STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Rodney James Bates
Hearing date:	21 July 2016, 12 September 2016
Date of finding:	14 September 2016
Place of findings:	State Coroners Court, Glebe
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	Coronial law-Cause and manner of death; Death in Custody
File number:	2015/00109556
Representation:	Peter Bain – Coronial Law Advocate – Advocate assisting the Coroner Steven Griffiths - for Corrective Services, NSW Michael Sterry and Ms Szulgit– for Justice Health and Forensic Mental Health Network
Findings:	**Identity of the deceased** The identity of the deceased is Rodney James Bates. **Date of death** Rodney Bates died on 13 April 2015. **Place of death** Rodney Bates died at the John Hunter Hospital,

	Rankin Park, NSW. **Cause of death** Rodney Bates died from a traumatic brain injury caused by blunt force to the head. **Manner of death** Rodney Bates died as a result of a fall. It is likely the fall was caused by a sudden loss of consciousness.

These findings have been written without the benefit of a transcript.

IN THE STATE CORONER'S COURT
GLEBE
NSW
SECTION 81 CORONERS ACT 2009

REASONS FOR DECISION

1. This inquest concerns the death of Rodney James Bates

Introduction

2. Rodney was born on 28 June 1959. He was one of five children born to Kevin and Leah Bates. He grew up in the Rydalmere area and completed his schooling at Macquarie Boys High School.

3. Unfortunately, Rodney developed substance abuse issues and as a result became involved in the criminal justice system at an early age.

4. Rodney was serving a custodial sentence at the Cessnock Correctional Centre at the time of his death. He had been sentenced at the Blacktown Local Court for a number of offences in October 2014. His earliest possible release date was 30 December 2015.

5. Recent case notes from the Department of Correctives Services file describe Rodney as "extremely polite and well mannered." He was considering pursuing an educational program and was focussed positively on his release. Unfortunately Rodney died on 13 April 2015. He was only 55 years of age.

The role of the Coroner and scope of the inquest

6. An inquest is intended to be an independent examination of all the available evidence in relation to the circumstances of a person's death. The Coroner is to make findings as to the identity of the nominated person and in relation to the date and place of death. The Coroner is also to address any issues concerning the manner and cause of the person's death.[1]

7. Where a person dies in custody, it is mandatory that an inquest is held.[2] The inquest must be conducted by a senior coroner.[3] When a person is detained in custody the State is responsible for his or her safety and medical treatment. Given that inmates are not free to seek out and obtain the medical treatment of their choice, it is especially important that the care they receive is of an appropriate standard. Even where the death appears to have been naturally caused, it is essential that any medical treatment provided is reviewed independently and its quality carefully assessed.

8. It should also be noted that a coroner has the power to make recommendations[4] connected with a death in an attempt to increase public health or safety, if it appears necessary or desirable on the evidence as it emerges.

The Evidence

9. The inquest heard oral evidence from Detective Senior Constable Melissa Martens of the Corrective Services Investigation Unit. A significant amount of documentary evidence was tendered including medical records, an expert report, departmental files, photographs and witness statements.

10. Shortly after the inquest commenced on 21 July 2016, Ms Jacqueline Conroy entered the court and directly advised the inquest that there were, to her knowledge, serious problems in the care Rodney Bates had received in

[1] Section 81 *Coroners Act* 2009 (NSW)
[2] Section 27 *Coroners Act* 2009(NSW)
[3] Section 23 *Coroners Act* 2009 (NSW)
[4] Section 82 *Coroners Act* 2009 (NSW)

custody. She stated that she was Rodney's former partner and that she was prepared to make a statement outlining her concerns. At that time she stated that she had possession of medical records that would shed light on the matter. The inquest was adjourned for further investigations. A statement was subsequently taken from Ms Conroy and further evidence was received on 12 September 2016.

Rodney's custodial and medical history

11. Rodney had been known to the criminal justice system since he was 16 years of age and had spent a number of significant periods in custody[5]. He had been convicted of a range of offences including dishonesty offences, drug matters, driving matters and matters involving violence.

12. A review of the records reveals that Rodney had been substance dependant for many years. At the time of his death he was on a methadone program. He reportedly suffered migraines and had been treated for skin cancers.

13. Rodney had undergone a skin graft related to a large squamous cell carcinoma which had been removed from his face. This procedure resulted in tattooed skin from his forearm being grafted onto his face and also left noticeable scarring. Ms Conroy told the inquest that Rodney felt "hurt and disgusted" by the tattoo on his face.[6] He had apparently been advised that the unmarked skin on his hip or bottom was not "strong enough" to be placed on his face. Ms Conroy believed the decision was "something about the movement needed to open his mouth and move his jaw. It was also something to do with the veins and blood vessels".[7]

14. Rodney had recently been treated for a broken right shoulder.

15. Most significantly, Rodney had suffered a number of episodes of loss of consciousness. The first record of such an event appears to be in 2009.

[5] Statement of Detective Melissa Martens, Exhibit 1, Tab 5. See also the Bail Report at Tab 8.
[6] Statement of Jacqueline Conroy, Exhibit 4, paragraph 5.
[7] Statement of Jacqueline Conroy, Exhibit 4, paragraph 5.

16. Justice Health records indicate that Rodney had several episodes of loss of consciousness from November 2014, however the reason for these episodes was undetermined. Some records indicate that Rodney was at times non-compliant with medical appointments, but this appears to have no relevance to his death.

Fall in December 2014

17. Records indicate that on 21 December 2014, whilst in custody, Rodney slipped and fell in a bathroom. While Rodney's brother later heard a rumour that Rodney had been assaulted[8] there is no evidence to support this.

18. Rodney was admitted to the Intensive Care Unit at Nepean Hospital under the care of Dr Al-Khawaja, neurosurgeon.

19. CT scans and MRI imaging showed the presence of cerebral contusions as well as a small subdural haematoma and skull fracture.

20. As a result of this episode Rodney was seen by a neurologist, Dr Ip to investigate the possibility of seizure activity. It was Dr Ip's opinion that there was no firm evidence of epilepsy. Rodney's electroencephalograms appeared normal. The doctor was of the view that the episodes may have been secondary to a cardiac event and recommended that there be cardiac follow up. There was also the possibility that methadone may have been involved.

21. Further MRI scans showed continued evidence of brain injury and it was decided that Rodney should be followed up by both the Brain Injury Unit at Westmead and the Neurological Clinic at Nepean. A cardiac review was also suggested.

Fall in February 2015

22. It appears that during January 2015, Rodney was still not feeling well. A Health Problem Notification Form (HPNF) was completed on 1 January

[8] See Statement of Stephen Bates, Exhibit 1, Tab 6.

2015.[9] Rodney had complained of headaches and of feeling light headed, unwell and drowsy at times. He indicated that he sometimes felt "confused, drowsy or unconscious". It was confirmed that he should be placed in a "two out" cell. This was extended on 13 February 2015.[10]

23. In February 2015 Rodney suffered another episode of loss of consciousness and fell again. This is said to have happened while he was eating his breakfast. In this instance it was reported by other inmates that Rodney had some jerky movements but no full seizure was found to have occurred. He was seen by the Westmead Brain Injury Unit and while the previous brain injury was noted, no other neurological conditions or concerns were identified. He was discharged with a plan for follow-up by the Neurological Department at Nepean Hospital. There was no suggestion that anticonvulsant medication was indicated or prescribed.

Events leading up to his death in April 2015

24. On the afternoon of 2 April 2015 Rodney was in the yard area of number 2 wing at Cessnock Correctional Centre. He appeared to suffer a seizure of some kind and fell backwards onto the concrete, striking the back of his head heavily as he landed on the ground. One inmate who saw Rodney just before he fell said Rodney "went very stiff as if he had a heart attack".[11] There is no CCTV footage available of this incident.

25. Inmates in the immediate vicinity came to his aid and quickly placed Rodney in the recovery position. Corrective Service Officers were notified and they arranged for Justice Health nursing staff to attend and assist, while an ambulance was called. Rodney was taken directly to John Hunter Hospital.

26. Unfortunately, on route to the Hospital Rodney suffered another seizure. Upon arrival at the Hospital he was immediately taken to the theatre for

[9] HPNF document. Exhibit 1, Tab15
[10] HPNF document, Exhibit 1, Tab16
[11] Statement of Joshua Deane, Exhibit 1, Tab17

emergency brain surgery. After surgery he was admitted to the Intensive Care Unit. He was in an induced coma and needed respiratory support.

27. The following day Rodney underwent further surgery in an attempt to ease the pressure on his brain. Brain scans conducted between 3 and 7 April 2015 showed no improvement. On 7 April 2015 sedation was ceased but Rodney did not regain consciousness.

28. After consultation with Rodney's family, respiratory support was removed on 13 April 2015. Rodney continued to deteriorate and was pronounced dead at 3.55 that day. Rodney's sisters Vicki and Lyn and brothers Craig and Steve were present on the ward.

The autopsy

29. An autopsy was conducted by Dr Leah Clifton at the Department of Forensic medicine, Newcastle on 15 April 2015. Dr Clifton was of the view that Rodney died from the effects of a blunt force injury to the head. There were significant head injuries including a skull fracture, multiple acute contusions and lacerations to the brain surface, bleeding on the surface of the brain and within the cranial cavity and significant swelling. She described the pattern of injury as consistent with a fall backwards from a standing height.

30. She noted that there was evidence of recent surgical intervention and saw that there were healed contusions of the surface of the brain which were consistent with the history given of a closed head injury in 2014. She noted he had other significant medical issues including liver cirrhosis, chronic hepatitis B and C, and valvular heart disease. However, these did not cause his death.

Independent review of Rodney's medical treatment

31. The Coroner obtained an expert medical review of Rodney's records from an independent consultant neurologist, Dr Dudley O'Sullivan.[12] Dr O'Sullivan had full access to Rodney's medical records.

32. Dr O'Sullivan was of the view that Rodney had received appropriate treatment in relation to the head injuries he suffered in December 2014 and February 2015. Immediate arrangements were made for his hospitalisation. Once in Hospital he was treated by appropriate specialists and the necessary investigations were carried out.

33. Dr O'Sullivan also considered whether Rodney's ongoing treatment on release from Hospital was adequate. In particular he considered whether Rodney's history indicated that anticonvulsant medication should have been commenced. Dr O'Sullivan was not critical of the decision to withhold anticonvulsant medication. He states "the neurologist obviously felt there was some evidence to suggest that he may have had some form of syncopal episodes rather than a true epileptic fit. There could be a case for him to be placed on anticonvulsant medication but of course the neurologist obviously would have considered that possibility". Dr O'Sullivan noted that there can be significant complications in patients prescribed both methadone and anticonvulsants. He also noted that the response in patients on methadone to anticonvulsant treatment "is poor and they will often have recurrent seizures despite medication".

34. Once Rodney had been admitted to John Hunter Hospital on 2 April 2015 it appears that his very significant injuries were not survivable, notwithstanding the emergency treatment he received.

[12] Report of Dr Dudley O'Sullivan, Exhibit 1, Tab25

Ms Conroy's concerns

35. Ms Conroy initially claimed that she had significant concerns in relation to Rodney's care. She said that he had not received appropriate care whilst in custody and that she had documents to prove it.

36. On 10 August 2016, Ms Conroy attended Blacktown Police Station to make a statement about her concerns. She did not have any documents from Westmead Hospital or further information to provide concerning the medical issues which led to Rodney's death. Nevertheless, Detective Senior Constable Melissa Martens obtained the Westmead Hospital medical records in relation to Mr Bates. I have had an opportunity to review those records and am of the view that they do not shed further light on the circumstances surrounding Rodney's death.

37. Ms Conroy was called to give evidence on 12 September 2016. She did not raise concerns about Rodney's treatment at the time of his fall or in relation to any known conditions which Justice Health had ignored, as she had originally suggested. I am now satisfied that further investigation of her initial claim of medical neglect is unwarranted.

Conclusion

38. The cause of Rodney's episodes of loss of consciousness was still unknown and under investigation at the time of his death. It was not a clearly diagnosed case of epilepsy. It was unpredictable and long standing. Dr Ip had reviewed Rodney's medical history and did not prescribe an anticonvulsant medication. This may have been at least partly influenced by Rodney's ongoing methadone treatment. In any event, it was, according to an expert review conducted by Dr O'Sullivan, a clinical decision properly available to Dr Ip in all the circumstances of the case.

39. There is nothing to suggest that Justice Health or Corrective Services provided less than appropriate care to Rodney. He was placed in a cell with another prisoner. He was provided timely emergency admission to Hospital

when required and appears to have been provided adequate follow-up. I note that his family have not raised any particular concerns in relation to the treatment of these episodes of loss of consciousness or in relation to the treatment he received after his fall in April 2015.

40. Tragically, Rodney died as a result of injuries he sustained in a fall. The exact cause of the underlying episodes of loss of consciousness remains unknown.

41. The evidence does not disclose the need for any recommendation in this matter.

Findings required by section 81 (1) *Coroners Act 2009* NSW

42. As a result of considering all the documentary evidence and the oral evidence heard at inquest, I am able to make the following findings.

Identity of the deceased

The identity of the deceased is Rodney James Bates.

Date of death

Rodney Bates died on 13 April 2015.

Place of death

Rodney Bates died at the John Hunter Hospital, Rankin Park, NSW.

Cause of death

Rodney Bates died from a traumatic brain injury caused by blunt force to the head.

Manner of death

Rodney Bates died as a result of a fall. It is likely the fall was caused by a sudden loss of consciousness.

I offer my sincere condolences to Rodney's family and friends.

I close this inquest

Harriet Grahame

Deputy State Coroner

14 September 2016