CORONERS ACT, 2003

SOUTH  *AUSTRALIA*

PRELIMINARY FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 24th day of March 2016 and the 5th day of April 2016, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Ian James Hunt.

The said Court finds that Ian James Hunt aged 82 years, late of Helping Hand, 2 The Strand, Mawson Lakes, South Australia died at Mawson Lakes, South Australia on the 26th day of February 2016 as a result of end stage dementia. The said Court makes the following preliminary findings:

1. Reason for Inquest

1.1. Mr Ian James Hunt was 82 years of age when he died at the Helping Hand Nursing Home at Mawson Lakes. At the time of his death Mr Hunt was the subject of orders pursuant to section 32 of the Guardianship and Administration Act 1993 (the Act). Included within the orders were the placement of Mr Hunt under the guardianship of his wife, Mrs Sylvia Hunt. In addition, there was an order that Mr Hunt be detained in such place as the guardian sees fit. In this case that place was the Helping Hand Nursing Home at Mawson Lakes. At the time of his death Mr Hunt was still under detention at the Mawson Lakes facility. This meant that pursuant to the provisions of the Coroners Act 2003, Mr Hunt's death was a death in custody in respect of which an Inquest into the cause and circumstances of Mr Hunt's death was mandatory.

2. Preliminary Findings

2.1. These are the preliminary findings of the Court in respect of Mr Hunt's death. The Inquest has been adjourned to a date to be fixed and for the substantive findings of the Court to be made.

2.2. A consequence of the requirement that a mandatory Inquest be held into Mr Hunt's death is that the cause of Mr Hunt's death is a matter that can only be the subject of a coronial finding in the context of that mandatory Inquest. In the normal course of events it is highly unlikely that this Inquest would have been commenced so soon after the death in question. On the other hand, if this matter had not as a matter of law been seen as a death in custody for which an Inquest was necessary, an administrative coronial finding as to cause of death could have been made within a short time following the death. Delays that are normally occasioned by the provision of a formal post mortem report do not exist in this case as a post mortem examination was not necessary in order to establish cause of death. The cause of death as expressed by Mr Hunt's general practitioner was considered to be accurate and acceptable. I will deal with that cause of death presently.

2.3. The reason for bringing this Inquest on early and at short notice is as follows. Ms Cacas, counsel assisting, has informed the Court that Mr Hunt's widow has been experiencing difficulty in gaining access to her late husband's superannuation fund or funds to which she is entitled, I assume, as a dependent. I have been informed by counsel assisting that the reason this difficulty has been experienced is that the superannuation fund or funds are insisting that they be provided with a formally documented cause of death in respect of Mr Hunt. For the purposes of the release of the superannuation entitlement, it appears that the requirement of a cause of death is to be distinguished from proof of the bare fact of Mr Hunt's death, a fact that is already well understood and well documented and in respect of which a death certificate[1] has been issued pursuant to the Births, Deaths and Marriages Act 1996. Section 37(4) of the Births, Deaths and Marriages Act 1996 empowers the Registrar, in relation to a death that has been reported to the State Coroner and in respect of which a finding as to cause of death has yet to be made, to issue a certificate certifying the fact of an individual's death. The certificate will not cite a cause of death. However, in the vast majority of cases reported to the State Coroner the cause of a deceased person's death is well established at an early point in time, is a cause that attracts no suspicion of foul play and is evidenced either by a clear report from a treating medical practitioner, as was the case here, a provisional post mortem report from a forensic pathologist or a pathologist's independent review of the person's medical history.

[1] Exhibit C8

2.4. It is the frequent experience of this jurisdiction to be told that in cases where a person's death has been reported to the State Coroner, access by a dependent to a deceased person's superannuation fund has been withheld or delayed until such time as a coronial finding is made into the deceased person's cause of death. This stance is maintained notwithstanding that a satisfactory cause of death is available, is one that does not involve foul play and is a cause that cannot be disputed. From time to time the Court is also told that payment of life insurance entitlements resulting from a reported death have been withheld or delayed pending a coronial finding as to cause of death. The advice to the holders of superannuation funds and to the writers of life insurance policies that a provisional cause of death is available typically falls on deaf ears. Complicating matters for the deceased's dependents in this case is the fact that a mandatory Inquest is necessary with the delay that this might also occasion.

2.5. In the past the State Coroner has made reference to these issues in his annual reports. I refer to the 2005-2006 annual report at paragraph 1.2, the 2008-2009 annual report at paragraph 4.7 and the 2013-2014 annual report at paragraph 4.6. In particular, the State Coroner has referred to the apparent unreasonableness of the withholding or delaying of life insurance access where a clear cause of death is available. I know of no response to these observations from the insurance industry. I note that the State Coroner's observations would appear to apply equally to the question of superannuation access.

2.6. Needless to say, the grief that a person might experience upon the death of a loved one on whom they were financially dependent can be compounded by delays in the finalisation of financial issues such as superannuation or life insurance access, especially where such access is withheld or delayed capriciously or for reasons that have no sensible basis in law, fact or logic.

2.7. This Court is not privy to the reasons why it is necessary for a formal finding as to cause of death to be made, as distinct from the fact of death, before access particularly to a superannuation entitlement can be made available to a dependent. If there is some relevant legislative requirement that is hidden from plain view within the labyrinthine federal legislation concerning superannuation and insurance, then the Court is not aware of it. This preliminary coronial finding acts as an invitation to any entity, including the holders of the superannuation fund or funds involved in Mr Hunt's case, to enlighten the Court as to these issues. In particular, if it is

suggested that certain causes of death might disentitle a dependent who would otherwise be entitled to a deceased's person's superannuation fund, the Court would like to hear about that in clear terms.

3. Cause of death

3.1. Mr Hunt's death was reported to the State Coroner by way of a written report compiled by Dr See Yeing Ooi who was Mr Hunt's medical practitioner. Dr Ooi reported the cause of death as end stage dementia. The reporting document's brief description of Mr Hunt's medical history and of the circumstances of the death supports that cause of death. As indicated above, a post mortem of Mr Hunt's remains was not necessary having regard to the clarity of Dr Ooi's report. A further detailed statement taken by police from Dr Ooi[2] describes Mr Hunt's medical history in more detail. It convincingly substantiates the assertion contained in Dr Ooi's original report that Mr Hunt's cause of death was end stage dementia. The witness statement of Constable Carly Formosa, one of the investigating police officers who attended at the Mawson Lakes facility following Mr Hunt's death[3], reveals that the circumstances surrounding Mr Hunt's death were not suspicious and that his death was expected. There were no visible signs of any injury upon the deceased.

3.2. It is plain, as it always has been, that Mr Hunt's cause of death was end stage dementia, and I so find.

3.3. I would only add at this point that this case appears to be yet another of the many examples seen in this Court of an unnecessary deployment of police and coronial resources occasioned by the fact that an Inquest into a death is mandatory by virtue of the deceased person's detention under section 32 of the Act. The cause of death in this case was clear from the outset, and as the investigation into this death currently stands it appears that this Inquest was, apart from its mandatory nature, wholly unnecessary. If the Inquest had not been mandatory it is likely that a conclusion would have been drawn that an Inquest was neither necessary nor desirable, and an administrative finding as to cause of death could expeditiously have been made. So far nothing unusual or questionable has been revealed about the circumstances of Mr Hunt's death that would warrant a mandatory Inquest. And it should be pointed

[2] Exhibit C3
[3] Exhibit C7

out that if there were such circumstances in existence, and an Inquest was not mandatory, the State Coroner would nevertheless have a discretion to hold an Inquest.

3.4. Similar observations have been made on occasions in the past both in the State Coroner's annual report and in the Court's findings[4].

3.5. Mr Hunt's case in particular also serves to illustrate that unwelcome and unnecessary consequences to a deceased person's family members can be occasioned as a result of the mandatory Inquest requirement.

3.6. It should not be thought that the early convening of an Inquest in circumstances such as these will be the norm. The circumstances here are exceptional in that this is a death in custody for which an Inquest is mandatory, is a case where the cause of death is immediately clear and a finding as to that issue can expeditiously be made and where demonstrable financial hardship might result if the matter was unduly delayed. The resumption of this Inquest will take place on a date to be fixed. There the circumstances surrounding Mr Hunt's death will be more closely examined and further findings will be made accordingly.

Key Words: Death in Custody; Section 32 Powers, Natural Causes

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 5th day of April, 2016.

Deputy State Coroner

[4] Most recently in relation to the death of James Angus Shirra – Inquest 36/2015