QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Steven John Dixon**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 2011/2224
DELIVERED ON:	22 June 2012
DELIVERED AT:	Brisbane
HEARING DATE(s):	20 June 2012
FINDINGS OF:	Christine Clements, Deputy State Coroner
CATCHWORDS:	CORONERS: Inquest – Death in custody, Sudden Unexpected Death in Epilepsy, appropriateness of medical care, policies and procedures

REPRESENTATION:

Counsel Assisting:	Ms E. Cooper, Office of the State Coroner
Counsel for Department Corrective Services:	Ms M. Zerner instructed by Department of Community Safety

Introduction

Steven John Dixon was born on 5 March 1986. He died on 1 July 2011 when he was twenty five years of age. He died at the Brisbane Correctional Centre at Grindle Road, Wacol in Queensland. At the time of his death he was an inmate serving a custodial sentence of two years and six months. The sentence was imposed by the District Court and commenced on 1 April 2011. Taking into account time already served, Mr Dixon was eligible for parole on 22 December 2011 and due to be released on 22 September 2013. He was transferred from Arthur Gorrie Correctional Centre to the Brisbane Correctional Centre to commence his sentence on 7 April 2011.

His death was therefore a reportable death to the State Coroner pursuant to s. 8(3)(g) of the *Coroners Act 2003* as he was being detained under the authority of a court order.[1]

In accordance with s. 11(7), as Deputy State Coroner, I directed the investigation of his death and have convened this inquest.[2]

The investigation was undertaken on the coroner's behalf by the Queensland Police Service Corrective Services Investigation Unit (CSIU).

A separate Queensland Police Services investigation was also undertaken.

Events leading to the death of Mr Dixon

On 30 June 2011 lockdown occurred at 6pm. This was the usual procedure locking prisoners in their cells overnight. Mr Dixon was observed to be moving about in his cell, number 37. There had been no indication he was experiencing any health concerns. Correctional Services Officer Loo performed the headcount at lockdown of Unit S19 and noted Mr Dixon in his cell.

Correctional Services Officers performed head counts throughout the night at 22:10, 23:20, 01:13 and 04:20. Cells were unlocked at about 07:00 on 1 July 2011. At about 08:00, Correctional Services Officers entered Mr Dixon's cell to check on him as he was still on his bed. It was then he was discovered to be in an unresponsive condition.

Mr Dixon was housed in a secure unit, meaning each inmate was locked into his individual cell at lockdown time. The process of ensuring prisoners remain in their cell overnight and are safe involves randomly timed headcounts. A correctional officer shines a light into each cell to establish the inmate is present and there is no indication of a problem. The officer does not unlock or enter the cell and the inmate is not roused, awoken or spoken to. It must be remembered that considerations of safety and security have to be balanced with basic human rights of privacy and the opportunity for uninterrupted rest and sleep. Obviously there is a risk this curtailed inspection misses an opportunity to intervene in any situation where a prisoner may have some

[1] Section 10
[2] Section27(1)

medical situation which is not immediately apparent on bare sighting of a prisoner through a cell window.

Mr Dixon was lying face down on his bed. When he did not respond to verbal and physical prompts he was examined more closely. It was confirmed he was not breathing and a code blue was called. A Correctional Officer commenced chest compressions and the nurse attended promptly. Within a very short time an assessment was made establishing Mr Dixon was clearly deceased, and had been for some time.

Autopsy

An external and full autopsy examination was undertaken by forensic pathologist, Dr Alex Olumbe. There were no signs of injury observed. The pathologist did note signs of post-mortem change. There was no rigidity of the body. Lividity was distributed on the front of the body and on the flanks. The signs of post mortem change included petechial-like areas of haemorrhages on the upper neck and lateral aspects of the torso. There was also lividity in the front of the legs. There were signs of early decomposition. Examination of the tongue showed a dark red bite mark on the left hand side.

Internal examination did not reveal any injuries. Examination of the brain revealed a normal brain. There was no sign of disease or infection that could account for his sudden death. There was evidence of aspiration in both lungs.

The pathologist was provided with background information about the time and circumstances in which Mr Dixon was discovered deceased. He noted Mr Dixon was found face down on his bed in his cell at about 08:00 after the cell had been unlocked at 07:00. He was unresponsive and examination revealed clenched fists, no respiration or pulse rate, and post mortem lividity from head to the feet. Chest compressions were commenced by the Correctional Services Officer but ceased at 08:06 when the nurse assessed Mr Dixon and declared him to be deceased. There was vomit in his mouth and there was urine on the bedding.

The pathologist noted a neighbouring inmate reported hearing thud noises earlier during the night of 30 June 2011. He banged on his wall but there was no further noise. The pathologist had access to Mr Dixon's medical history. In particular it was noted he had a history of epilepsy, since about 1999.

The pathologist noted the most recent seizure and hospitalisation in April 2011. Mr Dixon reported feeling an 'aura' which preceded the seizure. He confirmed he had missed his Tegretol medication due to a video linkup with court. He reported seizure frequency was about once every two months. At the time it was documented Mr Dixon thought this was stable. He declined a blood test in hospital to check his Tegretol levels. He was discharged back to prison. The hospital advised he should be reviewed by a neurologist if he experienced further seizures.

The pathologist also noted the medical record maintained by Department of Corrective Services (now Offender Health Services). It was documented he had epilepsy since childhood and was taking 200mg Tegretol twice a day.

Three episodes of seizure whilst in custody were documented.

The first seizure whilst in custody was in a watch house at Beenleigh on 25 May 2011. He was taken to Logan Hospital. He told medical officers he had not taken his Tegretol medication for three days prior to the seizure occurring. The second occasion was on 31 March 2011 after transport from the watch house to the Arthur Gorrie Correctional Centre. The third episode was on 14 April 2011 when he was found semi conscious in his cell at Brisbane Correctional Centre and taken to the Princess Alexandra Hospital. He was discharged back to prison the following day.

The pathologist concluded Mr Dixon died due to Sudden Unexpected Death in Epilepsy (SUDEP). He noted there were signs suggesting he had experienced a seizure overnight including the thud noises heard by a neighbouring inmate, a wet area on bed linen smelling of urine, an empty bladder, a fresh bite mark on the tongue and scarring of the tongue consistent with chronic epilepsy.

Toxicology testing confirmed the presence of carbamazepine (Tegretol) recorded at 8.5mg/kg, which is a therapeutic level of the medication. (4-12 mg/ kg.)

The pathologist remarked the finding of a ‘normal’ brain does not exclude a diagnosis of epilepsy. The mechanism of death in SUDEP is unclear, but the combination of uncontrolled seizures along with both respiratory and cardiac mechanisms are pertinent, particularly when the normal body reflexes have been impaired, and the person is more susceptible to aspiration of stomach contents leading to blockage of airways compounded with respiratory failure. SUDEP is most common in people who have generalised tonic-clonic seizures, especially in young adults between 20 and 50 years of age. The most important risk factors are poor seizure control and seizures occurring during sleep.

Health status prior to and during incarceration.

Apart from Mr Dixon’s history of epilepsy, diagnosed when he was aged about 12, Mr Dixon had also been diagnosed as hepatitis C positive and had previously attempted serious self harm on two occasions. In June 2000 there was a tablet overdose and in December 2010 he attempted to hang himself.

Previously he was hospitalised in Logan Hospital, Maryborough Hospital and Beaudesert Hospital.

Mr Dixon’s partner, Maree Stephan was in a relationship with Mr Dixon over an eight year period. The couple had four children. She provided a statement to police indicating he was unreliable with taking medication for his epilepsy. In her language she said, ‘He never took medication for his condition when he

was not in prison.'[3] She said he would average an epileptic seizure twice a week when he was drinking alcohol moderately. In the last year of his life he was drinking heavily and he averaged an epileptic seizure every couple of days. She said he also smoked marijuana. She visited him whilst he was in prison and saw him for the last time on 28 June 2011.

Medical care during incarceration

Mr Dixon was transferred to the Brisbane Correctional Centre on 7 April 2011. His medical care was managed by the Visiting Medical Officer, Dr William Lethbridge. Dr Lethbridge was aware of his history of epilepsy, and his previous seizure whilst at the Beenleigh Watch house on 25 March 2011. He noted the advice from the Forensic Medical Officer at the time that Mr Dixon had been non compliant with his Tegretol medication which had been prescribed at 200mg twice daily.

After the seizure which occurred on 14 April 2011 when Mr Dixon was transferred to Princess Alexandra Hospital, Dr Lethbridge arranged to review him upon return to the prison. He ordered a blood test to measure his level of Tegretol. Results of 4.3mg indicated the need to elevate the dose. Dr Lethbridge then prescribed 300mg twice daily. A follow up test result on 5 May showed a reading of 5.4mg which was within the low therapeutic range.

The doctor reviewed Mr Dixon again on 14 June 2011 relating to tonsillitis and dermatitis. He also reviewed his medication and blood test result and decided it was prudent to increase the Tegretol to 400mg twice daily. The follow up blood test result was reviewed on 28 June and showed a result of 6.9mg /kg. This reading was more appropriately within the therapeutic range which is stated as 4-12mg/kg. Mr Dixon had not suffered any further seizures since the last episode on 14 April 2011.

Independent review of medial care, including consideration of family concerns

Dr Les Griffiths is an experienced doctor working for the independent Clinical Forensic Medical Unit. At the coroner's request he reviewed the medical care received by Mr Dixon after perusing all relevant medical records and the autopsy report. He noted the prescribed medication of Tegretol which is appropriate to control tonic-clonic seizures. He observed it was important to manage the level of Tegretol closely as if it is too high, there is a risk of toxicity, and if it is too low, there is an elevated risk of seizure. Missing even one day's medication is a risk for the reoccurrences of a seizure. Dr Griffiths was satisfied Dr Lethbridge regularly monitored medication levels and adjusted the medication accordingly. A review of medication records indicate the correct dose was provided to him.

Dr Griffiths noted information from Mr Dixon's partner regarding the frequency of seizures when Mr Dixon was living in the community. In particular he noted the contrast in the frequency of seizures depending on whether Mr Dixon was living in the community or incarcerated. It was clear Mr Dixon was

[3] Statement of Maree Stephan, paragraph 2

experiencing fewer seizures when he was in custody and receiving regular medical care and monitoring of his anti-convulsant medication.

Dr Griffiths also reviewed the emergency response provided to Mr Dixon after he was found unresponsive in his cell at about 08:00 on 1 July 2011. He noted the correctional services officer provided chest compressions but did not commence any form of assistance with respect to respiration. However, Dr Griffiths was not critical of this in the circumstances because all of the evidence indicated Mr Dixon was deceased and indeed, had been deceased for some time.

Family members raised some issues including the doubling of the dose of Tegretol to 400mg twice daily. I have no hesitation in accepting the expert opinion of the independent doctor who considered the assessment, monitoring and adjustment of Tegretol levels was appropriate and achieved a therapeutic range of the medication, as evidenced by the reduced number of seizures experienced by Mr Dixon during his detention.

There was also some concern expressed by his partner when she observed what appeared to be a bruise on his body. This appearance was explained to be due to post mortem lividity, the fact Mr Dixon was lying face down when he died and the period of time after his death before he was found.

There was an indication in the evidence that Mr Dixon failed to take Tegretol on one day due to a video court commitment and this was followed by the seizure which occurred on 14 April 2011, requiring hospitalisation. This raises a couple of issues. Assuming it was just one dose that was missed it highlights Dr Griffith's advice that Tegretol must be taken strictly in accordance with the prescription to avoid the risk of a seizure. It is unclear whether or not the medication had been provided to Mr Dixon but Mr Dixon did not take it, or whether he missed the distribution of medication due to the court commitment. Dr Griffiths' review of medication charts indicated medication was dispensed regularly in accordance with Dr Lethbridge's prescription. However, it is also noted in the absence of an appropriate legal authority requiring Mr Dixon to physically consume the medication in sight of the nurse, it remained a matter for Mr Dixon whether or not he was compliant. There was evidence Mr Dixon was unreliable in taking any medication in the community. In contrast, the evidence suggests he was generally compliant whilst in prison because of the reduction in the incidence of seizures after he was incarcerated. Dr Griffiths noted there are other medications that can be added to a regime of Tegretol if break through seizures occur with the single medication. However, I accept his view that in Mr Dixon's situation there had only been one episode of seizure. At this time it was not apparent Mr Dixon required additional medication.

Findings

I have considered the investigations by CSIU and the Queensland Police Service. I am satisfied Mr Dixon's death has been properly investigated.

I am satisfied on consideration of all of the evidence that Mr Dixon's untimely and unexpected death was due to natural causes. I am satisfied he received appropriate medical care during the period of his incarceration and there was a timely and appropriate response to the discovery that he was unresponsive in his cell. I note the intercom in his cell was functioning although I doubt there was any possibility for Mr Dixon to use this if, as it might be presumed, he suffered a seizure which commenced after he had fallen asleep. I do not consider there was any possibility he could have been revived even had attempts commenced at unlocking at 07:00 rather than 08:00.

I make the following formal findings in accordance with s. 45 of the *Coroner's Act 2003*.

(a) The identity of the deceased was Steven John Dixon.

(b) Mr Dixon was a prisoner at the Brisbane Correctional Centre at the time of his death. He had a known history of epilepsy and was receiving medical care. At the time of his death he had a therapeutic level of an appropriate anti-convulsant medication, Tegretol, in his bloodstream. Mr Dixon died after suffering an epileptic seizure whilst sleeping. He was last seen alive at about 18:00 on 30 June 2011. He was discovered unresponsive at about 08:00 on 1 July 2011. Efforts to resuscitate him were abandoned after it was confirmed he was deceased.

(c) Mr Dixon died between 30 June 2011 and 1 July 2011.

(d) He died at Brisbane Correctional Centre, Grindle Road, Wacol, Queensland.

(e) Mr Dixon died due to Sudden Unexpected Death in Epilepsy (SUDEP)

Comments

Counsel representing Corrective Services submitted there was no basis to make comments where a conclusion had been reached that Mr Dixon's death was due to natural causes and could not have been prevented. While I accept the logic of the submission I do however consider it is worth reflecting on some matters.

Investigating police suggested an inmate with known epilepsy should be housed in a cell with a cell mate as a precautionary safety measure which might possibly increase awareness of a problem. There are difficulties with this suggestion which has been considered by Corrective Services and rejected as unviable. I accept there are primary considerations of security. In Mr Dixon's situation he had recently been sentenced and was still classified as a secure prisoner requiring accommodation in an individual cell.

I note there is the possibility of a flexible, individual and tailor made arrangement for a prisoner with special health needs via an Integrated

Management Plan which can be designed through cooperation and communication between Offender Health Services and Corrective Services. This appears to be the most useful possible means of improving safety for a prisoner such as Mr Dixon.

While I encourage consideration of this existing management strategy, I recognise there is no guarantee that co sharing of a cell or even a sleeping arrangement in a medically supervised environment could ensure safety. As the pathologist, Dr Olumbe has stated, Sudden Unexpected Death in Epilepsy is often associated with poorly controlled seizures and seizures occurring during sleep. On the evidence, Mr Dixon's previously poorly controlled seizures had been stabilised and, while Mr Dixon was known to recognise the sensation of an aura which preceded the onset of a seizure, the potential for attaining a position of safety prior to the onset of a seizure does not exist when one is asleep. Sudden Unexpected Death in Epilepsy remains a rare event which most often claims the lives of young adults. Compliance with medication to reduce the occurrence of seizures remains the best preventative strategy.

Where there is evidence the recurrence of seizures may occur with very little deviation from the prescribed medication regime, it is imperative the management of compliance with medication is optimised. In Mr Dixon's case he received ongoing careful assessment and monitoring of his response to appropriate medication throughout his incarceration. Education relating to risk might assist, although the age demographic of those most at risk militates against them appreciating their risk of mortality.

I thank Counsel Assisting and Counsel appearing before the inquest, which is now closed.

Christine Clements
Deputy State Coroner
22 June 2012
Brisbane