



# 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, Leigh Mackey, Coroner, having investigated the death of Susan Fay Mitchelmore

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

- a) The identity of the deceased is Susan Fay Mitchelmore (date of birth 6 September 1952). At the time of her death Ms Mitchelmore was subject to a Treatment Order (TO) issued under the *Mental Health Act 2013* (MHA). The existence of the TO gives rise to the question of whether an inquest is mandatorily required as part of the investigation into her death by the operation of s 24 of the *Coroners Act 1995* (the *Act*). I consider this question later in these findings. Ms Mitchelmore resided at Uniting Age Well Strathaven (RACF) and had a medical history which included chronic obstructive pulmonary disease, ischemic heart disease, hypertension, type 2 diabetes and bipolar affective disorder.
  
- b) Ms Mitchelmore became a resident at the RACF on 18 January 2023 when she was transferred from the Royal Hobart Hospital where she had been an inpatient since 23 November 2022 due to hypoglycaemic seizure, functional decline and recurrent falls at home. On arrival she was assessed by the RACF as a medium falls risk. She experienced balance and mobility deficits, cognitive and vision impairments and significant health comorbidities as outlined earlier in these findings. She mobilised using a 4-wheel walker or wheelchair for longer distances however could be impulsive and ambulated at times without using a walking aid.

Fall mitigation strategies in place for Ms Mitchelmore at the RACF included a clutter free room, mobility aid, call bell, low bed height, hip protectors, night light, physiotherapy balance and mobility assessments, and continency management and aids. Ms Mitchelmore was subjected to ongoing regular falls assessment reviews whilst resident at the RACF. A clinical nurse specialist, Mr Kevin Egan, reviewed the RACF records with particular focus on the falls assessments and prevention strategies

undertaken in respect of Ms Mitchelmore. Mr Egan noted that fall prevention can be difficult in respect of residents who are impulsive or who lack insight and found no issues of concern.<sup>1</sup> I accept his opinion and find that suitable assessments and strategies to mitigate Ms Mitchelmore's falls risk were in place at the RACF and that her falls at the RACF were likely the result of her impulsivity and failure to utilise the mobility resources available to her.

Ms Mitchelmore fell three times whilst resident at the RACF. She fell on 11 June 2023 whilst getting into bed and suffered minor bruising. She fell again on 26 June 2023 in her room. She was not using her 4-wheel walker and suffered minor abrasions to her back. Ms Mitchelmore's third fall at the RACF occurred on 6 July 2023. The fall was not witnessed and occurred in her room. Because of this fall Ms Mitchelmore suffered a right neck of femur fracture, was transferred from the RACF to the Royal Hobart Hospital (RHH) and underwent surgical fixation of the fracture by the insertion of a dynamic hip screw. Ms Mitchelmore's post operative recovery was complicated by her experience of delirium, reduced oral intake and increased respiratory effort. In discussion between her family and treating team Ms Mitchelmore's goals of care were changed to end-of-life care, she was commenced on a syringe driver and died. The decision making and communication around the transition to end-of-life care involved Ms Mitchelmore's family, was appropriate and reasonable.

- c) Ms Mitchelmore's cause of death was pneumonia and post surgical course following the repair of the fracture to the neck of her right femur which included delirium.
- d) Ms Mitchelmore died on 25 July 2023 at Hobart, Tasmania.

In making the above findings I have had regard to the evidence gained in the investigation into Ms Mitchelmore's death. The evidence includes:

- The Police Report of Death for the Coroner;
- Affidavit as to identity;
- Opinions of the forensic pathologist;
- TASCAT 180 day review of treatment order;

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<sup>1</sup> Report Kevin Egan RN, Crit Care Cert, MApp/Mgt (Nursing) dated 19 April 2024.

- Report Kevin Egan RN, Crit Care Cert, MApp/Mgt (Nursing) dated 19 April 2024;
- RACF falls questionnaire response and records; and
- Medical records of the Tasmanian Health Service and Empower Life Older Persons Health.

### **The Treatment Order**

In January 2022 Ms Mitchelmore experienced a decline in her mental health. She exhibited erratic and risky behaviours and held delusional beliefs. She was taken to the RHH by ambulance on referral from her psychiatrist for relapse of bipolar disorder. She was admitted to the RHH from 21 January to 9 February 2022. She was noted to be irritable and erratic, drinking alcohol and smoking cannabis. She was living with her son, Clayton, her nominated “carer” in dirty and chaotic conditions. Clayton assaulted her by slapping her and was intimidating and threatening toward carers attempting to enter the home, becoming a barrier to Ms Mitchelmore’s access to support services.

On 1 February 2022 Ms Mitchelmore became subject to a TO. The TO required her to take specified medication. The TO initially required her to be treated as an inpatient at the RHH, an approved facility, and was subsequently amended to enable community treatment in a residential setting when she was discharged from the RHH. The TO that was made by the Tasmanian Civil and Administrative Tribunal (TASCAT) pursuant to the MHA, was renewed on 27 January 2023 and was due to expire on 29 January 2024 unless renewed again. The TO was made as Ms Mitchelmore was assessed as being a risk to her own safety and to that of others. Specifically, she was experiencing symptoms of mania and was non-compliant with medication that had been prescribed for her bipolar affective disorder.

The RHH is an approved facility under the MHA. The approval is not confined to a specific ward or unit and covers the entire facility. Whilst an inpatient at the RHH pursuant to the TO Ms Mitchelmore was located at and treated by the Mental Health Inpatient Unit and team. At the time of her discharge, it was considered unsafe for her to return to her home with Clayton, and she was discharged initially to Mistral Place awaiting a bed at the Roy Fagan Centre. She remained at Mistral Place from 9 February to 7 March 2022 when, due to her stability and compliance with multiple periods of overnight leave, the decision was made to discharge her back home. She remained in the community, aside from hospital admissions at the RHH for chronic obstructive pulmonary disease, hyperglycaemia, falls and cognitive and functional decline until her transfer to the RACF on 18 January 2023.

On 27 June 2023 a psychiatric assessment of Ms Mitchelmore was conducted at the RACF for the purposes of TASCAT's 180-day review of the TO. Whilst the bipolar disorder was found to be in remission, Ms Mitchelmore was considered to still meet the criteria for a TO. It was noted that she had not experienced a manic episode for over a year and it was recommended that her dosage of olanzapine be reduced with a view to the taper, and ultimate cessation of the medication.

Upon Ms Mitchelmore's return to the RHH because of her fall at the RACF in July 2023, the TO was not varied to identify the RHH as the treatment setting for her mental health condition.

### **The nature of the inpatient stay in July 2023**

Upon her transfer by ambulance from the RACF to the RHH following the 6 July 2023 fall, Ms Mitchelmore was admitted to the orthopaedic unit and underwent surgical fixation of her neck of femur fracture. Her post-surgical course was complicated by the experience of symptoms of delirium and dementia.

On 13 July 2023 she was transferred from the orthopaedic unit to the older Person's Unit at the RHH where she was reviewed by psychiatrists, who noted a fluctuating mental state and likely persisting delirium in the context of bipolar disorder and cognitive impairment. The engagement with and assessments by psychiatrists does not change the character of Ms Mitchelmore's admission at the RHH and is explicable by her experience of delirium. She was not compelled, other than through the need for inpatient orthopaedic care, to be at the RHH. She was not detained at the RHH under the TO. Her post-surgical condition, including the experience of delirium and psychiatric review did not alter the character of her stay to an admission under the MHA and an admission required by the TO.

### **Is an inquest mandated in the circumstances of Ms Mitchelmore's death?**

An inquest is required to be held as part of the investigation of a reportable death if the deceased was immediately before the death held in care (s 24). The exceptions to this requirement provided for in s 25 of the *Act* do not have application to the circumstances of Ms Mitchelmore's death. A person held in care is defined in the *Act* to include, inter alia, a person detained or liable to be detained in an approved hospital within the meaning of the MHA (s 3).

Immediately preceding and up to the time of her death Ms Mitchelmore was subject to a TO issued by TASCAT. The RHH is an approved facility under the MHA. Ms Mitchelmore was transferred from the RACF to the RHH for the purposes of treating

the fracture to her right neck of femur. The question accordingly arises as to whether her presence at the RHH as an inpatient to receive treatment for a physical injury unrelated to the conditions that underpin the TO nevertheless renders her to be a person detained in an approved facility and as such a person held in care under the Act and who's death must be investigated by inquest.

In *IB* (2025 TASCDC 332) [2025] TasCorC 33 I considered the circumstances of a patient under a TO who was receiving treatment in a community setting and concluded that the textual, contextual and purposive meaning of the words "*liable to be detained*" did not extend to cover a person compelled to receive treatment under a TO in a community setting unless and until the matters required under ss 47 and 47A of the MHA to authorise detention under a TO existed:

*"the power to detain under the Mental Health Act 2013 only arises when, those matters identified in sections 47 and 47A as required before the detention of a patient in an approved hospital can occur, have been satisfied. The making or varying of a Treatment Order to one requiring community treatment and accommodation, does not of itself give rise to a liability for a patient to be detained. It is the variation of the Order under section 47 of the Mental Health Act 2013 to an order requiring detention at an approved hospital or the belief of the need for admission to an approved hospital by the treating practitioner arising from the reasonable likelihood of harm to the patient or others under sections 47 and 47A that gives rise to the liability to be detained under section 42 of the Mental Health Act 2013".*

The reason for Ms Mitchelmore's presence as an inpatient at the RHH was entirely divorced from the TO. The mere fact of her voluntary attendance at the RHH for treatment of her physical injuries did not change the character of her attendance to one of detention under the TO nor was Ms Mitchelmore a person in respect of whom the circumstances required by ss 47 and 47A of the MHA existed and was on that basis liable to be detained. I find that Ms Mitchelmore was not a person detained nor liable to be detained at an approved facility at the time of her death pursuant to the terms of the TO and MHA.

Having found that Ms Mitchelmore was not a person detained nor liable to be detained she was not a person under care within the meaning of the Act and an inquest is not mandated in the circumstances of her death. This leaves the question as to whether an inquest should nevertheless be held because it is desirable to do so. The cause and circumstances of Ms Mitchelmore's death are apparent on the evidence. The holding of an inquest will not further elucidate those matters and on that basis I find

that it is not desirable to hold an inquest as part of the investigation into Ms Mitchelmore's death. Ms Mitchelmore's senior next of kin have been notified in accordance with the *Act*, s 26, of the decision not to hold an inquest into Ms Mitchelmore's death.

### **Comments and Recommendations**

The circumstances of Ms Mitchelmore's death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I convey my sincere condolences to the family and loved ones of Ms Mitchelmore.

**Dated:** 12 December 2025 at Hobart, in the State of Tasmania.

**Leigh Mackey**  
**Coroner**