

CORONERS COURT OF SOUTH AUSTRALIA

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INQUEST INTO THE DEATH OF MIKKEL BLIGNAULT

[2026] SACC 42

Inquest Findings of his Honour Deputy State Coroner Evans

30 September 2026

CORONIAL INQUEST

Examination of the cause and circumstances of the death of a man who was formally detained in hospital under an Inpatient Treatment Order to allow medical treatment to be given while he was experiencing symptoms of heightened emotions and behaviours.

Held:

1. Mikkel Blignault, aged 39 years of Magill, died at the Royal Adelaide Hospital on 24 June 2023 as a result of rhabdomyolysis and lactic acidosis complicating Huntington's disease.
2. Circumstances of death as set out in these findings.

No recommendations made.

INQUEST INTO THE DEATH OF MIKKEL BLIGNAULT [2026] SACC 42

Introduction

- 1 The Court heard an inquest into the death of a young man during a period when an Inpatient Treatment Order had been imposed in order to facilitate necessary medical treatment.

Background

- 2 Mikkel Blignault was born on 6 September 1983. He had one brother. He was a quiet, laid-back person with a kind wit and a soft sense of humour. He enjoyed sports.
- 3 Mr Blignault's father died from a brain tumour at the age of 44.¹ Mr Blignault's mother and her family had a history of Huntington's disease. When Mr Blignault was in his mid-20s, he and his brother had genetic testing. Unfortunately, Mr Blignault returned a high result for likelihood of Huntington's disease.²
- 4 In 2011, Mr Blignault was diagnosed with a brain tumour at the base of his brainstem after he had experienced neurological symptoms. This was a medullary cavernous haemangioma.³ He underwent what was described as a high-risk procedure at the Royal Adelaide Hospital. Following the procedure, he suffered from issues with his balance, vision and ability to swallow and speak.⁴ He went through bouts of meningitis and other infections. After this, he lived with his mother for a period while he rehabilitated and then moved in to live with his brother in around 2013.
- 5 Over time, he was able to walk with the assistance of only a stick, he was able to eat solid foods and his speaking improved. He returned to a social life. He tried new activities, like water therapy with scuba diving equipment. He studied courses that interested him through WEA Adult Learning.
- 6 After some time, his condition began to deteriorate. He started experiencing mental health issues which were treated by his general practitioner. As part of his Huntington's disease, he experienced some paranoid delusions which were managed with psychotropic medication.⁵ His mobility began to decline due to back pain with bulging discs.
- 7 In May 2018, Mr Blignault went to the Lyell McEwin Hospital in relation to a foot injury and was admitted to the Hampstead Rehabilitation Centre. It was during this process that it was determined that supported living was necessary.

¹ Exhibit C7 at [3]

² Exhibit C6 at [4]

³ Exhibit C8 at 2

⁴ Exhibit C6 at [8]

⁵ Exhibit C8 at 2

- 8 In late 2018, Mr Blignault came under the care of Adelaide Disability Medical Services, mainly treated by Dr Raphael Ng. His paranoid delusions continued and were managed with olanzapine.⁶
- 9 Mr Blignault lived in a facility in Kensington for a few years and then to a facility in Magill in 2022. Mr Blignault's brother says that he adjusted well to living in care and his quality of life and mental state improved.⁷ He was able to continue to engage in social activities. His brother remained close with him, visiting him regularly and taking him out of the house. He also had the company and responsibilities of a pet beagle.
- 10 Notwithstanding his overall improvement in quality of life, Mr Blignault's Huntington's disease symptoms progressed while he was in care with his motor skills reducing and a tendency to tiredness. He became less active and he gained weight. He also experienced issues with the stability of his mood, with incidents of anger. This was the most significant symptom of his Huntington's disease which was otherwise fairly stable.⁸ A Behaviour Management Plan was created.
- 11 Mr Blignault's general practitioner last saw him in person on 31 March 2023 following a fall. The main symptoms of concern at that time were behavioural outbursts.⁹ Mr Blignault was reviewed in April 2023 by a psychiatrist, Dr Allan Nelson, and a decision was made for him to commence on amisulpride, with a view to then reducing or ceasing his other anti-psychotic medications.¹⁰

Incident at home

- 12 In late May 2023, Mr Blignault's quetiapine and olanzapine were reduced in an attempt to mitigate the risk of him having falls, which might cause serious injuries.¹¹ An unintended consequence was that this brought about a decline in the control of the behavioural aspects of Huntington's disease.
- 13 On 3 June 2023, Mr Blignault was experiencing an episode of heightened emotion. This was associated with his Huntington's disease. It is understood that he had been demonstrating angry behaviour for a period of days beforehand. Carers wanted to give him medication, but he refused. He had been yelling, spitting, thrashing around in the chair and trying to get up, but was unable to. He had used his walking frame to ram into staff.¹² After being unable to manage Mr Blignault's presentation for some days, his brother was called and attended. Notwithstanding his brother's comforting presence, Mr Blignault's anger continued.¹³ Carers called for an ambulance as they were concerned for Mr Blignault's wellbeing.
- 14 The Mental Health Co-Response team was dispatched.¹⁴ Mr Blignault's behaviour escalated quickly in response to seeing them. After they withdrew from his line of

⁶ Exhibit C8 at 2

⁷ Exhibit C6 at [18]

⁸ Exhibit C8 at 3

⁹ Exhibit C8 at 3

¹⁰ Exhibit C8 at 2

¹¹ Exhibit C11 at [7]

¹² Exhibit C11 at [8]

¹³ Exhibit C6 at [27]

¹⁴ Exhibit C11 at [3]

sight, Mr Blignault continued to yell for a period and then quietened down. The same thing happened again each time he saw the emergency workers. Given this repetition, it was determined that he was unlikely to de-escalate himself. Police were then asked to attend to assist with restraining Mr Blignault while a sedative medication was given by injection.¹⁵

- 15 While waiting for police to arrive, paramedic Alicia Marcus approached Mr Blignault and tried to convince him to take a lorazepam tablet, effectively in a last attempt to avoid sedation by force.¹⁶ In response, Mr Blignault's aggression escalated intensely and he swept his right arm behind a 60 cm fish tank, pushing the entire thing full of water onto the floor. The fish tank broke and shards of glass, water and fish were then surrounding him, increasing the seriousness of the situation and introducing new risks.
- 16 I received into evidence bodycam footage of what occurred for the remainder of this incident. A plan was formed by police and ambulance officers who had arrived. It was agreed that members of police and paramedics would work as a team. Police would hold Mr Blignault down while an injection was given by a paramedic. Given the broken fish tank, while the restraint and injection process was being done, another paramedic would try to get as much broken glass out of the way to ensure that the area was as safe as possible.¹⁷
- 17 Police then entered Mr Blignault's room and attempted to reassure him that they were there to assist him. As they approached to implement their plan, Mr Blignault lunged his arms forward at police and a paramedic. As he lunged up, police took hold of his arms. Mr Blignault continued to thrash around, trying to free himself from the team's grip. He tried to bite their arms. As he was doing this, he edged forward, his body twisted and he fell from his chair awkwardly.¹⁸ The injection was swiftly given. The team then immediately made efforts to check whether Mr Blignault had been injured by any of the broken glass. He was not. He laid on the floor and settled as the sedative took effect.
- 18 After a few minutes, Mr Blignault began complaining of ankle pain. It was then identified that his leg was injured and likely broken. After a brief period waiting for him to calm down further, paramedics applied a leg splint and then used a lifter to put him on a stretcher. A short time later, his aggression had wholly ceased and his restraints were removed entirely. Mr Blignault had returned to a state more aligned to his usual self and was taken voluntarily to hospital.
- 19 At the Royal Adelaide Hospital, Mr Blignault was diagnosed with a left tibial/fibular fracture.¹⁹ He underwent an internal fixation surgery. He had difficulty swallowing with his airway swollen and aggravated. As a result, he could not be extubated after the surgery and he was managed in the Intensive Care Unit. He was initially sedated to give him time to recover until he was able to breathe unassisted at which point extubation was achieved. He was able to be discharged to a general ward on 9 June 2023.

¹⁵ Exhibit C11 at [12]

¹⁶ Exhibit C11 at [13]

¹⁷ Exhibit C11 at [16]

¹⁸ Exhibit C11 at [18] and Exhibit C12 at [11]

¹⁹ Exhibit C9 at [11]

- 20 After this, Mr Blignault had completely returned to his usual demeanour. His leg injury had been treated and was no longer an issue.²⁰ However, his physical condition had deteriorated. He was kept in hospital for his rehabilitation which was rocky. He developed pulmonary emboli that were treated with enoxaparin. An ileus was managed with a nasogastric tube. He was treated for an E Coli infection with antibiotics. By this time, Mr Blignault's leg fracture did not require any further medical attention and was simply awaiting full recovery. The care provided focused wholly on his other conditions.²¹
- 21 Mr Blignault was given various antipsychotic medications because of the complex nature of his comorbidities, most notably his Huntington's disease. The process of selection and administration of antipsychotic medications was overseen by Dr Tam Le Cong, a consultant level doctor at the Royal Adelaide Hospital, who had formulated a psychiatric plan. This plan involved the continuation of all of Mr Blignault's current medications and introducing another medication once the ileus had resolved, conducting delirium testing as well as other measures such as providing a low stimulus environment, providing art activities as a diversion therapy, for the psychiatric team to continue to have input into any interventions and advocating for Mr Blignault to return home once he was stable enough.²²
- 22 Over time, his condition achieved a reasonable degree of stability.

Circumstances leading to death

- 23 In the early hours of 24 June 2023, Mr Blignault's presentation significantly deteriorated. He was about to be administered an antibiotic when he became agitated. He had both involuntary movements as a result of his Huntington's disease and also what appeared to be non-compliance, although this was also likely related to his disease or arising from treatment of it.²³ He began thrashing his arms and legs around. The evidence suggested that this episode may have been a dystonic reaction potentially as a result of the antipsychotic medications given.²⁴
- 24 During this episode, staff were unable to communicate with Mr Blignault at all. A Medical Emergency was declared at 1.48 am. At 1.58 am, an Inpatient Treatment Order was imposed under s 21 of the *Mental Health Act 2009*. The purpose of this order was to enable necessary treatment to be given forcefully because the presentation of Mr Blignault's condition was preventing that from happening.²⁵ The decision was formally made by Dr Denny Kim, but was made in consultation with other doctors dealing with the emergency.²⁶ The following reasons were recorded:

I have examined the above named person, and it appears that all of the following criteria for making the Level 1 Inpatient Treatment Order are fulfilled:

1. The person has a mental illness; and

²⁰ Exhibit C6 at [35]

²¹ Exhibit C9 at [21]

²² Exhibit C9 at [10]

²³ Exhibit C9 at [16]

²⁴ Exhibit C10 at [11]

²⁵ Exhibit C9 at [16] and [20]

²⁶ Exhibit C10 at [7]

2. Because of the mental illness, the person requires treatment for their own protection from mental or physical harm (including harm involved in the continuation or deterioration of their condition) or for the protection of others from harm; and
 3. The person has impaired decision-making capacity relating to the treatment of their mental illness, and
 4. There is no less restrictive means than an Inpatient Treatment Order of ensuring appropriate treatment of the person's illness.²⁷
- 25 After that order was made, injections of olanzapine and clonazepam were administered, but they had little impact and Mr Blignault's resistive and aggressive behaviours continued.²⁸ This meant that vital signs were still not able to be checked and important blood testing could not be conducted. On the assumption that the movements might have been dystonic, benztropine was administered but this also had no effect and Mr Blignault continued to thrash around.²⁹ Staff tried to call Mr Blignault's brother but could not reach him.
- 26 By 2.50 am, physical restraints had been able to be applied and a venous blood gas test was then able to be conducted. This revealed that severe lactic acidosis had developed during Mr Blignault's period of thrashing around. Doctors tried to treat this with adrenaline and sodium bicarbonate. Mr Blignault then suffered a further medical deterioration, with a cardiac arrest commencing at 3.39 am.³⁰ Resuscitation attempts were made between then and 4.17 am when it was determined that further attempts were futile. A declaration of life extinct was then made at 4.18 am.³¹

Investigation into the cause of death

- 27 A pathology review of the medical records was conducted by Dr Erin O'Connor through Forensic Science SA. Dr O'Connor was not able to determine what had brought about Mr Blignault's death from the records and so recommended a post-mortem examination which was directed by a coroner.³² This was then conducted by senior specialist forensic pathologist, Dr Karen Heath, with specialist neuropathology examination conducted by Dr Barbara Koszyca of the University of Adelaide. Dr Koszyca observed various pathological signs in Mr Blignault's brain that were in keeping with the clinical history of Huntington's disease, particularly cerebellar atrophy with loss of Purkinje cells which is seen in patients with early onset of the disease. No macroscopic changes in the brain had yet developed as a result of the disease. The brainstem had been altered through the previous removal of the tumour.
- 28 Assessing the physiological evidence, Dr Heath formed the view that Mr Blignault's death was as a result of rhabdomyolysis and lactic acidosis complicating Huntington's disease.³³ Given the circumstances, Dr Heath also allowed for the possibility of a role for prolonged extreme exertion. I accept Dr Heath's opinion which appears to properly

²⁷ Exhibit C15a

²⁸ Exhibit C9 at [17]

²⁹ Exhibit C10 at [13]

³⁰ Exhibit C9 at [19]

³¹ Exhibit C10 at [18]

³² Exhibit C2 at 2

³³ Exhibit C3 at 2

reflect the evidence. I enter a finding that Mr Blignault's death was brought about from the cause Dr Heath has described.

Assessment of the issues arising

Incident at home

- 29 In relation to the incident at home on 3 June 2023, I am satisfied that it was not causative and did not contribute to Mr Blignault's death. The only ongoing issue that arose during this incident was that Mr Blignault had a fractured leg. Surgery was performed and this was healing by the time of his death.
- 30 Having viewed the bodycam footage of the incident, I am satisfied that the members of police and the paramedics involved approached Mr Blignault's case with the care and compassion that one would expect of a modern healthcare system. In particular, the discussions between them as they were planning how to approach Mr Blignault were calm and respectful. It was evident to me that their approach was toward de-escalating the situation in the safest way possible, and that they had a clear focus on getting Mr Blignault the help that he needed. I am satisfied that Mr Blignault was not treated as though he posed a threat and that the discussions had been with Mr Blignault's best interests in mind. In particular, the language used by the member of police who entered first was calm in tone and content. He said 'Stay where you are, we'll come to help you' and 'What's happening, what do you want to talk to me about?'³⁴
- 31 While it is true that Mr Blignault's leg was broken during the event, this appears to have been a completely accidental and unintended consequence. The team appeared to plan for the possibility of bringing Mr Blignault to the ground after sedation, but not suddenly. I highlight that part of the plan involved removing as much broken glass as possible while Mr Blignault was being sedated. This demonstrates a clear intention to minimise any harm to him. The risk of him falling suddenly and awkwardly and breaking his leg does not appear to have been specifically identified, but was not a specific event that was *likely* to happen. I am therefore not critical of the fact that this was not discussed prior to intervening in a manner that was planned for general safety. In any event, I am satisfied that the team did not use excessive force or any inappropriate manoeuvres in restraining Mr Blignault. They appeared to have responded to a dynamic situation appropriately. Further, once the injury was identified it was quickly addressed.
- 32 Having viewed the bodycam footage objectively and read the accounts of those involved, I am unable to find anything inappropriate about the events of 3 June. I am satisfied that an appropriate level of care and compassion was brought to the task.
- 33 Mr Blignault's family provided the Court with a proposed protocol for how a person with disability should be dealt with in a situation like Mr Blignault's. I did not explore this in detail because, as I have explained, the incident on 3 June did not contribute to the cause of Mr Blignault's death. I observe that these situations are complex and highly varied, making it difficult to suggest anything more than general principles of care and compassion, which are already entrenched in emergency services training.

³⁴ Exhibit C15c

Incident at hospital

- 34 In relation to the incident in hospital that led to Mr Blignault's death, I start with the acknowledgment that Mr Blignault's behaviours were a feature of his progressing Huntington's disease. These behaviours required medication. Without medication, his behaviours would not have been possible to manage, as was demonstrated during the incident at home. In short, it was not possible to leave him unmedicated. While it appears that in hospital Mr Blignault was experiencing a dystonic reaction associated with the medications he was on, these were necessary and the most appropriate precise combination was being explored. The administration of the medications was overseen by a consultant-level doctor who had drawn up a formal plan for Mr Blignault's care which supported the medication decisions of his psychiatrist.
- 35 Mr Blignault then suddenly developed a presentation that made it impossible to provide him care. Staff at the Royal Adelaide Hospital made every effort to stabilise Mr Blignault in the face of the ferocity of his movements. This took some time to achieve. His ongoing movements in the meantime led to physical exertion, and rhabdomyolysis and lactic acidosis developed. That was identified as soon as restraints were able to be applied and it became safe to perform blood testing. Doctors then endeavoured to reverse these conditions, but without success.
- 36 In light of the sequence of events, I find that there is no criticism to be made of the approach of the staff at the Royal Adelaide Hospital who were clearly trying to deal with a difficult situation as best as they could.

Detention

- 37 As I have described, Mr Blignault was under an Inpatient Treatment Order at the time the lactic acidosis and rhabdomyolysis that caused his death arose. This means that his death fulfils the criteria of a 'death in custody' under the *Coroners Act 2003*. This can be a particularly difficult label for a family to deal with, especially where the person under the order lived a wholly law-abiding life. I wish to make it clear that, while his death fits within the statutory criteria of a death in custody, Mr Blignault was not detained due to any wrongdoing. He was exhibiting behaviours that were a consequence of his longstanding genetic neurodegenerative disorder, likely combined with the effects of medications used to manage those behaviours. These behaviours gave rise to the need for an order to compel necessary treatment.
- 38 A doctor with authority under the *Mental Health Act 2009* had exercised powers to detain Mr Blignault at the time of his death. Given the circumstances leading up to that decision, it was clearly properly made and was necessary to address Mr Blignault's presentation. Without treatment being provided, Mr Blignault was at risk. Provision of that treatment could not be achieved voluntarily. There can be no criticism of the decision to order Mr Blignault's detention for that purpose. I find that Mr Blignault was therefore lawfully in detention at the time of his death.

Recommendations

- 39 In light of the evidence and my assessment of the issues, I consider that there are no recommendations that can or should be made in this matter.

Condolences

- 40 Mr Blignault was clearly a loved member of his family. I observed that, following his Huntington's diagnosis and the progression of his disease, Mr Blignault's family continued to ensure that he lived a full life and that he participated in activities that were meaningful to him. Achieving this takes a great deal of effort and the fact that it occurred demonstrates the regard with which Mr Blignault was held by his family. I observed that high level of care to continue in the way in which his family participated in this inquest, which included Mr Blignault's brother addressing the Court about him. The consequence of holding someone in such high regard and caring for them so deeply is that their loss is all the more significant. I acknowledge their loss. I convey my sincere condolences to Mr Blignault's family and friends.