CITATION: *Inquest into the death of Angus Jimija Dixon* [2015] NTMC 024

TITLE OF COURT:	Coroners Court
JURISDICTION:	Alice Springs
FILE NO(s):	A0015/2015
DELIVERED ON:	25 November 2015
DELIVERED AT:	Alice Springs
HEARING DATE(s):	9 October 2015
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	**Death in Care, Natural causes, Delay in Reporting**

REPRESENTATION:

Counsel Assisting:	Kelvin Currie
Counsel for the Department of Health:	Joshua Ingrames

Judgment category classification:	A
Judgement ID number:	[2015] NTMC 024
Number of paragraphs:	28
Number of pages:	6

IN THE CORONERS COURT
AT ALICE SPRINGS IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. A0015/2015

In the matter of an Inquest into the death of

ANGUS JIMIJA DIXON

ON 9 OCTOBER 2015
AT ALICE SPRINGS

FINDINGS

Mr Greg Cavanagh SM:

Introduction

1. Angus Dixon was a 59 year old Aboriginal man born in Newcastle Waters (via Elliott) to his parents, Lady Maganjanwarra Collins and Pharlap Dilbi (also known as Dixon).

2. He resided in Newcastle Waters his whole life. He had a brief relationship with Amy Ladaur (now deceased) and with her had a daughter, Sonja Dixon.

3. He was known to drink alcohol and was a heavy smoker of both cigarettes and cannabis.

4. In 1978 Angus was diagnosed with Paranoid Psychosis. For the next 20 years he had numerous admissions to Royal Darwin Hospital and Alice Springs Hospital.

5. In 2004 Mr Dixon was diagnosed with Type 2 Diabetes and in 2010 he was diagnosed with ischaemic heart disease.

6. On 26 November the District Medical Officer contacted Dr Turnbull at Alice Springs Hospital with concerns that Mr Dixon was

wandering on the road and going the wrong way to a neighbouring community. He was evacuated to Tennant Creek Hospital and then on to Alice Springs Hospital.

7. He was admitted to Alice Springs Hospital for a mental health assessment and for treatment of a buttock abscess on 29 November 2014 under the surgical team for the abscess with plans to transfer him to the Mental Health Unit after medical clearance. However on 2 December 2014 he was mistakenly discharged directly from the surgical ward.

8. On learning of his discharge Dr Turnbull contacted Elliot Clinic. They reported they still had concerns regarding Mr Dixon's mental health. The Clinic Manager was of the opinion that Mr Dixon had not been "right" for about 6 weeks. He was said to have slurred speech, he walked on the road at night attempting to stop road trains, and he was unusually aggressive and talked to a fridge at the petrol station.

9. Accordingly, he was evacuated once more to Alice Springs Hospital on 15 December 2014 for admission to the Mental Health Unit. On assessment Mr Dixon said he was being teased and had been a member of the police force. Dr Turnbull considered he was likely delusional and admitted him as an involuntary patient.

10. Dr Turnbull arranged for medical investigations so as to exclude an organic reason for Mr Dixon's mental disturbance. Blood tests showed mildly abnormal liver function tests, low magnesium, elevated creatinine and elevated sugars. A CT brain scan was normal as was an ECG showing no changes since his last ECG the previous month.

11. A medical consultation was arranged and recommendations for management made but there was no sense that Mr Dixon was in need

of urgent medical intervention. The medical investigations were planned to be completed on the following Monday, 22 December 2014.

12. On 20 December 2014 a little before 10.30 am Mr Dixon went outside to have a cigarette. He stood in the area just outside the front of the Hospital near the Emergency Department main doors and began smoking.

13. He had a heart attack and collapsed. The Emergency Department was alerted and a Code Blue called.

14. The emergency staff commenced CPR but were unable to be revive Mr Dixon. He was declared life extinct at 10.58 am. The Coroner's Constable was contacted but on initial questioning was told that Mr Dixon was a voluntary patient.

15. On 22 December 2014 Senior Constable Phillip Brook-Anderson contacted the Associate Director of Medical Services at Primary Health Care to ask that Dr Foster review the file with a view to determining if he was able to provide a Death Certificate for Mr Dixon.

16. Dr Foster reviewed his medical records on PCIS the primary health care database and completed a Death Certificate that same day. The cause of death was recorded as Ischaemic Heart disease – Cardiac arrest on a background of diabetes. Contributing factors were noted to be alcohol abuse, his mental health and being a smoker.

17. On 3 March 2015 Dr Marcus Tabart recognised that despite the death being one of natural causes it was a reportable death by reason of Mr Dixon being held as an involuntary patient under the *Mental Health and Related Services Act* at the time of his death.

18. The failure to recognise his involuntary status in the Emergency Department was thought to be primarily because the Mental Health Unit uses different computer software to that of the Emergency Department.

19. Doctor Chris Turnbull was Mr Dixon's treating Psychiatrist. He gave evidence that the medical team were still investigating trying to find the cause of Mr Dixon's mental disturbance and it was unknown how long Mr Dixon might need to remain at the hospital. There was a suspicion that he may have suffered a stroke.

20. He told me that although some senior staff in the Emergency Department had access to CCIS, the mental health software, it was rather time consuming to log onto it and the limited numbers of people that could do so made it unlikely that it would be done.

21. However he also said that it was unusual for a person already admitted to the Hospital to end up in the Emergency Department, particularly without the knowledge of Mental Health.

22. Dr Turnbull was asked about whether alerts on the computer system might provide assistance. He indicated that may be administratively difficult. Alerts normally are for long term conditions like Guardianship or infectious diseases. Whereas, an involuntary status is very temporary and would need to be removed.

23. He was of the view that any issues could be managed by better communication between Departments by means of the phone.

24. Samuel Goodwin, the Acting Executive Director of Medical and Clinical Services at the Alice Springs Hospital gave evidence that the circumstances of this case were unusual also because the doctor providing the Death Certificate was not a part of the Hospital. That

prevented the normal systems and procedures of the Hospital from noting this as a reportable death at the time.

25. He nevertheless said that the Hospital had identified ways to provide better access to patient information. Those included a legal divider in all hardcopy patient records. However in his opinion the best way forward at this time included education and awareness for all clinicians regarding their reporting obligations.

26. There was one aspect of the material that he provided that caused me some concern. A new Mortality and Morbidity Review Policy was provided. It described in both matrix and flow chart form a process that appears somewhat different to the regime outlined in the *Coroners Act*. I would suggest that the Hospital look very closely at that policy with a view to ensuring that it is legislatively compliant.

27. I do not make any recommendations but encourage Alice Springs Hospital to continue their strengthening their communication and understanding of their reporting obligations.

28. Pursuant to section 34 of the Coroner's Act, I find as follows:

    (i) The identity of the deceased was Angus Jimija Dixon born on 6 January 1955, at Newcastle Waters, Elliott, Northern Territory, Australia.

    (ii) The time of death was 10.58 am on 20 December 2014. The place of death was Alice Springs Hospital, Alice Springs in the Northern Territory.

    (iii) The cause of death was Cardiac arrest caused by Ischaemic Heart Disease.

    (iv) The particulars required to register the death:

1. The deceased was Angus Jimija Dixon.

2. The deceased was of Aboriginal descent.

3. The deceased was not employed at the time of his death.

4. The death was reported to the Coroner by Alice Springs Hospital.

5. The cause of death was confirmed by Dr Stephen Foster.

6. The deceased's mother was Lady Maganjanwarra Collins and his father was Pharlap Dilbi (Dixon).

Dated this 25 day of November 2015.

_____

GREG CAVANAGH
TERRITORY CORONER