FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the ***Coroners Act 2008***

Court reference: 3546/07

Inquest into the Death of GARRY JOHN STEPHENS

Delivered On:	2nd December, 2011
Delivered At:	Melbourne
Hearing Dates:	8th August to 11th August, 2011
Findings of:	Coroner Iain Treloar West
Representation:	Ms Nadia Kaddeche for the family Mr John Goetz for St Vincent's Correctional Health Service Mr Danny Masel for Justice Health and Corrections Victoria Ms Claire Harris for G4S Custodial Services Mr Scott Smith for GEO Group of Australia
Place of death:	Port Phillip Prison, Laverton, Victoria 3028
PCSU:	Senior Constable King Taylor

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Court reference: 3546/07

In the Coroners Court of Victoria at Melbourne

I, IAIN TRELOAR WEST, Deputy State Coroner

having investigated the death of:

Details of deceased:

Surname: STEPHENS
First name: GARRY
Address: Port Phillip Prison, Laverton, Victoria 3028

AND having held an inquest in relation to this death on 8th August to 11th August, 2011 at Melbourne

find that the identity of the deceased was GARRY JOHN STEPHENS
and death occurred on or about 7th September, 2007

at Port Phillip Prison, Laverton, Victoria 3028

from
1a. VENTRICULAR ARRHYTHMIA IN A MAN WITH EPILEPSY AND DOCUMENTED EPISODES OF BRADYCARDIA

In the following circumstances:

1. Garry Stephens, aged 46 years, was of male gender and at the time of his death was an inmate at Port Phillip Prison, having been sentenced at the Melbourne County Court on the 4th September 2007. Prior to his incarceration he resided with his defacto partner at 44 Gibson Street, Broadmeadows. Mr Stephens had a long medical history stemming from his extensive drug use and in addition, he suffered from cardiac and epilepsy conditions. Following sentencing, Mr Stephens was sent to the Melbourne Assessment Prison for two days and after assessment, he was transferred to the Port Phillip Prison on the 6th September 2007, to commence his sentence. At 7.50am on the 7th September 2007 two prison officers conducted the morning "hand-on trap" muster. On opening the trap to Mr Stephens' cell and on looking inside, they observed Mr Stephens lying on the floor next to his bed and after calling to him and getting no response, they entered the cell and found him unresponsive. A medical assistance code pink was called resulting in officers and nurses from the prison hospital attending and commencing

cardio pulmonary resuscitation. Dr Tuck, the head of the prison hospital, also attended and assisted, however Mr Stephens could not be revived. Subsequent police attendance found no signs of any struggle and Mr Stephens had no bruising or other injuries to indicate that he had been assaulted or had taken his own life. No drugs were located in his cell. It was the opinion of investigating members that Mr Stephens had died of natural causes, relating to his ongoing heart condition and epilepsy.

CAUSE OF DEATH

2. On 12th September 2007 an autopsy examination was performed by Dr Michael Burke, Senior Pathologist with the Victorian Institute of Forensic Medicine. Dr Burke performed an external and internal examination of Mr Stephens at the mortuary, reviewed the circumstances of his death, the post mortem CT scan and provided a written report of his findings. Dr Burke reported that in all the circumstances a reasonable cause of death appeared to be ventricular arrhythmia in a man with epilepsy and documented episodes of bradycardia. Toxicological analysis of post mortem body fluid was positive for Phenytoin anti convalescent medication and tetrahydrocannabinol, the active ingredient of cannabis.

3. Despite Mr Stephens' history of epileptic seizures, sectional examination of the brain showed no abnormality. Nevertheless, Dr Burke explained that this does not exclude a history of epilepsy. In addition, he stated that there were no bruises or lacerations seen within the tongue, with the latter features seen as objective evidence of a terminal seizure, however, the absence of these findings does not exclude a seizure. The post mortem examination showed fibrosis within the heart, although there was no associated coronary artery arthrosclerosis. Nevertheless, Mr Stephens had a documented history of cardiac arrhythmia with his medical record showing a permanent pacemaker was inserted in 1999, however this was subsequently removed in 2003. Dr Burke stated that the autopsy examination could not differentiate between sudden death associated with a seizure and/or a sudden cardiac arrhythmia associated with his heart disease.

4. The Coroners Court of Victoria sought and obtained an independent opinion regarding Mr Stephens' cardiac history from consultant cardiologist, Dr David O'Donnell. Dr O'Donnell reviewed the medical records, the autopsy report and the circumstances surrounding the death as set out in the inquest brief. He explained that the relationship between epilepsy and sudden death is well documented and that the issue had been extensively researched and labelled as sudden unexpected death in epilepsy (SUDEP). In his opinion, this was the cause of Mr Stephens' death. He stated that Mr Stephens' ongoing tonic-clonic seizures and the fact that he was on anti epileptic drugs, placed him at an elevated risk of SUDEP. In addition he was asthmatic, middle aged with an uncertain cardiac history, smoked 15 to 30 cigarettes a day, had elevative cholesterol and was a heavy smoker of cannabis. He explained that the exact mechanisms of SUDEP remain uncertain and that more importantly, there are no specific treatments or prevention strategies that have been shown to be affective. The relationship between epilepsy

medication and a heart condition is somewhat uncertain, although epileptic seizures can be associated with alterations in the heart rate and rhythm, but also, anti convulsant medications can affect cardiac electrical parameters which can lead to a seizure. Dr O'Donnell further stated that SUDEP can occur with or without evidence of a preceding seizure, although in the majority of cases, there may be a seizure within 24 hours preceding the death. Death can occur suddenly with the individual not experiencing pain or any other symptom prior to its occurrence. Death from SUDEP in sleep is common among studied cases in the literature and anyone observing an individual in these circumstances, wouldn't be aware of the person suffering an arrest, or that they had past from sleep to death. Hence there is no evidence to suggest that monitoring reduces the risk of death, as studies have shown that SUDEP frequently occurs in tertiary hospitals. Similarly, there is no evidence to say that immediate rescue, or intervention will prevent a SUDEP death. Resuscitation is rarely successful in SUDEP related deaths. Dr O'Donnell stated that with regard to Mr Stephens' medical management, there was no evidence that it adversely impacted on the cause of his death. Dr O'Donnell also commented that Mr Stephens' comorbidities placed him at an elevated risk of sudden cardiac death, unrelated to epilepsy.

5. Dr Morgan of Pacific Shores Healthcare also gave evidence in relation to whether the death was associated with a seizure, or heart disease. He was sceptical of the report by Mr Stephens of his near death experience as noted by Nurse Boyle **(para 9)**, telling the inquest that after an event of that magnitude, with no independent verification of seizure, the individual would have no awareness, as they would be in an unconscious state if it were a real seizure. The nurse noted that when the complaint was made to her, Mr Stephens presented as well, with no evidence of injury and his vital signs were all within normal limits and there had been no complaint by him, at the first opportunity upon release from his cell. This was contrary to Dr Morgan's expectation as in his experience prisoners would notify what occurred overnight immediately upon release from their cell. Dr Morgan concluded that it was entirely possible that the death was due to a heart related incident, with Mr Stephens having required a pacemaker in the past that was subsequently removed at his insistence, against medical advice.

6. The evidence indicates that Mr Stephens' death was a natural cause death. There is no clear and concise evidence as to whether the terminal event of ventricular arrhythmia was associated with heart disease, or the result of an epileptic seizure. Speculation in these circumstances is inappropriate and unhelpful. Dr Burke stated the cause of death as "ventricular arrhythmia in a man with epilepsy and documented episodes of bradycardia", while Dr O'Donnell formulated the cause as sudden unexpected death in epilepsy. These causes are not mutually exclusive, as SUDEP embraces Dr Burke's cause of death and accordingly, I accept Dr Burke's formulation, as accurately stating the cause of death.

PLACEMENT HISTORY

a. Reception and assessment at Melbourne Assessment Prison (MAP)

7. As previously indicated, Mr Stephens was sentenced in the Melbourne County Court on the 4th September 2007, after which he was conveyed to the MAP where he underwent a health intake screening assessment at 5.45pm in order to determine his health status, risks and needs. This assessment was undertaken by a registered psychiatric nurse, with Mr Stephens' health details being recorded as suffering life threatening epileptic seizures; that he was allergic to diazepam and that he was on medication three times daily. It was also recorded that he was a daily high use cannabis taker and that he was taking Epilim, Dilantin, Capria, Aspirin and Lipitor prescription medications. His personal safety concerns were noted, with him indicating that he had been in protection on previous occasions due to ongoing problems within the mainstream prison. It was noted that he had some anxiety regarding being in jail, but that he believed he would be able to cope during the course of this sentence. In addition, Mr Stephens was assessed to determine his needs in relation to psychiatric services, with his interim risk management plan, rating suicide and self-harm as category S3, (potential risk of suicide/self harm) with his psychiatric rating being P4 (past history of mental health contact, but no current needs) and him requiring hourly observations for his epilepsy. Further, he had an MO status which was read from the E-Justice[1] system, indicating that he had no acute medical concerns. His protection status was based on the fact that he had given evidence against another prisoner (whom he named), during a previous period of imprisonment, with this application being approved. This documentation was placed on a temporary file since Mr Stephens' prison individual management plan (IMP) file was not currently available, as it had been archived to the Corrections Victoria offsite storage area, due to Mr Stephens not having been in custody for a period of six years. The temporary file was created in line with usual practice and a formal request for the IMP file was made to retrieve it from archive.

8. On the 5th September 2007, Mr Stephens was medically examined by Dr Edward Morgan, who was employed by Pacific Shores Healthcare at the Melbourne Assessment Prison, where he had worked for nine years. The health assessment involved Dr Morgan charting Mr Stephens' current medications and cross-referencing those medications with the health summary that was obtained from his general practitioner, Dr Tran. Dr Morgan completed a medication chart to arrange the dispensing of Aspirin (100mg Mane), Dilantin (100mg T.D.S), Epilim (100mg T.D.S), Lipitor (40mg nocte). However, having been told by Mr Stephens that contrary to his doctor's prescription he had been taking 200mg of Dilantin at night, Dr Morgan changed the entry on the medication sheet to read Dilantin 100mg morning, 100mg midday, 200mg at night. The chart was subsequently faxed off to the offsite pharmacy for dispensing of the medication. Dr Morgan noted that Mr Stephens suffered from "instability of epilepsy" and

[1] The E-Justice application is used to manage cell placements, prisoner movements and transfers, property and general prisoner information.

recorded his disclosure of "seizure last week". This would require an M2 status on the E-Justice management system, that is a patient requiring a chronic health care plan, however the E-Justice system was not changed as Dr Morgan did not have authority to do so.

9. Following the health assessment Mr Stephens returned to the unit for the day and the next morning, on the 6th September, he was again seen prior to transfer to the Port Phillip Prison later that day. Mr Stephens was initially seen by Registered Nurse Boyle at 8.50am, when he stated to her that he had "a full on seizure and nearly died" overnight. Nurse Boyle noted this comment in the clinical record, along with further statements by Mr Stephens that he was on insufficient Epilim and that he also should have been on Capria. She noted that he had been self-medicating double doses of Dilantin and that he had notified staff of the 'fit' that morning. Observations were taken with his temperature being 36°, his blood pressure 110/70, his pulse 67, his pupils equal and reacting to light, that he was alert and orientated. Nurse Boyle noted that he had already taken his morning medication, that he appeared well, with no evidence of impending 'fit'. She marked him as suitable for transfer to the Port Phillip Prison and that he was fit to travel. Nurse Boyle later in the morning relayed these comments and observations to Dr Morgan and on the basis of what she relayed, it was decided that indeed Mr Stephens was fit to travel and to be transferred to Port Phillip Prison.

b. Port Phillip Prison (PPP)

10. Port Phillip Prison is a maximum security men's facility, which holds prisoners with diverse backgrounds, the majority of whom have been convicted of serious criminal offences. The prison is operated by GS4 Custodial Services Pty Ltd and has a capacity of 823 prisoners, with approximately 20,000 prisoner transfers occurring each year in and out of the facility. The prison provides medical care for all prisoners requiring secondary and tertiary medical care (Section 47 of the Corrections Act provides that prisoners have the right to access reasonable medical care and treatment for the preservation of their health) and in order to facilitate this level of care, the prison has three medical units, comprising an inpatients psychosocial unit, an inpatient medical facility and an outpatient medical clinic. In addition, St Vincent's Hospital employs clinical staff at Port Phillip Prison, including medical officers, registered nurses and registered psychiatric nurses, pharmacists and pharmacy technicians.

c. Reception and assessment at PPP

11. Following his arrival at the Port Phillip Prison, Mr Stephens was again assessed by both correctional staff and a St Vincent's Correctional Health Service (SVCHS) psychological nurse. Mr Stephens was one of twenty nine new admissions scheduled to arrive at the prison that day. He was assessed by Registered Psychiatric Nurse, Dennis Carter, who had extensive experience in the areas of inpatient and outpatient community based services since graduating in 1993. Nurse

Carter had available to him the temporary file and the information contained in it relating to Mr Stephens' assessment and reception at MAP on the 5th September. There was no history of previous periods in custody available at the time of the assessment. Nurse Carter reviewed the file before meeting Mr Stephens at 12.45pm and undertaking a health assessment using the standard assessment tool protocol. The file revealed a history of epilepsy, heart disease, allergy to Diazepam and that he was Hepatitis C positive. It recorded a seizure a week prior to reception into the MAP and Nurse Carter noted that Mr Stephens was concerned about this seizural activity and the current dose of anti-convulsants that he had been prescribed at the assessment prison. He stated that he had had a seizure the night before and that he had, prior to arriving in the prison, been self medicating with his anti-convulsants. A thorough history was obtained regarding his medical conditions of epilepsy, asthma and cardiac history, together with past illicit drug use and current smoking habits. He stated that he had had two minor heart attacks and a pace maker had been removed in 1999. Mr Stephens denied having ever been diagnosed with a mental illness and no depressive features were evident during the course of the assessment. At the conclusion of the assessment Mr Stephens was given his midday medication which had previously been prescribed at MAP, consisting of 100mg of Dilantin and 100mg of Epilim. Mr Stephens was keen to have an early nurse clinic review which was acknowledged as being appropriate by Nurse Carter and he was assured that his medication would be on the evening trolley (Nurse Carter was not aware the evening dose of Dilantin had been increased) and that an appointment for review by a registered nurse in the general nurse clinic would be expedited. A management plan was formulated by Nurse Carter, taking into account the following matters:

i. That Mr Stephens had been assessed and reviewed by a medical officer at MAP;
ii. That he had reported a siezural activity to a registered nurse at the MAP who consulted with a medical officer;
iii. That he presented as being well with no disorientation, confusion or irritability;
iv. That he had been deemed fit for transfer to PPP.

12. It was noted that Mr Stephens had arrived at the prison with an S3 rating, indicating that there had been some risk factors pertaining to self-harm at some time in the past. There was no documentation to suggest any recent self-harm ideation, or why he was currently on an S3 status. He had been deemed fit for transfer and presented well, was orientated to time, place and person, was not irritable, or confused and his judgement was intact. An interim risk management plan was completed and the Unit correctional staff and therapeutic services staff, were notified of Mr Stephens current risk status and that he had unstable epilepsy, but no current self-harm ideation. An appointment for Mr Stephens to attend the general nurse clinic was made, with the earliest appointment date available being the 10th September 2007. This was scheduled on the patient administration system and an appointment was made with the psychiatric nurse for the 18th September 2007. Because Mr Stephens stated recent seizural activity, a hand written request advising of this activity and the possibility of his current medication dose being sub-therapeutic, was completed. (This request form was subsequently acted upon by Registered Nurse Dianne

Paul during the night duty shift, for handover to the nurse working in the General Nurse Clinic on the morning of the 7th. The handover occurred at 7.00am when Registered Nurse Tania Dans, attended at the clinic, with the request being made that Mr Stephens be reviewed as a matter of urgency. The code pink call at 8.00am overtook this occurring.)

13. A prisoner information management form was completed by the nurse and recorded that Mr Stephens was on diazepam medication and that he suffered from unstable epilepsy. Mr Stephens signed this form consenting to the information contained in it being made available to correctional staff and transport providers. Due to his S3 rating he was subject to an observation regime in accordance with the interim risk management plan that recorded nil suicidal ideation, intent or plan. The form also indicated that Mr Stephens was suitable for normal cell placement. Mr Stephens was subsequently admitted at 6.15pm to Serius East Unit, due to his protection classification, and was allocated to cell 70, a double occupancy cell, which he occupied alone. After a period of interaction with other prisoners the cells were locked down at 7.45pm. Although Mr Stephens was to be on hourly observations during the day, he was on no observations during the night and there was no guard on overnight in the Serius East Unit, because no prisoner in the unit was on nightly observations. Each cell had an intercom system, which was explained to Mr Stephens and which he understood, such that when a prisoner called on the intercom and requested assistance, two guards would attend the unit. There was no communication by Mr Stephens during the course of the night and there is no evidence of another prisoner within the Unit hearing anything emanating from his cell overnight.

14. Nurse Carter filled out an interim risk management plan, which in part addressed the issue of accommodation. Although the Corrections staff were responsible for cell allocation, nevertheless they would follow recommendations by the Health Services staff, as to particular cell accommodation required for medical reasons. Following the reception assessment undertaken by Registered Nurse Carter, he recommended a "normal cell" accommodation placement in the interim risk management plan form. This form was placed on the temporary IMP file and sent through to the Corrections staff in the Sirius East Unit. Mr Stephens was allocated to a two-person cell in the Unit, which he occupied alone. Nurse Carter further reported on the interim risk management plan that observations be normal observations with two conversations occurring during the day. In addition, it was to be normal run-out for daily activities and in respect to the treatment plan his comment was for therapeutic services follow-up. Family were critical of the single occupant cell placement and also questioned why he was not referred to the St John's Ward within the prison. It is open for an assessing nurse or other medical officer at reception to recommend a prisoner be transferred to the St John's Unit, or to spend a night in the Unit for observation, if a prisoner's medical condition is considered to warrant it. On the basis of the information available to Nurse Carter, that being the material contained in the temporary health file and on his own assessment of Mr Stephens, as being alert, orientated and appearing well, he did not consider that it was warranted to place him in the St John's Unit. In addition, he was aware that he had been cleared for transfer following medical

review at MAP and nurse assessment followed by a discussion with the medical officer. Despite having written on the interim risk management plan "unstable epilepsy" and "nil suicidal ideation intent or plan", Nurse Carter conceded that in hindsight it would have been preferable to have written "shared cell," rather than "normal cell". Nevertheless, I am satisfied that Nurse Carter's actions were not unreasonable given the basis of the information he had before him and his observations of Mr Stephens. Nurse Carter observed him to be relaxed, orientated and to have concentration intact , as well as being quite positive. His placement in a unit with routine observation throughout the night or in the St John's Medical unit, would not necessarily have prevented the tragic outcome. The evidence before the Inquest is clear that Mr Stephens may have died from SUDEP or non epilepsy related cardiac arrest, without a prior seizure, or any other prior symptom or sign which would warn Mr Stephens or anyone with him of the impending arrest. SUDEP can cause death in a matter of seconds as can cardiac arrest when it is unrelated to epilepsy. Even if Mr Stephens had been admitted to the St John's Unit, the evidence is that monitoring does not prevent SUDEP and there is no evidence to suggest that immediate resuscitation will reduce the likelihood of death. To quote Dr O'Donnell "*the exact mechanisms of SUDEP remain uncertain and more importantly, there are no specific treatment or prevention strategies that have been shown to be effective.*" Similarly in regard to cardiac arrest, there was no guarantee that monitoring or immediate resuscitation would have prevented the death.

COMMENTS:
Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comments connected with the death:

1. The focus of a coronial investigation is to determine what happened, not to ascribe guilt, attribute blame or apportion liability and by ascertaining the circumstances of a death, a coroner can identify opportunities to help reduce the likelihood of similar occurrences in future.

a) Melbourne Assessment Prison

- I am satisfied the reception and assessment at MAP was reasonable. When a prisoner is admitted to Port Phillip Prison he is expected to be accompanied by a Warrant for his placement in custody, relevant transfer documents and an indent report, together with his individual management plan file. In addition to these general correctional records, the prisoner's medical file is also expected to accompany him to the prison. The medical file is secured in a sealed bag to maintain confidentiality of the medical information contained in the medical file. However, all medical files are archived after 5 years of not being used. This was the case with Mr Stephens' file, however, there is no cogent evidence that staff having his archived medical file would have changed the medical rating, or the outcome. Similarly in respect to the absence of the judge's sentencing remarks, or any reports tendered at the time of sentencing.

- Mr Stephens' transfer from MAP was not premature and was reasonable, based on his presentation, the information available and assessments undertaken by staff. In any event, the medical services available at the PPP, were superior to those at MAP.

b) Port Phillip Prison

- I am satisfied Mr Stephens' reception and assessment at PPP was reasonable and that he was suitable for placement within the PPP.
- Whilst there was an expectation in respect to cell placement, that Mr Stephens would be sharing a double cell, I am satisfied that his placement alone in a double cell, was not unreasonable. He was not a current suicide risk and given his medical presentation and the cause of death, it cannot be concluded that having another occupant in the cell, would have prevented the tragic outcome.
- It cannot be concluded that had Mr Stephens been subject to routine observations, or had he been admitted to the St John's Hospital unit, it would have prevented the death.
- Although staff had limited medical history available, assessment resulted in appropriate procedures being put in place for medical review. The restriction preventing the upgrading of Mr Stephens' medical status in the E Justice system from MO to M2 is a background circumstance and not causative of the death.
- Although there had been an increase in the night dose of Dilantin that had not been dispensed to Mr Stephens, the evidence does not support a finding that this adversely impacted on the cause of death. The evidence is silent as to whether it was dispensed by the off site pharmacy and if so, whether it was delivered to the prison; speculation as to what happened to it is inappropriate and unhelpful.
- I am satisfied that a number of response issues arising out of this incident, but not impacting on the outcome, have been addressed. These include:

  (i) the need to retrieve additional medical equipment in responding to the Code Pink and its timely retrieval,
  (ii) the use of Code Pink and Code Black emergency response codes,
  (iii)timely admission of Emergency Services into the prison,
  (iv)reinforcing with staff the importance of recording appropriate notations in the IMP file,
  (v) role of Control Room staff member when an emergency incident occurs.

RECOMMENDATIONS:

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendations connected with the death:

1. That the Melbourne Assessment Prison and Port Phillip Prison ensure protocols are in place that confirm the original medical file accompanies a prisoner upon transfer to another prison; i.e, that transfer does not occur until the file is available.

2. That the Melbourne Assessment Prison and Port Phillip Prison ensure protocols are in place that confirm timely dispensing of prescribed medication and that a prisoner's medication accompanies him upon transfer to another prison.

I direct a copy of this finding be provided to the following:

- Family of the deceased
- St Vincent's Correctional Health Services
- Justice Health and Corrections Victoria
- G4S Custodial Services
- GEO Group of Australia

Signature:

Iain T West
Deputy State Coroner

2nd December, 2011