CORONERS ACT, 2003

SOUTH *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign King at Adelaide in the State of South Australia, on the 14th day of May and the 13th day of September 2024, by the Coroners Court of the said State, constituted of David Richard Latimer Whittle, State Coroner, into the death of Noel Allen Mortess.

The said Court finds that Noel Allen Mortess aged 75 years, late of Yatala Labour Prison, 1 Peter Brown Drive, Northfield, South Australia died at Northfield, South Australia on the 26th day of December 2021 as a result of end stage myelodysplastic syndrome and end stage renal failure on a background of ischaemic, hypertensive, and valvular heart disease and metastatic prostate carcinoma. The said Court finds that the circumstances of his death were as follows:

1. Introduction and cause of death

1.1. Noel Allen Mortess was born on 22 February 1946 and died on 26 December 2021 at the Yatala Labour Prison, aged 75 years.

1.2. His cause of death according to a pathology review undertaken by Dr Alexandra Yuill and discussed with Associate Professor Neil Langlois of Forensic Science South Australia was 'end stage myelodysplastic syndrome and end stage renal failure on a background of ischaemic hypertensive and valvular heart disease and metastatic prostate carcinoma'.[1] I find this to have been the cause of his death.

[1] Exhibit C2a

2. Reason for inquest

2.1. As Mr Mortess was serving a custodial sentence at the time of his death, his death is a death in custody and thus a mandatory inquest was held pursuant to Section 21 of the Coroners Act 2003.

3. Background

3.1. Mr Mortess was born in South Australia and grew up in Plympton with his parents and older brother.

3.2. Mr Mortess resided in Kurralta Park and worked for 30 years as an electrical fitter until 1994 when he retired due to ill health.

4. Custodial sentence

4.1. On 25 June 2015 Mr Mortess was sentenced to 10 years imprisonment with a non-parole period of 4 years, backdated to 19 June 2015 being the date he was taken into custody for the offences for which he was ultimately sentenced.

4.2. He was initially placed at Yatala Labour Prison (YLP) and subsequently transferred to other correctional facilities within the State, finally transferring back to YLP on 16 June 2020.

5. Mr Mortess' medical history

5.1. In 2008, Mr Mortess was diagnosed with prostate cancer.

5.2. Upon admission to the Adelaide Remand Centre in 2015 Mr Mortess disclosed a history of prostate cancer for which he had been treated at the Royal Adelaide Hospital (RAH). His other reported medical history at this time was gastroesophageal reflux disease, previous myocardial infarction and the insertion of two cardiac stents, type 2 diabetes, asthma, sleep apnoea and use of CPAP machine, allergies to pethidine and morphine, urinary frequency, use of a walking frame for mobility, vision impairment and general aches and pains. Mr Mortess was overweight, weighing 125 kilograms at that time.

5.3. Conditions recorded on his South Australian Prison Health Service (SAPHS) file during the course of his incarceration include hypertension, high cholesterol, low thyroid, reflux disease, obesity, sleep apnoea, anaemia, stage 4 chronic kidney disease, ischaemic heart disease, triple vessel disease, metastatic prostate cancer, myelodysplastic disorder, non-Hodgkin's B cell lymphoma and type 2 diabetes.

5.4. Mr Mortess regularly attended hospital as an inpatient and outpatient and saw a range of specialist consultants, including cardiology, haematology and oncology.

6. Circumstances leading to Mr Mortess' death

6.1. On 14 December 2021 Mr Mortess was admitted to the RAH and found to have pneumonia and an acute kidney injury, thought to be as a result of dehydration. Mr Mortess was also anaemic. Treatment included intravenous fluids and a blood transfusion, as well as oxygen.

6.2. On 15 December 2021 Mr Mortess was reviewed and found to be feeling significantly better. He no longer required oxygen, had resumed eating and did not require intravenous fluids.

6.3. On 16 December 2021 Mr Mortess was further reviewed and showed continual improvement with all observations appearing normal. Clinical staff were satisfied Mr Mortess could be discharged back to the YLP infirmary with a care plan of continuing to take a course of cefuroxime antibiotics for a further five days, a daily blood test and cessation of verapamil.

6.4. The SAPHS progress sheet dated 20 December 2021 recorded an entry relating to the recommendation made by the RAH for Mr Mortess to continue to receive cefuroxime from 16 December 2021, twice daily, and to complete the course on 20 December 2021. The SAPHS progress sheet entry of 20 December 2021 stated that there was no record of Mr Mortess having received the treatment between those dates. An instruction to recommence the cefuroxime treatment was then recorded on the progress sheet and Mr Mortess was then provided the treatment daily until and including 23 December 2021.

6.5. On 17 December 2021 Mr Mortess was reviewed by the palliative care team. During the review a resuscitation plan was updated which detailed Mr Mortess was not to receive any further life-prolonging treatment.

6.6. On 24 December 2021 there was another palliative care team review. Due to deterioration of his health, measures were put in place for end-of-life comfort care.

6.7. Mr Mortess' condition continued to deteriorate, and he was declared deceased at approximately 6am on 26 December 2021.

7. SAPHS Critical Incident and Adverse Event Team Review

7.1. Following the death of Mr Mortess, the Department for Correctional Services (DCS) undertook a Critical Incident and Adverse Event Team Review on 19 January 2022, focusing on identifying whether there were any gaps in service relating to the provision of comfort measures.

7.2. The review identified that there was a delay in the provision of fentanyl to Mr Mortess due to unavailability on-site, and an initial delay in provision of a pressure area care mattress. Related recommendations were made as a result of the review.

7.3. The review does not mention the delay of several days in Mr Mortess receiving cefuroxime. An affidavit was sought from SAPHS Medical Director Dr Turnbull about that matter. Dr Turnbull stated the reason for that delay was not within his knowledge, but the delay in recommencing cefuroxime was not a significant issue in the SAPHS Critical Adverse Event Team Review, as it could not significantly change the prognosis at that stage of Mr Mortess' end-of-life care. Dr Turnbull opines that the omission of some days of cefuroxime would not have changed the natural progression of Mr Mortess' multiple chronic diseases and malignancy which ended his life.

8. Conclusion and recommendation

8.1. I find that at the time of his death Mr Mortess was in the lawful custody of the Department for Correctional Services. The circumstances surrounding the death of Mr Mortess are not suspicious and do not indicate the involvement of any third party.

8.2. I find that the medical treatment Mr Mortess received while in custody was of an appropriate standard.

8.3. I make no recommendations.

Key Words: Death in Custody; Natural Causes; Prison

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

Seal the 13th day of September, 2024.

State Coroner