm the doctors updated the custodial officers and advised that Mr Roman would not survive, and that they will be administering comfort care.[45]

**64.** Records reflect that by 6.15 pm steps had already been put in place to inform Mr Roman's family of his condition. It cannot now be known when such steps commenced, and it is unclear as to whether a record of the commencement time was made.[46]

**65.** It appears that contact was made with the family member who was the next of kin noted in Mr Roman's prison records upon his admission to Casuarina Prison. The admission records contain a requirement that at least two next of kin be recorded, and it cannot now be known why there was only one next of kin recorded for Mr Roman. Ordinarily the next of kin names are provided by the prisoner, and there is capacity to record up to five or six next of kin.[47]

**66.** Whilst steps to inform Mr Roman's recorded next of kin may have already commenced by approximately 6.15 pm, that person did not actually become aware of the situation concerning Mr Roman until approximately 7.30 pm, though there were some prior missed calls on her phone, because she did not have access to her phone. When the prison officer informed her that Mr Roman had been placed into hospital, she contacted Mr Roman's sister

[43] ts 40 to 42.
[44] Exhibit 1, tab 11; ts 42.
[45] Exhibit 2, tab 15.
[46] Exhibit 2, tabs 8 and 15.
[47] Ibid.

in Perth, who promptly contacted Rockingham General Hospital to ask after him.[48]

**67.** The next of kin and the sister contacted Rockingham General Hospital and made numerous attempts to find out what was happening with Mr Roman. Due to patient confidentiality, they were not able to be provided with information as to his condition or his prognosis.[49]

**68.** This would be consistent with the hospital policy concerning management of prisoner patient information, that states no information is to be provided as to whether a prisoner is on a health service premises. There are obvious privacy and security implications that underlie this.[50]

**69.** The family was not informed of Mr Roman's clinical deterioration until a late stage. It was distressing for them to find out that he had died. Understandably they would have wanted to seek to be with him to comfort him.

**70.** A total of approximately three hours passed from the time of Mr Roman's evident clinical deterioration until his death. Further, two hours passed from the time the doctors advised the custodial officers that he would not survive, until his death.

**71.** This shows the importance, in similar circumstances, of commencing steps to advise families of prisoners of a clinical deterioration at the earliest reasonable stage, given that a number of telephone calls need to be made, from the custodial officers, to the operations centre, to the home prison, to the next of kin. It also shows the importance of recording more than one next of kin, in case difficulties are experienced in making urgent contact. In this case the recorded next of kin was unable to access her telephone as she was at work.

**72.** Since the time of Mr Roman's death the Department of Justice have updated their Commissioner's Operational Policy and Procedures, and there is guidance concerning next of kin notifications, referred to later in this finding under the heading *Improvements*.

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[48] ts 45 to 46.
[49] Ibid.
[50] Exhibit 2, tab 18; ts 51.

## OMISSION REGARDING PLACEMENT ON TERMINALLY ILL LIST

**73.** Dr Joy Rowland (Dr Rowland), Director of Medical Services, Health Services, Department of Justice, informed the court that Mr Roman had not been added to Casuarina Prison's Terminally Ill List before his acute deterioration on 10 May 2018, and that ideally, he should have been added to that list upon his admission to Casuarina Prison due to his complex health needs.[51]

**74.** I am satisfied that this omission did not result in any adverse health impacts for Mr Roman and my reasons are outlined under the heading *Comments on Supervision, Treatment and Care* below. At the inquest I explored the question of whether there may have been better information available to the family if Mr Roman had been placed upon the Terminally Ill List upon his admission.

**75.** Dr Rowland explained that when a prisoner is added to this list at Casuarina Prison that person is informed that they are of significantly increased risk of death due to one or more medical conditions. Looking back, Dr Rowland testified that if she had received the communication from a clinician, to the effect that a new prisoner has been admitted with conditions such as those that Mr Roman had, she would have reviewed the medical records and likely recorded him as being a Stage 3 Terminally Ill prisoner. Stage 3 is where:

> **a)** The prisoner has a medical condition where death is expected in three months or less; or
>
> **b)** The prisoner has one or more medical conditions which alone or in combination, increase their risk of sudden death, or a sudden event.[52]

**76.** Stage 3 is for a prisoner whose health is unstable or vulnerable. This would amongst other things precipitate a discussion with the prisoner, to inform him of his risk, in the context of his placement on the Terminally Ill List, at Stage 3. It is an important step, and whilst Dr Rowland felt that Mr Roman

[51] Exhibit 2, tab 17.
[52] ts 32.

would have had an appreciation of the seriousness of his health conditions, I nonetheless consider that he ought to have been placed on the list and informed of his status.[53]

**77.** It is more than an administrative step. It provides a prisoner with clarity as to their health status and opens up a channel of communication should the individual wish to discuss it further. It conveys to that individual that they are very unwell and at risk of dying.

**78.** Self-evidently the conversation with the prisoner must be carefully held, so as not to generate unnecessary anxiety and Dr Rowland explained how this would occur, with sensitivity and accuracy.[54]

**79.** It would have been up to Mr Roman to decide what, if anything, to tell his family about a placement on the Terminally Ill List, at Stage 3, and the implications that could flow in respect of his health status (had he been placed on that list).[55]

**80.** It cannot now be known whether Mr Roman would, hypothetically, have passed any component of such information onto his family, and any further comment would be speculative. Whilst I accept it is likely that Mr Roman knew he was quite unwell, it would have been preferable to have placed him on the Terminally Ill List, Stage 3, and explained the implications to him, with sensitivity and accuracy.

**81.** It is clear that Mr Roman did inform his family about some of his health conditions while he was in custody, and that his family maintained an interest in his health and medical care.

## COMMENTS ON SUPERVISION, TREATMENT AND CARE

**82.** I am satisfied that Mr Roman's supervision, treatment and care in custody was of an appropriate standard. He resided primarily at the infirmary at Casuarina Prison. He received regular primary health care and specialist

[53] ts 31 to 34.
[54] ts 33 to 34.
[55] ts 34.

reviews. His complex medical needs were attended to. He was treated in hospital when required. He was regularly escorted to his dialysis sessions. His observations of vital signs were monitored on a weekly basis. A multidisciplinary team was involved in his care.[56]

**83.** Overall, during his time in custody Mr Roman's chronic health conditions were managed well, resulting in a reduction in hospital admissions. He gained muscle weight. With encouragement he achieved a high rate of attendance at his dialysis sessions. He ceased smoking, and he gained a level of independence with his activities of daily living. These were all improvements to his overall health and his compliance with medical advice.

**84.** I have considered the omission to place him on the Terminally Ill List, as outlined above. Within the context of his specific healthcare needs, I am satisfied that this omission had no adverse impact. I accept that Mr Roman was receiving appropriate ongoing care by the clinicians in the Casuarina Prison infirmary, that he was conveyed to the dialysis clinics as required, that he was under the care of a Consultant Nephrologist, that his progress was monitored by the Prison Medical Officer and that he was conveyed for treatment in hospital as appropriate.[57]

**85.** I have also considered the fact that at the material time, Mr Roman was not required to have an Annual Health Review at Casuarina Prison. This is an annual nurse-based health review for prisoners who have not had any form of comprehensive health assessment for 12 months. It includes an assessment of general health, including screening to address preventative health needs. At the inquest Dr Rowlands explained that, given Mr Roman was in the infirmary receiving specialist care, he was not considered for the Annual Health Review.[58]

**86.** Again, within the context of the treatment of his specific healthcare needs there is no evidence that this had an adverse impact. Mr Roman received appropriate care for his conditions, including preventative care, management

[56] Exhibit 2, tabs A and 17.
[57] ts 21 to 22.
[58] Exhibit 4; ts 25 to 26.

of risk factors, education, lifestyle advice and self-management advice as part of his ongoing care at the infirmary.[59]

**87.** The improvements regarding the process for adding prisoners to the Terminally Ill List, and the change in policy regarding Annual Health Assessments are addressed under the heading *Improvements*, later in this finding.

**88.** In commenting upon Mr Roman's supervision, treatment and care, I have explored his family's concerns about changes in his dialysis treatment and considered whether there were any warning signs for a subdural haematoma. My comments on these aspects appear below.

***Family concerns about changes in dialysis treatment***

**89.** Mr Roman's family informed the court that during his lifetime, he had told them that he was concerned about the clinical decisions being made around the removal of fluid during dialysis.[60]

**90.** At the inquest the Consultant Nephrologist Dr Jamboti explained that when Mr Roman first came to be treated at the Fiona Stanley Hospital in 2015 and subsequently in 2016, endeavours were made to address his fluid overload and ascertain a correct dry weight for him. They brought his dry weight down to 74.5 kilograms so that he would not suffer from fluid on the lungs and the associated breathing difficulties and anxiety.[61]

**91.** In 2017 Dr Jamboti noted that Mr Roman's weight had gone up to 82.5 kilograms which at the inquest he described as "*good weight*" because it was muscle weight. Dr Jamboti posited that as a consequence the time frame for the individual dialysis treatments was extended in order to cautiously address his fluid balance, given his weight gain.[62]

**92.** This adjustment, which appears to have been necessary, is the most likely explanation for the reason Mr Roman felt his treatment regime was different in the Northern Territory. There was an effect on the flow rate, and

[59] Exhibit 2, tab 17; ts 26.
[60] ts 13.
[61] ts 13 to 14.
[62] ts 14.

Dr Jamboti testified that he had endeavoured to explain this himself to Mr Roman.[63]

**93.** During the inquest there was some focus upon Mr Roman's dry weight in the context of his dialysis treatment. Concern had been expressed about Mr Roman's initial weight loss shortly after he was returned to Western Australia, and whether it was due to a change in the manner in which the dialysis was being performed here.

**94.** At the inquest it was posited that a combination of a decline in health because of several missed dialysis sessions, coupled with some anxiety as a result of his court appearances, may have played a part in his initially observed weight loss. I have considered this issue and while it is likely that there were numerous variables involved in his initial weight loss, there is no evidence to suggest that errors in the performance of the dialysis treatment in Western Australia played a part in an untoward weight loss.[64]

**95.** Through their lawyer the ALS, Mr Roman's family queried whether Mr Roman may have been considered for a kidney transplant. At the inquest Dr Jamboti explained that Mr Roman had severe ischaemic heart disease, for which he had surgery in April 2016, and COPD. In such circumstances he would not have met the criteria for consideration for a kidney transplant. I am satisfied that dialysis was the appropriate treatment option for Mr Roman.[65]

***Were there warning signs for subdural haematoma?***

**96.** At the inquest Dr Rowland opined that there were no warning signs before Mr Roman was taken for his dialysis on 10 May 2018. The observations of his vital signs were generally within range. While his blood pressure was on the low side, it had been at a similar level previously, and he was not reporting any symptoms as a result of that.[66]

[63] Ibid.

[64] ts 18.

[65] Ibid.

[66] ts 29.

**97.** Dr Rowland pointed to the risks of missing a dialysis session, due to the resultant fluid imbalance and build-up of toxins.[67]

**98.** Mr Roman had been taking aspirin, a blood thinner, since 2016 for his ischaemic heart disease and cerebrovascular disease, to prevent blood clots. He required the administration of heparin (an anticoagulant) during each dialysis. The administration of dosages of heparin, using weight adjusted calculations, is the standard practice to prevent blood clotting during dialysis, when the blood comes into contact with the dialysis membrane, and he would have been administered the heparin on each occasion. The heparin has an immediate action and lasts for approximately six hours after administration.[68]

**99.** Bleeding including subdural haemorrhage is a known adverse event associated with the use of a medication such as heparin. At the inquest Dr Jamboti outlined this risk and opined that it is a risk that needs to be taken in order to dialyse a patient.[69]

**100.** In Dr Jamboti's experience, the most common cause for an acute subdural haematoma is trauma. A very small percentage of dialysis patients might experience a subdural haematoma, and he has not seen a previous case in a dialysis patient.[70]

**101.** Dr Rowland's evidence was that there was nothing in Mr Roman's medical records to indicate that he had suffered a head trauma in the lead up to his dialysis on 10 May 2018. The doctor referred to the visibility of prisoners within the Casuarina infirmary, such that a fall would be witnessed by nursing staff, custodial staff or another prisoner (unless it happened in the privacy of a cell or ablution facilities). Mr Roman did not report a fall, nor did any other person.[71]

**102.** Dr Jamboti also opined that Mr Roman was at high risk for an episode of bleeding on the brain because of the combination of aspirin and heparin (both

[67] ts 29.
[68] Exhibit 1, tab 13; ts 11; ts 15.
[69] Exhibit 1, tab 13, ts 11.
[70] ts 12.
[71] ts 30.

being anticoagulants) and that this risk was exacerbated by his pre-existing diabetes, ischaemic heart disease and COPD.[72]

**103.** Mr Roman complained of a headache approximately three hours after the commencement of his dialysis on 10 May 2018. In hindsight, it is now known that this may have been the warning sign in respect of a subdural haematoma. However, the nursing staff, who gave him paracetamol and continued the dialysis, would not normally be expected to suspect this because as outlined by Dr Jamboti, a headache is a common complaint, and at that stage his vital signs were within the normal range.[73]

**104.** At the inquest Dr Jamboti added that in addition to the paracetamol at that stage, the nurses might try to adjust the fluid removal, because if hypothetically it has been excessive it can cause a headache. He observed that the dialysis had been stopped by the nurse before Mr Roman lost consciousness. In Dr Jamboti's opinion, taking account of the fact that it was an acute bleed, it was likely to have been going on for a few hours.[74]

**105.** At the inquest the deceased's family through their lawyer the ALS questioned Dr Jamboti and Dr Rowland about the likelihood of Mr Roman having suffered episodes of loss of consciousness during his time in custody. It appears Mr Roman had mentioned such episodes to his family.[75]

**106.** Dr Jamboti confirmed that dialysis sessions would not have this affect. Dr Rowland explained that the deceased's pre-existing COPD, including infective episodes of COPD, his susceptibility to pulmonary oedema and his history of smoking predisposed him to coughing. His airways were affected. On occasion he received oxygen supplementation, and he was hospitalised several times.[76]

**107.** There is nothing in Mr Roman's medical records that refers to a loss of consciousness. At the inquest Dr Rowland posited that Mr Roman may have experienced episodes of coughing hard, or that his blood pressure fluctuated, and these incidents may have made him feel quite unwell. Dr Rowland noted

[72] ts 15 to 16.
[73] ts 12.
[74] ts 16.
[75] ts 18; ts 34 to 35.
[76] ts 35.

that Mr Roman was in the infirmary it is very unlikely that he suffered from a loss of consciousness without clinicians, custodial staff or other prisoners seeing it.[77]

**108.** In the context of Mr Roman's cause of death, I am satisfied that there is no evidence of a history of loss of consciousness such as would have given rise to a concern about a potential neurological condition.

**109.** I am satisfied that at the material time, when Mr Roman attended the dialysis session on 10 May 2018, and when he initially complained about having a headache, there was no reason for the attending nurses to suspect he had a subdural haematoma. His condition declined rapidly and unexpectedly, and an ambulance was promptly called. Having regard to the loss of consciousness, the information was passed on to Rockingham Hospital to the effect that a brain bleed was suspected. There are no other steps that the clinicians at Fresenius ought to have taken in the circumstances.

## IMPROVEMENTS

**110.** The Department of Justice informed the court of the following relevant improvements since the time of Mr Roman's death,

**a)** Within the context of omitting to place Mr Roman on the Terminally Ill List – there has been education for all clinical staff about the Terminally Ill Module and patient suitability. Nursing staff in the infirmary have been educated and encouraged to proactively identify patients who may be suitable for this list;[78]

**b)** Within the context of Mr Roman not having an Annual Health Review because he was already receiving comprehensive health care in the infirmary – the Annual Health Review Policy as of 17 September 2020 contains a recommendation for an annual health review every 12 months, and if the prisoner is on a care plan, the

[77] Ibid.
[78] Exhibit 2, tab 17.

screening component of the annual health review is still to be completed;[79]

**c)** Within the context of the family not being made aware of Mr Roman's clinical deterioration and poor prognosis at the material time – the updates to the Commissioner's Operating Policy and Procedure concerning Prisoner Access to Health Care contains guidance in relation to next of kin notifications (subject to security considerations). The policy includes notification when a prisoner is removed to a hospital because of serious illness, and notification when there is a deterioration of a prisoner's health. At the inquest Ms Palmer informed the court that the new policy places an extra onus on staff members to record contact with the next of kin, and to include details of attempts to contact the next of kin.[80]

## CONCLUSION

**111.** Mr Roman received a proper level of ongoing medical care and treatment during his time in custody. He had experienced an improvement in his overall health and his ability to manage his activities of daily living. With encouragement he became compliant with his dialysis treatment, that was important for his overall health. He gained muscle weight and ceased smoking. His COPD symptoms settled. However, he did have a number serious medical conditions, one of which was his end stage renal disease that could only be managed through dialysis, not cured.

**112.** He died as a result of a brain bleed that led to a loss of consciousness at his dialysis session. The brain bleed could not have been predicted, it was a sudden and unexpected event. He was promptly taken by ambulance to Rockingham General Hospital, but he could not be revived.

**113.** It is possible that the anticoagulant medication associated with Mr Roman's dialysis treatment may have contributed to the brain bleed. However, it is not possible to assess any potential contribution, having regard to his other

[79] Exhibit 5; ts 25 to 27.
[80] Exhibit 5; ts 43.

risk factors, namely his pre-existing diabetes, ischaemic heart disease and COPD. The risk posed by the anticoagulant medication had to be balanced against the need to perform the dialysis, and I am satisfied that the continuation of his dialysis was of primary importance.

**114.** Mr Roman's family continue to mourn his loss. The Department of Justice has identified improvements to support families of prisoners receiving timely and adequate notification of a deterioration in a prisoner's health. This would include recording a number of next of kin contact details for a prisoner, if that is possible.

R V C Fogliani
State Coroner
4 February 2022