



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 18th day of November 2015 and the 5th day of May 2016, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Rodney Lyle Mitton.

The said Court finds that Rodney Lyle Mitton aged 63 years, late of 2 Nevis Court, Noarlunga Downs, South Australia died at Noarlunga Downs, South Australia on the 8th day of June 2013 as a result of coronary artery thrombosis. The said Court finds that the circumstances of his death were as follows:

1. Introduction and reason for Inquest

- 1.1. Rodney Lyle Mitton was 63 years of age when he died on 8 June 2013. At the time of his death Mr Mitton was the subject of a detention order under the Mental Health Act 2009 and his death is therefore a death in custody within the meaning of that expression in the Coroners Act 2003, and this Inquest was held as required by section 21(1)(a) of that Act.
- 1.2. Mr Mitton had a medical history which included oesophageal cancer, high blood pressure, obesity, sleep apnoea, hyperthyroidism, diabetes, bipolar disorder with chronic relapse, hypercholesterolemia, antisocial traits, tyroidectomy, endoscopy and hernias, for which he had undergone surgery, most recently on 19 April 2013. Mr Mitton was also a cannabis user.

2. Background and the events leading to Mr Mitton's death

- 2.1. On 19 May 2013 Mr Mitton's wife took him to the Emergency Department of the Noarlunga Hospital. Mrs Mitton indicated to medical staff that in the wake of surgery Mr Mitton tended to become depressed. Mrs Mitton had become concerned for his welfare following his hernia operation in April 2013 and so they attended at the hospital voluntarily.
- 2.2. At 4pm on that day Mr Mitton was detained on a Level 1 Inpatient Treatment Order under the Mental Health Act 2009 by Dr Daniel Adams. That order was due to expire at 4pm on 24 May 2013. On 20 May 2013 at 10am the Level 1 order was confirmed by Dr Edward Kaung. At 6pm that same day Mr Mitton was admitted to the High Dependency Unit of Morier Psychiatric Ward, which is a closed ward. On 24 May 2013 at 1:15pm a Level 2 Inpatient Treatment Order was confirmed by Dr Nguyen, a psychiatrist. The explanation for the Level 2 order was that Mr Mitton remained manic and grandiose, with both hostile behaviour and threats of violence and he required closed ward management. The expiration of that order was 5 July 2013 at 1:35pm.
- 2.3. On 28 May 2013 Mr Mitton was transferred to an open ward without incident and his expected discharge date was set for two to three weeks given the progress he was making. On 3 June 2013 there was a meeting between Mr Mitton, Dr Brigid Condon, a mental health nurse, Susanne Bevan, and consultant psychiatrist, Dr Nguyen. A decision was made for a possible discharge the following week with graduated leave to be granted in the meantime leading up to the discharge, along with an effort to down-titrate his medications prior to the discharge. On 3 June 2013 a leave of absence form was signed and granted for the following day by Dr Brigid Condon in accordance with the decisions of the meeting. The conditions of leave were that it would be for a two-hour period with his wife at an outside cafe or Colonnades for coffee or lunch. Further conditions were that no drugs or alcohol would be consumed. That particular leave of absence went well and Mr Mitton adhered to the conditions.
- 2.4. On 5 June 2013 a leave of absence was again granted by Dr Brigid Condon for a period of four hours for that day. The leave of absence was to allow Mr Mitton to visit his home to see his children, again to be accompanied by his wife, and with the strict conditions of no drugs or alcohol to be consumed. This visit went very well.

- 2.5. On 6 June 2013 a further leave of absence was granted by Dr Brigid Condon for a period of six hours. During this absence Mr Mitton was able to visit his home, see his wife and family and undertake the paying of some bills and dealing with matters of that kind. The conditions on this occasion were that no drugs or alcohol would be consumed and that Mr Mitton would return at the agreed time.
- 2.6. On 7 June 2013 a further leave of absence form was completed, this form being a recurring leave of absence from that day forward for a period of 8 hours with a return to the facility in the evening. The standard conditions that there be no drugs or alcohol consumed whilst on leave were imposed.
- 2.7. Dr Brigid Condon, who signed each of these leave of absence forms, was a second-year resident medical officer working on the Morier Psychiatric Ward at Noarlunga Hospital at the time. She first had contact with Mr Mitton on 21 May 2013. She was present when Mr Mitton's Level 1 Inpatient Treatment Order was reviewed by the consultant psychiatrist. Mr Mitton was reported as being groggy and suffering some abdominal pain, but the plan was made to reduce some of the medications that may be contributing to his drowsiness. He was to be reassessed later that day when he would be less drowsy to obtain collateral information from his wife and his son.
- 2.8. The statement of Dr Condon¹ provides a thorough overview of Mr Mitton's stay on Morier Ward. Dr Condon had close contact with Mr Mitton throughout that time and was essentially his primary treating doctor, on the level below the consultant psychiatrist. Over the course of Mr Mitton's stay his mental state improved and he gained insight into his condition and associated behaviours. By 4 June 2013 an expected discharge date of 11 June 2013 was set down. During discussions regarding Mr Mitton's discharge a concern was raised by nursing staff that Mr Mitton had been experiencing some vomiting and, as a result of that, Dr Condon was tasked to investigate further. Mr Mitton was reviewed on 4 June 2013 with regard to his physical presentation. Mr Mitton gave a history of vomiting small volume mucous-like material and that this was not unusual for him and happened often since his oesophagectomy in 2010 for the oesophageal cancer. Mr Mitton advised that he was reviewed six-monthly by his surgeon, Mr David Watson, and had oesophageal dilations which helped relieve

¹ Exhibit C5a

this problem for him. He had an appointment booked to see Mr Watson again in August 2013.

- 2.9. Further questioning of Mr Mitton by Dr Condon revealed that he was experiencing slight abdominal pain following his hernia operation but that it had improved over time. He reported no change in his bowel movements or any fevers and this was supported by nursing observations. Mr Mitton said he was otherwise feeling well. On examination Dr Condon reported that he looked well, his abdomen was soft and non-tender and his incisional hernia surgical wound was healing well. Dr Condon's ultimate assessment was that Mr Mitton's presentation was a long-standing complication of his previous oesophagectomy. In any event, Dr Condon requested blood analysis to check that his drug levels were acceptable and not contributing to the vomiting. The analysis requested showed that all blood levels were fine and so the leave and discharge plans were to proceed as agreed.
- 2.10. It was during one of Mr Mitton's periods of leave on 8 June 2013 that he passed away at home. Mr Mitton and his wife arrived at their home address in Noarlunga Downs at approximately 9am. They had coffee and Mr Mitton complained of feeling tired. Mr Mitton and his wife slept for approximately two hours. Mr Mitton awoke at around noon and was hungry. His wife made some lunch which Mr Mitton ate in the lounge room. Throughout this time he and wife conversed normally. Mr Mitton then returned to bed. He had a vomiting episode at around 1pm, however his wife did not consider this abnormal as she had observed him to suffer from this complaint following his oesophageal issues in 2010. Mr Mitton went back to sleep. At around 2pm Mr Mitton's wife went into the bedroom to check on him and found him to be unresponsive. She called emergency services and the Morier Ward, but unfortunately Mr Mitton had passed away.

3. Cause of death

- 3.1. An autopsy was conducted by Dr Karen Heath, forensic pathologist at Forensic Science South Australia. In her report Dr Heath gave the cause of death as coronary artery thrombosis², and I so find.

² Exhibit C2a

- 3.2. Dr Heath's anatomical findings confirmed that at autopsy Mr Mitton had severe triple vessel coronary artery atherosclerosis with near total occlusion of all three major epicardial coronary arteries. Acute thrombus was histologically identified within one coronary artery. In addition, there was scarring of the posterior and lateral walls of the left ventricle consistent with previous myocardial infarction. Although there was no histological evidence of acute myocardial infarction, these changes take several hours to develop before they can be seen microscopically and their absence does not preclude myocardial infarction as the cause of death. In addition, lethal arrhythmia can occur in the absence of overt infarction. Other findings at autopsy included the extensive intra-abdominal fibrous adhesions consistent with previous surgery, there were extensive bilateral fibrous pleural adhesions. The deceased had a history of non-insulin dependent diabetes and the kidneys showed evidence of renal failure or ketoacidosis. Analysis of a specimen of blood obtained at autopsy showed therapeutic concentrations of olanzapine, valproate and gliclazide. Alcohol, amphetamines, cannabinoids, morphine, cocaine, benzodiazepines and other common drugs were not detected. There were no findings to indicate other than natural causes for the death and there were no injuries or markings on the body to indicate the involvement of any other person in the death.

4. Conclusion

- 4.1. I find that Mr Mitton was suffering from a mental illness and that the orders for detention under the Mental Health Act 2009 were lawful and appropriate.
- 4.2. I find that the medical treatment provided to Mr Mitton during his period of detention at the Noarlunga Hospital was appropriate and necessary.

5. Recommendations

- 5.1. I have no recommendations to make in this matter.

Key Words: Death in Custody; Natural Causes

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 5th day of May, 2016.

State Coroner

Inquest Number 30/2015 (0938/2013)