CORONER'S COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	**Inquest into death of JAMIE LAWRENCE MITCHELL**
Citation:	**[2019] ACTCD 18**
Findings Date:	22 November 2019
Before:	**Coroner Morrison**
Decision:	See [61]-[63].
Catchwords:	**CORONIAL LAW** – cause and manner of death – whether submissions raise questions as to cause of death – "common sense" test of causation – whether public hearing necessary – whether matter of public safety arises.
Legislation cited:	*Coroners Act 1997* (ACT), s 13(1)(e), 13(1)(f), 52
Cases cited:	*The Queen v Coroner Maria Doogan; ex parte Australian Capital Territory* [2005] ACTSC 74 *March v E & MH Stramare Pty Ltd* (1991) 171 CLR 506
File Number:	CD 252 of 2014

CORONER MORRISON:

1. The death of Jamie Lawrence Mitchell, a 36 year old man at the date of his death, was reported to me in accordance with section 13(1)(e) of the *Coroners Act 1997* (as it then was) as he died within 24 hours of an operation of a medical, surgical or like nature. [I note that in subsequent versions of the Act this time based criterion has now been replaced by a causation criterion.]

Preliminary Observations

2. On further examination of the circumstances of this case, I am not persuaded that section 13(1)(e) was a proper basis to report Mr Mitchell's death to the ACT Coroner, as no operation or procedure relevantly occurred within the specified time limit. However, I am satisfied that another reporting basis existed which gives me jurisdiction to enquire into the circumstances of his death, specifically section 13(1)(f) [a doctor has not given a certificate about the cause of death].

3. That initial error as to the basis upon which jurisdiction exists does not affect the exercise of the jurisdiction because a valid basis did and does exist.

4. During the course of the investigation I invited and received submissions on whether a public hearing should be held. Mr Mitchell's family submitted that a public hearing should be held. It is appropriate to make some observations about the powers of a Coroner in the context of public hearings.

5. In the Australian Capital Territory the role of the Coroner is defined in the *Coroners Act 1997* (ACT). Primarily it is to determine the manner and cause of a person's death where the person has died in circumstances prescribed by the legislation.

6. The decision on whether or not to hold a hearing depends, in large part, upon whether or not a hearing is necessary to determine the manner and cause of death. That in turn depends upon what evidence is already available to the Coroner, without a hearing, about the manner and cause of death.

7. The evidence before me as to the direct cause of the death of Mr Mitchell is the expert opinion expressed by Associate Professor Sanjiv Jain in the post mortem report dated 27 November 2014. As I understand the submissions which have been made to me there is no challenge to that expert opinion.

8. The submissions on behalf of Mr Mitchell's family (again as I understand them) raise questions about what might be described as possible underlying, contributing or more remote causes of Mr Mitchell's death and to questions of whether a matter of public safety arises.

9. The Supreme Court in the Territory has considered the approach to be taken to what is the "cause" of an event for coronial purposes. In *The Queen v Coroner Maria Doogan; ex parte Australian Capital Territory* [2005] ACTSC 74 ("Doogan"), the Court said this:

> *A line must be drawn at some point beyond which, even if relevant, factors which come to light will be considered too remote from the event to be regarded as causative. The point where such a line is to be drawn must be determined not by the application of some concrete rule, but by what is described as the "common sense" test of causation affirmed by the High Court of Australia in* March v E & MH Stramare Pty Ltd *(1991) 171 CLR 506. The application of that test will obviously depend upon the circumstances of the case and, in the context of a coronial inquiry, it may be influenced by the limited scope of the inquiry which, as we have mentioned, does not extend to the resolution of collateral issues relating to compensation or the attribution of blame.*

10. The expert opinion of Associate Professor Jain is that the cause of Mr Mitchell's death was:

> *septicaemia and cerebral artery air embolism, due to complications related to closed radiofrequency ablation of left atrial tract for treatment of atrial fibrillation.*

11. The submissions made on behalf of Mr Mitchell's family raise the following questions:

    a. Were appropriate investigations undertaken prior to the ablation procedure?

    b. Was the ablation procedure (including post-operative care) performed appropriately?

    c. Was appropriate information given to Mr Mitchell about the ablation procedure?

    d. Could the complications ultimately suffered by Mr Mitchell have been discovered at RAH or by Dr Alasady?

e. Was the treatment Mr Mitchell received from Dr Pordeli and at Goulburn Base Hospital appropriate?

f. Was the treatment Mr Mitchell received at The Canberra Hospital appropriate?

12. The submissions call for consideration of whether the questions raised go to matters too remote to be considered as causative. That determination must be made in the context of the limited scope of a coronial enquiry and the unchallenged evidence that the manner and cause of death was septicaemia and cerebral artery air embolism, due to complications related to closed radiofrequency ablation of left atrial tract for treatment of atrial fibrillation.

13. There is an obvious, but superficial argument that a causal connection exists simply because the ablation had been carried out, and Mr Mitchell's death is due to complications related to the procedure. Such a line of reasoning would however run contrary to the decision of the High Court in *March v E & MH Stramare Pty Ltd* (1991) 171 CLR 506 and impliedly adopted in this jurisdiction in *Doogan* that the "but for" or "causa sine qua non" test is not a definitive test of causation.

14. I am also conscious of the comment in Doogan that:

> *The application of the common sense test of causation will normally exclude a quest to apportion blame or a wide-ranging investigation into antecedent policies and practices.*

15. On the basis of the material before me, I am satisfied that the manner and cause of Mr Mitchell's death, for the purposes of section 52 of the Act, is established by the evidence comprising the expert opinion of Associate Professor Jain and that no public hearing is necessary for the purpose of making that determination.

16. I also conclude that questions raised in submissions on behalf of the Mitchell family go to matters too remote to be considered as causative for the purposes of a coronial inquest. It follows that further investigation of those matters by way of a public hearing for the purpose of determining any contribution by them to the cause of death is not justified.

17. The other important preliminary observation is about matters of public safety.

18. If, in the course of holding an inquest (either with or without a hearing), a Coroner is satisfied that a matter of public safety is found to arise then the

Coroner must report upon that matter of public safety at the conclusion of the inquest. It is important to recognise however that the authority to report on matters of public safety is an incidental power. It is triggered only if "a matter of public safety is found to arise in connection with the inquest" – and does not of itself require the holding of a hearing, if it is not otherwise necessary to do so.

19. In this context I have considered two questions. The first is whether, on the basis of the evidence before me, I can find that any matter of public safety arises.

20. The second is whether in all the circumstances it is appropriate to hold a public hearing to determine whether such a finding can be made despite a hearing not being necessary to determine the manner and cause of death.

21. I have concluded that, in relation to each of the questions raised in the submissions on behalf of Mr Mitchell's family, the state of the evidence which is before me does not justify a finding that a matter of public safety arises, and further, in each case, that the holding of a public hearing to determine whether a finding should be made is not justified.

22. For the sake of completeness, I set out below a short chronology and then a summary of the relevant evidence in relation to each of the questions raised in the submissions on behalf of Mr Mitchell's family.

Chronology

23. The evidence in this matter is as follows:

    a. Mr Mitchell was diagnosed with atrial fibrillation in 2010, for which he received different treatments over time.

    b. On 1 October 2014 Mr Mitchell underwent radiofrequency ablation of left atrial conduction pathway for treatment of atrial fibrillation at the Royal Adelaide Hospital ("RAH"). The procedure was performed by Dr Alasady, who also practices in Canberra. Mr Mitchell received some treatment for chest pain the day after the procedure. He was discharged from RAH on 3 October 2014 and returned to his residence in Goulburn.

    c. On 4 October 2014 Mr Mitchell presented at Goulburn Base Hospital complaining of chest pain. After investigations showing no new changes and observations within normal limits he was discharged on 5 October 2014.

d. On 8 October 2014 Mr Mitchell attended on his GP, Dr Pordeli, complaining of chest pain.

e. On 10 October 2014 Mr Mitchell presented again to Dr Pordeli complaining again of chest pain, and was referred immediately to Goulburn Base Hospital. He was transferred to Calvary Public Hospital ("Calvary") with a presumptive diagnosis following a CT scan of oesophageal perforation. He was transferred to The Canberra Hospital ("TCH") on 11 October 2014 after being at Calvary for approximately 2 hours.

f. On 11 October 2014 at TCH Mr Mitchell underwent an emergency three stage operative procedure which included repair of atrio-oesophageal fistula with patch of left atrial wall, intercostal patch repair of oesophageal perforation and laparotomy with insertion of gastrostomy tube. He had a complicated post-surgical course in the hospital with development of fungaemia and E Coli faecalis septicaemia, and multiple embolic strokes.

g. From 25 October 2014 Mr Mitchell began to have episodes of unresponsiveness.

h. A CT scan performed on 1 November 2014 was reported as showing multiple bilateral cerebral air emboli with bilateral cerebral infarcts and oedema, as well as pseudoaneurysm and evidence of splenic and renal infarcts. In consultation with Mr Mitchell's family treatment was withdrawn and life extinct was pronounced at 7:45 pm on 1 November 2014.

i. I directed that a post mortem examination of Mr Mitchell take place. Associate Professor Sanjiv Jain opined that Mr Mitchell died from septicaemia and cerebral artery air embolism, due to complications related to closed radiofrequency ablation of left atrial tract for treatment of atrial fibrillation.

24. I obtained an expert review and opinion from Associate Professor Stuart Thomas, a cardiologist with experience in conducting ablation procedures presently practicing at Westmead Hospital, Sydney. Mr Mitchell's family also obtained an expert review and opinion from Professor Michael O'Rourke AM, a cardiologist of in excess of 45 years practice (albeit with no practical experience in conducting ablation procedures) and the former head of the Coronary Care Ward at St Vincent's Hospital, Sydney. Professor O'Rourke's report was forwarded to me by Mr Mitchell's family for my assistance.

Submissions by Mr Mitchell's family

25. The following are the questions put forward for my consideration by Mr Mitchell's family.

Were appropriate investigations undertaken prior to the ablation procedure?

26. It was suggested that insufficient investigations were undertaken of Mr Mitchell prior to the catheter ablation process being undertaken. Dr Alasady rejected the proposition outright. Associate Professor Thomas advised that there were no agreed standard set of investigations for prospective ablation patients, and noted that a number of tests had been undertaken in Mr Mitchell's case, including documentation of the arrhythmia by echocardiogram (ECG), blood tests and a CT scan. While noting that other investigations such as testing the atrial wall thickness and epicardial fat could have been undertaken, the Associate Professor stated these tests were not routine, they were often difficult, and the interpretation of the results not clear. Professor O'Rourke did not provide any comment on this topic.

27. The state of the evidence which is before me does not justify a finding that appropriate investigations were not undertaken prior to the ablation procedure or that a matter of public safety arises around those investigations. To the extent that there is a conflict in the evidence, the holding of a public hearing to resolve the conflict is not justified.

Was the ablation procedure (including post-operative care) performed appropriately?

28. It was submitted by Mr Mitchell's family that the catheter ablation procedure was not performed appropriately, and that post-operative care was deficient. Associate Professor Thomas stated that in his opinion the procedure performed on Mr Mitchell used common techniques accepted as standard in the field. The Associate Professor commented that the detail of the procedure in Mr Mitchell's patient progress notes from the Royal Adelaide Hospital were limited, and specifically, he did not locate a formal operation report or details such as the power of ablation, or whether any measures were taken to protect Mr Mitchell's oesophagus. Professor O'Rourke also commented on the lack of an operation report, and stated that the absence of detail was a major factor in appropriate treatment being delayed and in Mr Mitchell's death. An operation report was

later obtained by the Court directly from Dr Alasady, but it is evident that the operation report was not on the hospital records.

29. Professor O'Rourke stated that the taking of oesophageal protection measures would have prevented injury to Mr Mitchell's oesophagus, and commented specifically on using an optimal heat energy sufficient to have the desired medical effect but not damage surrounding tissues, but did not provide any detail as to what that optimal level might be. He indicated that while it is possible to deflect the oesophagus, this does not necessarily avoid injury, and this technique is not routinely applied now; endoluminal oesophageal displacement appears to be the current preferred technique. The Professor noted that the risk of oesophageal injury is higher, relevantly, where a general anaesthetic was used (as it was for Mr Mitchell). He said also that the risk is reduced with oesophageal temperature monitoring.

30. Associate Professor Thomas noted that oesophageal injury had been reported despite the use of protection measures, and there is no agreement as to what combination of procedural parameters is optimal to reduce the risk of injury to surrounding structures. In relation to a specific question from Mr Mitchell's family about temperature monitoring, Associate Professor Thomas stated that while widely used the procedure is not considered mandatory, that research to date has not demonstrated a benefit from this monitoring, and that some studies suggest such monitoring can itself be a source of oesophageal injury.

31. Having obtained the operation report from Dr Alasady it appears that an oesophageal temperature probe was used in Mr Mitchell's procedure. I note that Dr Alasady says that he limited the operating temperature to 20-25 watts in the posterior wall of the left atrium.

32. The state of the evidence which is before me does not justify a finding that the ablation procedure or post-operative care was performed inappropriately or that a matter of public safety arises around the procedure or the post-operative care. To the extent that there is a conflict in the evidence, the holding of a public hearing to resolve the conflict is not justified.

<u>Was appropriate information given to Mr Mitchell about the ablation procedure?</u>

33. I was urged to inquire as to the adequacy of pre- and post-procedural information given to Mr Mitchell. I note that I have no direct evidence before me in relation to the pre- and post- procedural information given to Mr Mitchell other

than what can be inferred from hospital records. I note, as Associate Professor Thomas has identified, that there exists a comprehensive written document describing the procedure and obtaining Mr Mitchell's consent to treatment.

34. Insofar as it is suggested by Professor O'Rourke that:

    a. Mr Mitchell was not fully informed about the risks of ablation by Dr Alasady;

    b. Dr Alasady failed to consider other treatments for Mr Mitchell's condition;

    c. there was actually no urgency to conduct the procedure on Mr Mitchell, and it was not clinically indicated

    Dr Alasady refutes all such allegations.

35. Dr Alasady also stated that he specifically warned Mr Mitchell about the risk of oesophageal fistula at the pre-operative consultation on 5 September 2014, as documented by him in the letter to the referring doctor Dr Allada of 8 September 2014, and he gave Mr Mitchell a seven page handout to take away which included the following information:

    What are the risks of an atrial fibrillation ablation procedure?

    …

    In general it has been estimated that the risk of any complication is between 4 and 6%. While much of this is related to complications related to access into the vein (local bleeding, blood clot, or haematoma (large bruise)) there can be more serious complications (1-2%). Some of these are listed below.

    - *…*
    - *Damage to the oesophagus (the swallowing tube) as it passes next to the heart. This is thought to be a very rare complication but is often fatal.*

    In fairness to Professor O'Rourke, this information was provided to the Court directly by Dr Alasady well after Professor O'Rourke had reviewed Mr Mitchell's records of treatment.

36. I note that Associate Professor Thomas has suggested that the treatment was not inappropriate for Mr Mitchell and that there is some evidence to suggest that early intervention for atrial fibrillation may be associated with better outcomes.

37. Professor O'Rourke suggested that Mr Mitchell should have had discharge notes to describe what symptoms to be concerned about, and should have had a report from and a contact for the proceduralist (Dr Alasady) who conducted the

procedure. Professor O'Rourke considers that the delay in seeking attention for Mr Mitchell between 4-10 October 2014 [considered below on other bases] is caused mainly by Dr Alasady's failure to provide appropriate information to Mr Mitchell, and that RAH is also at fault for not providing information about Mr Mitchell for doctors treating him after the procedure.

38. However, Associate Professor Thomas noted that additional pre-procedural information was unlikely to have helped Mr Mitchell because he presented to hospital in a timely way in the absence of written advice. I agree. The Associate Professor also suggested that it is common to give verbal advice to patients about potential complications on discharge from hospital.

39. The state of the evidence which is before me does not justify a finding that appropriate information about the ablation procedure was not given to Mr Mitchell or that a matter of public safety arises around the information given. To the extent that there is a conflict in the evidence, the holding of a public hearing to resolve the conflict is not justified.

<u>Could the complications ultimately suffered by Mr Mitchell have been discovered at RAH or by Dr Alasady?</u>

40. I sought the advice of the experts about whether Mr Mitchell's complications could or should have been discovered pre-discharge from RAH, or whether discharge should have been delayed. Certainly Dr Alasady was of the view that neither he or RAH could have identified the complication.

41. Professor O'Rourke indicated that it was appropriate for Mr Mitchell to have been discharged when he was, but Mr Mitchell should have received additional discharge information [explored above]. He stated that there were no specific tests that accurately evaluate thermal injury to the oesophagus. He said that thermal injury evidence can be seen as inflammation to or ulceration of the oesophagus within a few days of an ablation procedure, and that oesophagoscopy and esophagogastroduedenoscopy were not favoured as the procedures themselves may damage a weakened oesophagus or cause air embolism. The Professor said that thoracic CT scanning was the best test to detect for fistula development, and that PET scanning may prove useful in future. He stated that *"[i]t probably took 24-48 hours for oesophageal ulceration and fistula to develop, so that [a] CT scan would probably have been normal up until this time."*

42. Associate Professor Thomas stated that in his opinion the investigations at Royal Adelaide Hospital after the procedure were appropriate, that the findings and treatment provided were consistent with pericarditis, and that many of the clinical findings were expected findings after a catheter ablation procedure. He stated that the presentation of atrioesophageal fistula is often subtle and difficult to distinguish from the very common condition of pericarditis, which itself is a common complication of catheter ablation and a normal cause of post-procedural pain. The Associate Professor also noted that it takes time for atrioesophageal fistulae to form, citing a recent study that the time to symptom onset was 19.3 +/- 12.6 days with a range of 6-59 days, stating that he would not expect Mr Mitchell to have displayed signs of this complication prior to discharge from RAH. While Professor O'Rourke did not concede the latter point, he agreed that thermal injury to the oesophagus is evident *"within a few days after an ablation procedure"*.

43. Both the experts concur that Mr Mitchell's fistula would probably not have been detectable at the time of his discharge from RAH.

44. Professor O'Rourke also stated that Dr Alasady failed to follow up Mr Mitchell and did not schedule a follow-up appointment. Later material provided by Dr Alasady demonstrates that Mr Mitchell was discharged with written instructions to follow up during the week of his discharge from hospital on 3 October 2014. In any case, I consider the evidence before me does not rise to a level where I could find that any failure to follow-up by Dr Alasady was contributory to Mr Mitchell's death, particularly in the light of the rapid cause of Mr Mitchell's disease and his self-directed seeking of medical attention.

45. The Professor made additional comments in his report about Dr Alasady's accreditation at various hospitals and the appropriateness of medical practice across state borders.

46. The state of the evidence which is before me does not justify a finding that the complications suffered by Mr Mitchell could or should have been discovered at RAH or by Dr Alasady or that a matter of public safety arises around those complications. To the extent that there is a conflict in the evidence, the holding of a public hearing to resolve the conflict is not justified.

Was the treatment Mr Mitchell received from Dr Pordeli and at Goulburn Base Hospital appropriate?

47. I was asked to investigate the appropriateness of Mr Mitchell's treatment at the Goulburn Base Hospital, and of Dr Pordeli's actions. Professor O'Rourke was of the opinion that while it would have been possible for Mr Mitchell to have received treatment on 8 October 2014 (the first attendance on Dr Pordeli) which might have lessened the risk of a fatal outcome for Mr Mitchell, that possibility had evaporated by 10 October 2014. The Professor stated that Dr Pordeli could have contacted Dr Alasady herself or sent Mr Mitchell to Dr Alasady, and should have done so in relation to the 8 October consultation, but ultimately concluded that Dr Pordeli's actions probably conformed to the expected standard. There appears to be a conflict between Mr Mitchell's family's instructions and the documentary record about whether Dr Pordeli was aware of the RAH discharge summary, but Professor O'Rourke concluded, on the basis that the RAH discharge summary was located in the Goulburn Base Hospital records, that Dr Pordeli probably did not see the contents of the document.

48. Professor O'Rourke's opinion was that the treating doctor for Mr Mitchell's first admission to Goulburn Base Hospital on 4 October, Dr Sasikaran, did not show the requisite skill and attention required for a doctor in his position, in failing to recognise the possibility of a serious postoperative complication, not arranging for routine tests to done (the Professor suggested ECG and chest CT scan), not contacting Dr Alasady who conducted the procedure, and not referring Mr Mitchell to Dr Alasady. He suggested that if Dr Sasikaran had had the benefit of a report from Dr Alasady or RAH, Dr Sasikaran could have sought advice from Dr Alasady about Mr Mitchell's symptoms in the event that Dr Sasikaran was unaware of the potential complication. He also suggests the elevated Troponin level was almost certainly caused by thermal damage to the left atrium followed by infection, and warranted further attention and specialist advice. Professor O'Rourke states that the chest pain and symptoms suggest pericardial involvement and a chest CT done at this time would have *"shown some of the conclusive evidence of pathology noted 5 days later and [which ultimately] led to urgent surgery for repair of atrioesophageal fistula at TCH ... [reducing] the risk of a fatal outcome"*. The Professor references a case report where two patients developed symptoms compatible with infectious endocarditis 3-5 days post-

operatively and suffered cerebral and myocardial damage, and who were each ultimately found to have an atrioesophageal fistula. Another of the papers he references refers to a study of patients whose symptoms of esophageal perforation became evident 9-28 days after ablation.

49. Associate Professor Thomas stated that in his opinion, Mr Mitchell first presented at Goulburn Base Hospital with symptoms consistent with pericarditis, at a time when it would not be expected that a fistula would have developed. He states that chest pain, elevated Troponin and elevation of the white cell count is not uncommon and perhaps to be expected after catheter ablation. He noted that Mr Mitchell did not present with any specific features of fistula and it is possible but in his opinion unlikely that a CT scan at this time would have shown any air in the mediastinum. The Associate Professor referred to the literature as demonstrating that in many cases, diagnosis of oesophageal fistula is not made until after neurological changes, serious bleeding or death. He considered that Mr Mitchell's managing doctors ultimately made the correct diagnosis relatively quickly given that Mr Mitchell did not present with any of the defining features of fistula such as fevers, rigors, haematemesis or neurological issues.

50. Associate Professor Thomas stated his opinion that the assessment of Mr Mitchell on his second presentation at Goulburn Base Hospital was appropriate, an urgent investigation was performed, the correct problem was identified, the correct person who could plan appropriate therapy was notified, appropriate treatment was given and an urgent transfer planned and carried out. Indeed, the Associate Professor said, *"[t]he fistula developed earlier than average and was detected prior to the development of neurological complications ... [b]ased on my reading of the files the performance of the staff at Goulburn was better than expected ... particularly ... when it is considered [Mr Mitchell] presented to hospital in a smaller centre."* Professor O'Rourke also indicates he has no concerns with the actions undertaken at Goulburn Base Hospital on 10 October 2014.

51. The state of the evidence which is before me does not justify a finding that the treatment Mr Mitchell received from Dr Pordeli and at Goulburn Base Hospital was not appropriate or that a matter of public safety arises around that treatment. To the extent that there is a conflict in the evidence, the holding of a public hearing to resolve the conflict is not justified.

Was the treatment Mr Mitchell received at Calvary Hospital appropriate?

52. It was suggested that the delay necessitated by Mr Mitchell's transfer to Calvary instead of TCH may have been material to Mr Mitchell's ultimate outcome. Associate Professor Thomas believed that Mr Mitchell was prescribed and given appropriate medications at Calvary. The Associate Professor stated that while any delay in treatment for this condition is undesirable and may worsen progress, delays because of the need for imaging are not unexpected, and the overall delay between diagnosis and surgery (which was in the order of 12 hours all up) was not in all the circumstances excessive. Professor O'Rourke does not provide any comments specifically on the extent of delay, suggesting Dr Alasady chose Calvary for Mr Mitchell as *"a hospital of his convenience"*, and that the attendance at Calvary was not necessary and wasted time. Dr Alasady denies that allegation, saying that the reason for Mr Mitchell's initial transfer to Calvary was to permit timely assessment given Dr Alasady was then the on-call cardiologist for Calvary, and that he made arrangements for an urgent transfer to TCH after having reviewed Mr Mitchell.

53. The state of the evidence which is before me does not justify a finding that the treatment Mr Mitchell received from Dr Pordeli and at Goulburn Base Hospital was not appropriate or that a matter of public safety arises around that treatment. To the extent that there is a conflict in the evidence, the holding of a public hearing to resolve the conflict is not justified.

Was the treatment Mr Mitchell received at The Canberra Hospital appropriate?

54. I sought the advice of the experts about whether Mr Mitchell received appropriate treatment at TCH from a number of perspectives, including the delay between diagnosis and surgical intervention, the choice of surgical options open and the decision of when to stent, and other specific aspects of treatment.

55. Professor O'Rourke makes the general comment that everything done for Mr Mitchell from 10 October 2014 was too late; that the oesophagus had ulcerated, and oesophageal contents had spilled causing an abscess and sepsis.

56. Associate Professor Thomas noted a delay between the diagnosis of oesophageal perforation and surgical treatment, but considered the delay could be at least partly explained by the apparently stable condition of Mr Mitchell, the need for transfer between hospitals, and the late hour of these events (occurring

effectively overnight). The Associate Professor stated that the overall duration of the delay was not surprising to him.

57. Associate Professor Thomas observed that oesophageal perforation or fistula was a very rare complication of catheter ablation, and said that there was no definitive evidence governing treatment practice for this complication. He referred to two studies which reported mixed mortality results for stenting as a treatment for this condition. In relation to Mr Mitchell, the Associate Professor stated that he understood the stenting was undertaken after the failure of previous surgical procedures to clear Mr Mitchell's infection, and while he understood the decision, he was not surprised the procedure was unsuccessful if there was still an abscess or significant infection. He said that stenting in isolation for a large defect in the oesophagus on a background of ongoing infection would not be appropriate, that the literature suggests extensive surgery as a first step was appropriate, but stenting might have been successful in the light of Mr Mitchell's previous surgeries.

58. It was reported that there were some issues with Mr Mitchell's gastric tube and drain on 30 October 2016, and the experts were asked to comment in relation to this event. While proper nutrition is important, Associate Professor Thomas considered that by that stage Mr Mitchell's fistula had persisted and sepsis was already well established, so issues with the feeding tube were unlikely to have contributed significantly to the ongoing sepsis. Professor O'Rourke agreed in general terms that septicaemia had already developed and there were no issues in regard to the gastric tubes.

59. The experts were also asked to comment on Mr Mitchell having suffered seizures in the period before his death. While indicating no particular expertise in the treatment of seizures, Associate Professor Thomas stated that the seizures were likely to be a product of Mr Mitchell's underlying infection and in his medical context indicated a very poor prognosis. He stated he did not believe that any alteration in the assessment or management of Mr Mitchell's seizures would have altered the final outcome. Professor O'Rourke similarly considered that the actions taken in respect of Mr Mitchell's seizures were appropriate and timely.

60. The state of the evidence which is before me does not justify a finding that the treatment Mr Mitchell received at The Canberra Hospital was not appropriate or that a matter of public safety arises around that treatment. To the extent that

there is a conflict in the evidence the holding of a public hearing to resolve the conflict is not justified.

Conclusions

61. Accordingly, I find as follows:

> Jamie Lawrence Mitchell died on 1 November 2014 at The Canberra Hospital, Dann Close, Garran in the Australian Capital Territory. The manner and cause of Mr Mitchell's death is septicaemia and cerebral artery air embolism, due to complications related to closed radiofrequency ablation of left atrial tract for treatment of atrial fibrillation.

62. In the material before me Professor O'Rourke expresses the opinion that the consequence of the acts and omissions of Dr Alasady, Dr Sasikaran and RAH was the death of Mr Mitchell, and that but for those acts and omissions Mr Mitchell would have survived if he had been managed.

63. For the reasons already given:

    a. I have made findings as to the manner and cause of Mr Mitchell's death;

    b. I have dispensed with the holding of a hearing;

    c. I have made the findings as to the manner and cause of death without the need to further investigate or determine the questions raised in the submissions made by Mr Mitchell's family;

    d. I have not reached any conclusion and therefore make no finding in relation to the questions raised in those submissions; and in particular I make no adverse findings against any person; and

    e. I make no finding that a matter of public safety has been found to arise.

Final Matters

64. This matter took longer to finalise than is ideal. The process of locating physicians with appropriate expertise who were willing to assist me in this inquest was difficult and took considerable time. I am grateful to both experts for their willingness to assist in this matter.

65. In terms of other sources of delay, I wrote to Mr Mitchell's family in July 2016 after I had received the first report of Associate Professor Thomas seeking comment and indicating a preliminary view that the inquest could be finalised on the basis of the report. Mr Mitchell's family, through their legal representatives, requested that I defer my decision to allow them to obtain further expert opinion. The reports of Professor O'Rourke were forwarded to the Court in January 2017. I sought additional comment from Associate Professor Thomas on Professor O'Rourke's reports in February 2017, and the response from Associate Professor Thomas was received in April 2017. In June 2017 I received correspondence from the Mitchell family lawyers requesting that I either terminate my inquest without findings, or suspend my inquest pending litigation intended to be brought on behalf of Mr Mitchell's estate. I declined to do either, and in August 2017 letters were sent at my direction to the medical practitioners involved in this case (as potential interested parties) and Mr Mitchell's family indicating an intention to resolve the matter with findings and seeking comment on potential adverse findings. Around the same time, Court staff identified that Associate Professor Thomas had failed to return the original records of Mr Mitchell's treatment that had been supplied to him for the purposes of his review. Contact was made with Associate Professor Thomas but he indicated his belief that he had returned the records. Court staff and Police undertook many searches to locate the missing records, but to no avail. It was not until March 2019 that Associate Professor Thomas found the missing records, and April 2019 until they arrived back at the Court. One of the interested parties indicated an inability to provide a response to me until they had reviewed the records of treatment, and I extended the deadline for provision of their response accordingly; the final response was received at the Court in September 2019. As is apparent there were multiple sources and causes of delay, some of which were unavoidable. I observe however the undoubted adverse effect of the delay on Mr Mitchell's family and the additional distress this must have caused them.

66. I note also the comment from both Mr Mitchell's family and Associate Professor Thomas that there is a need for more research about patients with post-ablation oesophageal complications. This is not a matter that I can formally direct be taken up but I direct that a copy of my findings in this matter be forwarded to the Cardiac Society of Australia & New Zealand for their information and any action they consider appropriate.

67. I direct that these findings be published in due course on the Coroner's Court website, together with any responses I might receive.

68. I extend my condolences to Mr Mitchell's family and friends.

DATED 22 November 2019

P J MORRISON
CORONER