



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 4th and 5th days of December 2012, the 15th day of April 2013 and the 19th day of August 2013, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of William Edward Hunt.

The said Court finds that William Edward Hunt aged 62 years, late of Yatala Labour Prison, Peter Brown Drive, Northfield, South Australia died at the Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 21st day of March 2010 as a result of chronic congestive cardiac failure due to severe aortic valve stenosis and incompetence, and cardiomyopathy. The said Court finds that the circumstances of his death were as follows:

1. Introduction and reason for Inquest

- 1.1. The deceased, William Edward Hunt, died on 21 March 2010. He was 62 years of age. Mr Hunt was convicted of murder in December 2001. For this he was sentenced to life imprisonment with a non-parole period of 15 years backdated to 25 November 2000.
- 1.2. He underwent his incarceration in a number of different institutions operated by the Department for Correctional Services. Specifically, he was incarcerated at the Mobilong Prison between 19 April 2006 and 24 October 2008. He was then transferred to the Cadell Training Facility. He remained at Cadell until 16 February 2010 when he was transferred to the Yatala Labour Prison in connection with his

declining health. He remained at Yatala until his transfer to the Royal Adelaide Hospital (RAH) where he remained until his death on 21 March 2010.

- 1.3. Mr Hunt was still serving his sentence of imprisonment at the time of his death. Mr Hunt's death was therefore a death in custody as defined in the Coroners Act 2003. For this reason an Inquest into his death was mandatory.

2. Cause of death

- 2.1. Mr Hunt died at the Royal Adelaide Hospital from heart disease. This disease had been well understood clinically for several years. In the event a post-mortem examination of Mr Hunt's remains was not necessary. Mr Hunt's casenotes from the RAH were reviewed within Forensic Science South Australia by Dr Iain McIntrye and the forensic pathologist, Dr John Gilbert. The two medical practitioners concluded that Mr Hunt's cause of death was chronic congestive cardiac failure due to severe aortic valve stenosis and incompetence, and cardiomyopathy¹. Mr Hunt's physician at the RAH at the time of his death, Professor Stephen Worthley, told the Court in evidence that he agreed with that recitation of Mr Hunt's cause of death². An independent physician who was asked to review the matter of Mr Hunt's death, Associate Professor Bruce Davis, who provided a written report³ and also gave oral evidence in the Inquest, expressed no disagreement with the stated cause of death. Accordingly, I find that Mr Hunt's cause of death was chronic congestive cardiac failure due to severe aortic valve stenosis and incompetence, and cardiomyopathy.

3. Background

- 3.1. Mr Hunt's heart disease, albeit at a lesser degree of severity than that which would ultimately cause his death, was identified when Mr Hunt was a relatively young man. He had undergone a mitral valve replacement for rheumatic heart disease in 1978. Later in his life, and after nearly 3 years in prison, he was found to have aortic valve stenosis. This was confirmed on echocardiography in 2003. Mr Hunt became symptomatic in respect of his aortic valve stenosis in 2008. At the same time an enlarged heart was identified. Although he was treated with medication, it does not appear that surgery for an aortic valve replacement was seriously considered between 2003 and 2008. Had aortic valve replacement occurred at a time before Mr Hunt

¹ Exhibit C2a

² Transcript, page 58

³ Exhibit C25

became symptomatic, or at the time he first displayed symptoms in 2008, it is possible that he would have derived significant ongoing benefit from it, thus prolonging his life beyond the relatively young age of 62. He did not undergo any such surgery. By January 2010 it was recognised that he had been developing worsening symptoms related to his aortic valve disease. The diagnosis in January 2010 was that Mr Hunt had severe aortic stenosis with evidence of mild to moderate left ventricular dysfunction. Mr Hunt may have benefited from surgery for aortic valve replacement even as late as that point in time. However, Mr Hunt would deteriorate significantly within the next few weeks to the point where it became plain that surgery would no longer be appropriate for him on a risk / benefit analysis. On 19 February 2010 he was admitted to the RAH with evidence of severe left and right heart failure and secondary liver failure. In the event Mr Hunt died at the RAH on 21 March 2010.

- 3.2. In this Inquest I examined the quality and appropriateness of Mr Hunt's medical treatment whilst a prisoner with the corrections system in this State and investigated whether Mr Hunt's death in March 2010 could have been prevented and whether his life expectancy could have been improved.
- 3.3. It goes without saying that a prisoner serving a sentence of imprisonment should not be in any less favourable position as far as health care and is concerned than a person living within the general community who has access to the public health system in this State.

4. Mr Hunt's medical treatment while in custody

- 4.1. Mr Hunt's medical history during his incarceration was explained in the statement and oral evidence of Dr Peter Frost who is the Clinical Director of the South Australian Prison Health Service⁴. Dr Frost's statement sets out in some detail Mr Hunt's treatment and medical history from the time of his initial incarceration, but the Inquest was for the most part concerned with the situation as it stood between 2008 and March 2010 when Mr Hunt died.
- 4.2. It will be observed that because for the most part Mr Hunt was accommodated in country correctional institutions, his medical care was provided by privately practising medical practitioners pursuant to an arrangement with the SA Prison Health Service. Dr Frost did not at any time have personal involvement in or oversight of Mr

⁴ Exhibit C23

Hunt's medical treatment. As I understood the position, clinicians within SA Prison Health service do not necessarily have direct involvement in or oversight of an individual prisoner's medical management in cases where the prisoner is accommodated in country institutions. There is an issue as to whether such a situation promotes effective and proper continuity of care.

- 4.3. I have already alluded to the fact that it was in 2003 that Mr Hunt's aortic valve stenosis was identified for the first time. Ultrasound diagnosis in 2008 revealed that by then the aortic valve was moderately to severely narrowed with evidence of cardiac dysfunction and moderate heart failure. Mr Hunt experienced symptomatology based for the most part upon his difficulty in breathing. The evidence seems to be clear that the most appropriate period for effective surgery to have taken place in respect of aortic valve replacement was between 2003 and 2008. Although Professor Worthley, who was to treat Mr Hunt in 2010, had no dealings with Mr Hunt in the 5 years between 2003 and 2008, he nevertheless offered the opinion in his witness statement⁵ that the best window of opportunity for treatment or intervention was in that 5 year period. Associate Professor Davis stated in his report⁶ that the best time to treat aortic stenosis is before symptoms develop and before the secondary effects on other structures of the heart have progressed. He was of the view that it is clear that that time was close to 2003 in Mr Hunt's case. The explanation as to why surgery was not contemplated within that period seems to be that Mr Hunt remained symptom free and that no specific intervention by way of surgery was thought to have been required.
- 4.4. In 2008 Mr Hunt was incarcerated in the Mobilong Prison. On 11 June 2008 Mr Hunt was sent by ambulance from Mobilong Prison to the Bridge Clinic at Murray Bridge after complaining of dyspnoea whilst exercising. He was diagnosed with congestive cardiac failure and was commenced on Lasix. A referral for an echocardiogram was sent to the RAH. On 18 June 2008 he was commenced on Tritace, another medication shown to be of benefit in treating cardiac failure. An appointment for an echocardiogram at the RAH was made for 13 August 2008. Although this would have necessitated Mr Hunt's transfer from Mobilong to the RAH, the appointment would not have required him to be accommodated overnight in a prison in Adelaide. However, come the day of the appointment, Mr Hunt refused to attend and so he was not transferred from Mobilong for this purpose. If any reason for his refusal was

⁵ Exhibit C24

⁶ Exhibit C25

elicited from Mr Hunt at the time, it was not recorded. During the course of this Inquest evidence was given to the effect that prisoners harbour a reluctance to be transferred from one centre to another for medical purposes due to a perception that they may lose privileges accumulated in their usual prison accommodation. Also there is a general aversion on the part of prisoners to be kept overnight at Yatala Labour Prison. As it happens, this very state of affairs was described to the Court in the context of another prisoner's medical treatment and subsequent death in custody⁷. There is no evidence that these considerations operated in respect of Mr Hunt's refusal to attend his echocardiogram appointment at the RAH on 13 August 2008. To my mind this explanation is unlikely having regard to the fact that Mr Hunt's examination at the RAH would not have required him to be kept overnight either within the hospital or at Yatala Labour Prison. It is likely he would have been returned to Mobilong on the same day. The fact that the reason for Mr Hunt's refusal was not recorded represents a lack of due rigour on the part of those responsible for Mr Hunt's clinical management at the time. In this case it has hampered the Court in assessing with any certainty such matters as whether or not Mr Hunt's reason for refusal may have been overcome by appropriate persuasion and medical advice, whether or not his lack of consent to be transferred was fully informed or whether his reason for not attending was so trivial that it may have been overcome by some other means such as re-scheduling. In the event Mr Hunt did not undergo important diagnostic measures in August 2008 and the Court is left in the position where does not know the precise reasons why this did not occur. This represents something of a missed opportunity for him to have been properly diagnosed and his true condition evaluated, and indeed a missed opportunity for appropriate surgical intervention to have taken place at that time.

- 4.5. I would suggest that whenever a prisoner refuses treatment, a thorough record of the prisoner's refusal and the medical advice that has been tendered, including advice as to the possible consequences of that refusal, be made at the time. Clinicians treating prisoners should bear in mind, especially in the case of elderly prisoners with serious illnesses, that some of these prisoners will die as a consequence of those illnesses and will do so whilst still in custodial circumstances and that their clinical management will be a matter that will be scrutinised by this Court by operation of law. I am informed that there is now a protocol in place to ensure that proper enquiry of a

⁷ Inquest into the death of Franklin Delano Miller (aka James Watson McKernan) – Inquest 32/2009

prisoner's refusal to attend for medical investigation or treatment occurs and that appropriate documentation is raised.

- 4.6. After August 2008 Mr Hunt experienced other symptoms that included chest pain, diaphoresis and significantly elevated blood pressure in February 2009. It was recorded that advice was given by a medical practitioner at the Waikerie Hospital that Mr Hunt should remain in the prison health centre for observation. It was recorded that Mr Hunt settled in an hour and a half and returned to his cell. He did not report chest pain again. This incident occurred when Mr Hunt was accommodated in the Cadell Prison.
- 4.7. On 19 December 2009 Mr Hunt complained of nocturnal dyspnoea and orthopnoea. A referral was sent to the Department of Cardiology at the RAH where he was seen by the cardiology Registrar on 25 January 2010. In a letter dated 25 January 2010 written by the RAH cardiology Registrar to clinicians at Yatala Labour Prison and the Adelaide Remand Centre, the Registrar reported Mr Hunt's worsening symptoms of exertional dyspnoea and orthopnoea together with several episodes of right upper quadrant pain. A bedside echocardiogram was reported to have shown mild to moderate left ventricular systolic dysfunction with a significantly lowered ejection fraction. This confirmed that by then Mr Hunt's aortic stenosis was severe. The letter reported that the Registrar had organised for Mr Hunt to undergo a coronary angiogram and a right heart study with Dr Peter Steele, a consultant cardiologist, 'in the upcoming weeks'⁸.
- 4.8. The situation that had developed in respect of Mr Hunt's health as at 25 January 2010, and what could and should have been done about it at the time, was the subject of controversy during the Inquest. The matter appears to have been left on the basis that in the fullness of time, and certainly not as a matter of urgency, Mr Hunt would undergo further examination and treatment as would be clinically indicated. In the event, things did not transpire with haste and in the coming weeks Mr Hunt deteriorated to a point where he was essentially beyond hope. The areas of controversy concern whether Mr Hunt should have had more urgent evaluation than what was contemplated in the letter of 25 January 2010, whether surgical intervention at that time was appropriate and whether it would have been of benefit to Mr Hunt and have prolonged his life.

⁸ Exhibit C22, page 40

- 4.9. As already alluded to, in the next few weeks following 25 January 2010 Mr Hunt's health took an unexpectedly rapid turn for the worse that left him with little prospect of surgery and therefore of survival. Associate Professor Davis' report concerning Mr Hunt's management dealt with Mr Hunt's situation in early 2010. Associate Professor Davis noted that a coronary angiogram that took place on 5 March 2010 demonstrated only minor coronary artery disease, which was naturally a matter in Mr Hunt's favour. He said it was to be assumed that this examination was part of an assessment for aortic valve replacement surgery and of that there can be little doubt. In that report Associate Professor Davis did not express any view that the necessary examinations and surgery could have or should have occurred urgently following the appointment of 25 January 2010. However, in his oral evidence before the Court Associate Professor Davis expressed the opinion that it is possible that if in January 2010 Mr Hunt had been admitted on an urgent basis, he may not have succumbed to his final and fatal deterioration. He said he could not be certain about that as a number of other factors needed to be taken into consideration⁹. For instance, he did acknowledge that there was no evidence, such as may have been revealed by blood tests, to indicate Mr Hunt's level of renal or hepatic function and that this would be a matter that would also have been needed to be taken into consideration when surgery was contemplated. Associate Professor Davis also acknowledged that much would have depended at that time upon Mr Hunt's own attitude to surgical intervention¹⁰. Nevertheless, Associate Professor Davis suggested that there was a need to have acted with haste in late January 2010¹¹. On a risk / benefit analysis, Associate Professor Davis suggested that Mr Hunt's risk of surgery was probably of the order of 15% to 20% as at 25 January¹². Further, he opined that if aortic valve replacement surgery had then been successfully conducted, Mr Hunt's life expectancy would probably have been better than 50% at 5 years¹³.
- 4.10. Associate Professor Davis was cross-examined by Ms Karpinski¹⁴ as to whether Mr Hunt's rapid decline following 25 January 2010 could have been predicted. In answer Associate Professor Davis said this:

'We know he deteriorated. He had deteriorated by the time he was seen in outpatients on 25 January so we knew things weren't as good as they'd been over the previous period

⁹ Transcript, page 81

¹⁰ Transcript, page 85

¹¹ Transcript, page 86

¹² Transcript, page 87

¹³ Transcript, page 93

¹⁴ Counsel for the Central Adelaide Local Health Network and Professor Worthley

and he was more short of breath, so I think that's a sign of things were getting worse and no-one ever knows at what rate they are going to continue to deteriorate and, therefore, I think it is reasonable to assume that they would deteriorate further and it's a sign or an indication that it's time to move a bit more quickly and instigate the appropriate investigations and therapy.'¹⁵

- 4.11. Although Associate Professor Davis was clear in his evidence that rapid investigation and therapy was indicated as at 25 January, he did not go so far as to say that a decision not to perform immediate evaluation and surgery was wholly unreasonable.
- 4.12. In his oral evidence Professor Worthley did not deal in any detail with the question of the appropriateness of surgery as at the end of January 2010 as the issue had not, at that point of the Inquest, crystallised. However, after Associate Professor Davis gave evidence, Professor Worthley was invited to comment upon Associate Professor Davis' assertions that Mr Hunt may have been salvageable if surgery had taken place at that time and to deal with his suggestion that this should have been considered as a matter of some urgency. In an addendum statement¹⁶ Professor Worthley acknowledged that the coronary angiogram that was contemplated in the letter of 25 January 2010 was with a view to proceeding subsequently to surgery. While Professor Worthley agreed with Associate Professor Davis that the risk of surgery as at 25 January 2010 was approximately 20%, that may not be an accurate estimate because it was not known what Mr Hunt's renal function was at that time. He did agree with Associate Professor Davis that Mr Hunt's condition did deteriorate between 25 January 2010 and 19 February 2010 when Mr Hunt presented virtually in extremis but asserts that his deterioration, occurring as it did in a period of 3 to 4 weeks, was not foreseeable and that the delay was not unreasonable. He states:

'In my view, there was less than a 5% chance of deterioration to that extent within 3-4 weeks based on what was known as at 25 January 2010. In light of the symptoms displayed by Mr Hunt and the results of the echocardiogram on 25 January 2010, it is my view that it was a reasonable plan to do all the remaining tests when he was admitted.'¹⁷

Thus, while there is no material disagreement that in late January 2010 Mr Hunt may have benefited from aortic valve replacement surgery and that the risks were not prohibitive, Professor Worthley suggests that it was reasonable at that time not to have performed that surgery urgently and that it was not unreasonable for Mr Hunt's management to have involved waiting for a relatively short period of time. As seen,

¹⁵ Transcript, page 97

¹⁶ Exhibit C24a

¹⁷ Exhibit C24a

on this it must be said that Associate Professor Davis' evidence did not suggest in terms that the decision to wait and not perform urgent surgery was unreasonable; rather, he suggests that when the matter is viewed in hindsight, the surgery would optimally have taken place at that time. The Court observes that regardless of whether the delay was unreasonable or not, there is no evidence that there was any compelling reason to have delayed further evaluation.

5. Conclusions

5.1. The Court drew the following conclusions:

- The deceased, William Edward Hunt, died in the Royal Adelaide Hospital on 21 March 2010. The cause of death was chronic congestive cardiac failure due to severe aortic valve stenosis and incompetence, and cardiomyopathy;
- Mr Hunt was diagnosed with aortic valve stenosis in 2003. In 2008 it was recognised that this condition had become symptomatic. An appointment in August of that year for evaluation of his condition was not kept for reasons that are unclear except for a notation in Mr Hunt's clinical record that he refused to attend. It is also unclear as to whether what further medical evaluation was provided to Mr Hunt or what further opportunities for the same were provided to him;
- It is clear that Mr Hunt would have been a suitable candidate for aortic valve replacement between 2003 and 2008 in which year he became symptomatic, and indeed for some time after 2008. The evidence is not clear as to whether or not, following 2008, aortic valve replacement surgery was contemplated for Mr Hunt;
- Mr Hunt underwent a clinical evaluation in the Royal Adelaide Hospital on 25 January 2010. The severity of his heart condition was then recognised. I conclude that, notwithstanding that severity, he was still at that point a suitable candidate for aortic valve replacement surgery had it been performed at that time;
- It is not possible to determine by what magnitude Mr Hunt's life expectancy could have been increased as a result of aortic valve replacement surgery performed at that time;

- Mr Hunt presented effectively in extremis at the Royal Adelaide Hospital within a few weeks of 25 January 2010, by which time he was not a suitable candidate for aortic valve replacement surgery;
- I accept that Mr Hunt's relatively rapid decline between 25 January 2010 and 19 February 2010 could not have been wholly predicted. However, I accept the evidence of Associate Professor Davis that it would have been better if the question of aortic valve replacement surgery had been considered at a time sooner rather than later following Mr Hunt's evaluation on 25 January 2010.

6. Recommendations

- 6.1. Pursuant to Section 25(2) of the Coroners Act 2003 I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the Inquest.
- 6.2. The one matter that this case has illustrated is that due to the fact that prisoners are from time to time accommodated in different custodial institutions within the State, there is a tendency towards lack of continuity of care, illustrated by the fact that different medical practitioners are involved in the treatment of a serious chronic condition such as Mr Hunt's. This does not always provide an ideal medical service for a long serving prisoner. It occurs to the Court that in cases where a prisoner suffers from a serious chronic condition such as that suffered by Mr Hunt, such a lack of continuity of care might be overcome by clinicians in the Prison Health Service having oversight of a long-term prisoner's care. The undesirability of a lack of continuity of care occasioned by the fact that different privately practising medical practitioners provide services to the Prison Health Service in country custodial situations has been the subject of coronial comment in the past. I refer to the findings in the matter of the death of Franklin Delano Miller¹⁸. In that Inquest the Court made a number of recommendations designed to promote more effective continuity of care in respect of prisoners with severe chronic conditions. Some of those recommendations are apt in respect of the current circumstances as identified in this Inquest. I repeat the first such recommendation herein.

¹⁸ Inquest into the death of Franklin Delano Miller (aka James Watson McKernan) – Inquest 32/2009

- 6.3. I recommend that the Medical Director of the South Australian Prison Health Service assign to a senior medical officer or officers within the Service the responsibility of maintaining oversight of the medical treatment and investigation of those prisoners within institutions operated by the Department for Correctional Services who are suspected of suffering from a serious or life threatening illness, especially in circumstances where the medical treatment and investigation of such prisoners is being conducted by medical practitioners who are not employees of the Service.

Key Words: Death in Custody; Natural Causes

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

Seal the 19th day of August, 2013.

Deputy State Coroner