MAGISTRATES COURT TASMANIA

# MAGISTRATES COURT *of* TASMANIA

## CORONIAL DIVISION

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# Record of Investigation into Death (Without Inquest)

*Coroners Act* 1995
*Coroners Rules* 2006
*Rule* 11

I, Simon Cooper, Coroner, having investigated the death of Gordon Arthur David Mitchell

**Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that**

a) The identity of the deceased is Gordon Arthur David Mitchell;

b) Mr Mitchell died in circumstances set out further in this finding;

c) The cause of Mr Mitchell's death was an acute myocardial infarct; and

d) Mr Mitchell died on 10 July 2019, at 79 Friend Street, George Town, Tasmania.

In making the above findings, I have had regard to the following information:

- Police Report of Death for the Coroner;
- Affidavits establishing identity and life extinct;
- Report – Dr Donald Ritchey, Forensic Pathologist;
- Records – Ambulance Tasmania;
- Medical Records – George Town Medical Centre;
- Coronary Angiogram Disc;
- Précis of medical records – Ms L Newman, Clinical Nurse Specialist, Forensic Pathology;
- Report - Dr Luke Galligan, Cardiologist – Hobart Heart Centre; and
- Report – Dr Anthony J Bell, Medical Advisor to the Coronial Division.

**Introduction**

Mr Mitchell's medical history included throat and tongue cancer (he was an ex-smoker), hypertension, hypothyroidism, gastro-oesophageal reflux and obesity.

**Circumstances of death**

On 5 July 2019, Mr Mitchell was taken by ambulance to the Emergency Department of the Launceston General Hospital (LGH). He had been unresponsive prior to transportation to hospital. At the Emegency Department (ED), he was diagnosed as having suffered an acute myocardial infarction. He underwent a procedure for the placement of a stent in an occluded right coronary artery. That procedure was successful.

Mr Mitchell was discharged from the LGH at approximately 4.15pm on 8 July 2019 with beta-blocker, double antiplatelet agents, statin and an angiotensin receptor blocker medications. On the way home, he developed chest pain, shortness of breath, and cold sweats. An ambulance met him at his home where paramedics found his heart rhythm was ventricular tachycardic. However, his rhythm reverted to sinus (i.e. normal) without any intervention on the part of paramedics. Nonetheless, he was transported urgently back to the LGH where upon arrival his heart rhythm again went into ventricular tachycardia.

Mr Mitchell was given anti-arrhythmic medication and admitted to the hospital's critical care area for monitoring. Initially, he appeared stable and his clinical observations were unremarkable. At a time not recorded in the LGH medical records, Mr Mitchell was discharged home on 10 July 2019, but collapsed and died at about 9.00pm that evening. He was only 54 years of age.

**Investigation**

The fact of Mr Mitchell's death was reported pursuant to the provisions of the *Coroners Act* 1995. His body was formally identified and then transported by mortuary ambulance to the Royal Hobart Hospital. At the Royal Hobart Hospital, the Tasmanian State Forensic Pathologist, Dr Donald Ritchey, performed an autopsy. Dr Ritchey expressed the opinion that the cause of Mr Mitchell's death was an acute myocardial infarct complicating advanced atherosclerotic coronary vascular disease. He found an enlarged heart with marked thickening of the wall of the left chamber of the heart in a pattern that was clear evidence of long-standing heart disease. I accept Dr Ritchey's opinion.

Given the circumstances of Mr Mitchell's death (following recent treatment in hospital and discharge home), his case was reviewed by the Coronial Division Medico Legal committee. That investigation and review involved his medical records being obtained and interrogated. A detailed précis of those records was prepared by Clinical Nurse Specialist, Ms L Newman. The Medical Advisor to the Coronial Division provided a report, as did highly experienced Cardiologist, Dr Luke Galligan.

All of the information from these sources has informed my findings and conclusion.

**Conclusion**

I am satisfied that Mr Mitchell's treatment and discharge on 5–8 July 2019 was appropriate. The surgical procedure appears to have been carried out competently and the decision to discharge cannot be criticised.

However, the same cannot be said in relation to his second presentation on 8–10 July 2019 and the decision to discharge him on 10 July 2019. It is evident that Mr Mitchell had suffered recent infarct. He suffered periods of ventricular tachycardia three days post infarction, something Dr Galligan considered to be a "much more threatening prognosis than ventricular arrhythmias occurring in the initial hours of infarction." The risk that this posed to his life appears not to have been recognised.

At the very least, Mr Mitchell should have been monitored in hospital for a longer period. There is a strong argument for the insertion of a defibrillator - something that does not appear to have even been considered.

So as to afford procedural fairness to the LGH, and indeed seek its assistance generally, the findings (along with Dr Galligan's and Dr Bell's reports) were sent to the LGH, in draft, on 26 November 2021, requesting any comment by 17 December 2021. Although the hospital indicated it would provide its comments by the requested date, it did not.

The whereabouts of any comments were followed up by Coronial Division Staff on 5 January 2022. In response, the LGH sought an extension of time. I granted a brief extension. However the LGH, through its Executive Director of Medical Services – North, indicated it would "not be able to provide feedback on [the draft] findings."

Accordingly, I have proceeded to determine the matter in the absence of any further material or submissions from the LGH.

**Comments and Recommendations**

In his careful and comprehensive review of the circumstances of Mr Mitchell's death, Dr Galligan observed that access to specialist cardiological advice and intervention is not routinely available in rural Australia, Launceston included. He suggested that "with modern technology it would be relatively easy to have a system where an immediate review of patients' ECGs and clinical scenario [is] provided by one or two cardiologists covering the whole country after hours." National arrangements for cardiological (or other specialist medical) review are not within my jurisdiction, however I **comment** that I consider there is much to be said for such an arrangement being implemented in this State.

I convey my sincere condolences to the family and loved ones of Gordon Arthur David Mitchell.

**Dated** 28 January 2022 at Hobart in the State of Tasmania.

**Simon Cooper**
**Coroner**