



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 10th, 11th and 13th days of May 2011, the 26th day of July 2011 and the 26th day of October 2012, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Paul Laurie Mitton.

The said Court finds that Paul Laurie Mitton aged 32 years, late of 7 Seaview Court, Morphett Vale, South Australia died at Flinders Medical Centre, Flinders Drive, Bedford Park, South Australia on the 19th day of January 2009 as a result of hanging. The said Court finds that the circumstances of his death were as follows:

1. Introduction and cause of death

1.1. Mr Paul Laurie Mitton died on 19 January 2009 at the Margaret Tobin Centre in the Flinders Medical Centre. He was aged 32 years at the time of his death. An autopsy was carried out by Professor Byard of Forensic Science South Australia who gave the cause of death as hanging¹, and I so find.

2. Reason for Inquest

2.1. At the time of Mr Mitton's death he was subject to a detention order which had been made at the Noarlunga Health Service two days earlier. Accordingly, his was a death in custody and this Inquest was held as required by section 21(1)(a) of the Coroners Act 2003.

¹ Exhibit C2a

3. Background

- 3.1. Mr Mitton had no history of mental illness prior to a motor vehicle accident in 2001. He had been a qualified carpenter and was married with two children. In September 2001 he was involved in a motor vehicle collision as a result of which he suffered a closed head injury. Despite a remarkable recovery he was left with damage to his eyes and his balance. He also suffered from depression following the accident. The following year he was diagnosed with bipolar disorder. Thereafter he experienced periods of calm but also periods of mania requiring hospitalisation, sometimes under detention.

4. Mr Mitton's detention

- 4.1. On 16 January 2009 Mr Mitton took an overdose of diazepam tablets and consumed a quantity of alcohol. He was taken to the Noarlunga Hospital for medical evaluation. An assessment could not be carried out that evening because of his sedation. He was seen the following morning for a medical clearance. However, at approximately 7:30 that morning he left the hospital without informing medical or nursing staff. Nursing staff contacted his family and the police were alerted. Mr Mitton's family located him and he accompanied them back to the Noarlunga Hospital later that morning². He was seen by a psychiatric registrar who considered him to be suffering from a major depressive illness and at high risk to himself with suicidal thoughts. Mr Mitton was detained under the Mental Health Act. After he was detained a psychiatric nurse in the Emergency Department undertook a mental health risk assessment. He was considered by the psychiatric nurse to be a high risk to himself with suicidal ideation. There were no available beds and Mr Mitton remained in the Emergency Department overnight for further assessment and treatment the following day.
- 4.2. On 18 January 2009 Mr Mitton was reviewed by a consultant psychiatrist for the purposes of confirming or revoking his detention. The psychiatrist, Dr McLachlan, gave evidence at the Inquest. Dr McLachlan confirmed the detention order. Dr McLachlan said that Mr Mitton expressed that he felt worthless, that he was experiencing suicidal ideation and was ambivalent about being alive. Dr McLachlan considered him to be acutely unwell and a significant risk to himself. Dr McLachlan felt that a locked ward would be the best place for Mr Mitton at that time and made

² 17 January 2009

arrangements for him to be transferred to Ward 5J at the Margaret Tobin Centre. Dr McLachlan was aware that Mr Mitton had been subject to a nursing special the previous evening and therefore had been the subject of constant observation. He gave evidence that he understood that Ward 5J was a closed psychiatric ward designed to ensure the safety of acutely unwell people. He understood that it had a higher nursing ratio to deal with the acuity of the condition of patients who were housed there. Dr McLachlan did give evidence that he had no particular expectation that Mr Mitton would have a nurse special in the Margaret Tobin Centre but that he would have expected that a risk assessment would be completed upon his admission to that ward³.

- 4.3. Mr Mitton arrived at the Margaret Tobin Centre, Ward 5J, shortly after midday on 18 January 2009.
- 4.4. Upon his admission to the Margaret Tobin Centre, Mr Mitton should have been subjected to a risk assessment and a nursing observation assessment as part of what was described as the admission pack. The risk assessment document was never completed at all. The nursing assessment document was only partially completed. The progress notes contain only one progress note entered by Enrolled Nurse Higgins to the effect that at 1515 hours Mr Mitton was compliant with nursing requests but his mood was flat, he was very depressed and he stated that he was disappointed that the overdose had not worked and was unhappy to be alive.
- 4.5. An on-call doctor attended at the ward to write up Mr Mitton's medication chart, authorising sodium valproate and olanzapine. The doctor did not see Mr Mitton, but that was apparently standard practice at that time and I make no particular comment about it. Mr Mitton was given some cream for his hands and he retired to his room at approximately 10pm. He was subjected to half hourly checks by nursing staff which was the standard default regime unless a higher level of supervision was ordered.
- 4.6. Thereafter half hourly checks were conducted until just before 1am. At that time a psychiatric nurse, Mr Riley, attempted to conduct a check on Mr Mitton but found his door to be locked and unable to be opened.
- 4.7. Mr Riley attempted to open the door and then noticed approximately 6 inches of what appeared to be bed sheet protruding from the top of it. Mr Riley and two other staff

³ Transcript, pages 39-40

members, Mr Lovegrove and Mr Semmens, attempted to force the door. They were unable to do so and so they cut the portion of the sheet protruding from the doorway and then used a screwdriver to force the remaining piece of sheet back through the door. They were then able to force the door open but experienced some resistance which was found to be due to Mr Mitton's body weighing against the door on the inside. Once the nurses gained entry to Mr Mitton's room they found a sheet wrapped around his neck. He was not breathing and had no pulse. CPR was commenced, a Code Blue was called at 0113 hours and, after approximately 40 minutes of resuscitation efforts, Mr Mitton was pronounced deceased.

- 4.8. On 18 January 2009 there were 6 patients on Ward 5J which was a 10-bed ward. The ward was fully staffed. The risk assessment form⁴ was completely blank and the nursing admission assessment⁵ was only partially completed. As a result, Mr Mitton was assigned the standard level of nursing observations, namely the observations at half hourly intervals. Mr Mitton was in the Margaret Tobin Centre for between 12 and 13 hours prior to his death. Given the fact that the ward was only just over half full and yet fully staffed, it is surprising that the admission documents for Mr Mitton were not completed during that period. However, the progress note made by Ms Higgins was reasonably comprehensive and its text was picked up in the handover document which was passed over to the nightshift⁶.
- 4.9. I should also say that the staff at the Margaret Tobin Centre had the benefit of the documentation which had been completed at the Noarlunga Health Service. In particular, these included the original detention order and also Dr McLachlan's confirmation of detention document⁷. The first of these referred to Mr Mitton's overdose with suicidal intent two days prior, reference to him leaving the hospital prior to being assessed and the continuation of depressive symptoms and active suicidal intentions. The confirmation of detention document stated that the basis for confirmation was that Mr Mitton was depressed, hopeless about his future and had suicidal ideation. That document also referred to the suicide attempt and to Mr Mitton having absconded from the Emergency Department against medical advice. Dr McLachlan also completed a Form 8 transfer of detained patient document and that referred to the need for Mr Mitton to be admitted to a closed ward due to the high

⁴ Exhibit C28

⁵ Exhibit C28

⁶ Exhibit C35a

risk of absconding in the context of risk to himself. All of these documents made the situation reasonably clear, and whether or not there was an appropriate risk assessment and nursing assessment upon admission to the Margaret Tobin Centre, it should have been clear to all concerned that Mr Mitton remained a high risk to himself. This could only have been reinforced by the nursing note by Ms Higgins that his mood was flat, he was very depressed and had stated that he was disappointed that the overdose had not worked and was unhappy still to be alive. That information was also conveyed in the nursing handover sheet⁸. In all the circumstances, it is difficult to see that even if the documentation to which I have referred had been duly completed, any greater level of observation would have been carried out upon Mr Mitton that night.

- 4.10. Mr Riley was, as I have said, one of the nightshift nursing staff. He gave evidence that he spoke to Mr Mitton at about 8pm in the general ward area and that Mr Mitton appeared to him to be fairly relaxed. Mr Riley and Mr Mitton talked about Mr Mitton's hands which were sore and Mr Riley offered to provide him with some cream to assist. Mr Riley recalled that Mr Mitton later attended the nurse's station to obtain some cream. Mr Riley regarded this as a positive factor in that Mr Mitton was taking some positive action in relation to his own wellbeing which was suggestive of forward planning and thinking about his life. Mr Riley said that he did not perceive any potential for Mr Mitton to commit suicide. It was Mr Riley's opinion that a nurse special was not required.

5. The root cause analysis following Mr Mitton's death

- 5.1. A root cause analysis was conducted as a result of Mr Mitton's death⁹. Most notable of the recommendations arising from that process is recommendation 5 which states that all Ward 5J patients must be on close observation and should be observed irregularly every 15 minutes¹⁰. This is a regime of observations which is twice as intense as those that were applied to Mr Mitton. Had Mr Mitton been observed at that level of frequency it is possible that his death may have been avoided. It appears to me that this in itself is an acknowledgement by the Southern Adelaide Local Health Network that, at least implicitly, Mr Mitton's supervision was inadequate.

⁷ Exhibit C28

⁸ Exhibit C35a

⁹ Exhibit C33

¹⁰ Exhibit C33

- 5.2. Nevertheless, the change to 15 minute observations is a prudent decision by Southern Adelaide Local Health Network and I hope that it will be maintained.
- 5.3. The evidence has also shown that following Mr Mitton's tragic death, changes have been made to the physical environment of Ward 5J. There are now 8 beds as opposed to 10 so that the 2 beds furthest from the nurse's station have been eliminated. CCTV cameras are now in place to monitor many parts of the ward from the nurse's station. Very importantly, substantial changes have been made to the doors used in the ward. According to the evidence of Mr Regter¹¹:

'The solution adopted was to have a door within the door installed that swings outward and can therefore be opened by staff from the outside when the main door is closed ... each of the ... doors was replaced during the period February to March 2009. The new doors were constructed off-site and incorporated a new design of door handle that is intentionally shaped to thwart an attempt to anchor a ligature on it.'¹²

- 5.4. I commend these changes. I am satisfied that the difficulties encountered by the nursing staff in attempting to gain access to Mr Mitton in this case would not occur in a similar situation in future as a result of this initiative.
- 5.5. I note also that as a result of the root cause analysis recommendations were made and accepted for the implementation of a new risk assessment policy. The assessment is now conducted online using the CBIS system. As a result, all clinical staff in Ward 5J can call up the risk assessment online on a computer terminal without needing to see the medical notes.

6. Recommendations

- 6.1. As a result of the changes which I have referred to, and other changes which I have not specifically mentioned but can be found in the evidence as a result of the root cause analysis, I do not consider that it is necessary to make any recommendations in this case. Nevertheless, it is plain that Mr Mitton's death was preventable and one would certainly not expect a person in a high level intensive psychiatric unit to harm himself in this manner. It was certainly the expectation of Mr Mitton's family that he no longer remained a risk to himself. His family had the opportunity to ask questions through a spokesperson in the course of the Inquest. The family felt that Mr Mitton was not cared for as well as he should have been. I think this has been implicitly

¹¹ Exhibit C37

¹² Exhibit C37, page 6

acknowledged by the changes that have been made as a result of the root cause analysis following Mr Mitton's tragic death. The family's representative did indicate during closing submissions that the Inquest had afforded an opportunity to provide answers to some of the questions that they have been pondering. It is my hope that the family has gained some sense of comfort from hearing the evidence in this case.

Key Words: Suicide; Psychiatric/Mental Illness

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

Seal the 26th day of October, 2012.

State Coroner