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, the 5th day of April 2016, the 11th day of April 2017 and the 18th day of May 2017, 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. Introduction

1.1. On 5 April 2016 the Court delivered its preliminary findings into the death of Ian James Hunt. Those findings were confined to the issue of Mr Hunt's cause of death. The Court found that the cause of death was end stage dementia.

1.2. At the time the Court delivered its preliminary findings, the Court's inquiry into the circumstances of Mr Hunt's death had not been completed. Police investigations to that point in time were still ongoing.

1.3. This was a mandatory Inquest due to the fact that Mr Hunt died while under the detention imposed upon him by section 32 of the Guardianship and Administration Act 1993. Due to financial hardship that was being experienced by Mr Hunt's widow as a result of the insistence on the part of financial institutions for coronial a finding as to cause of death, the Court had decided to commence this Inquest earlier than what might normally have been expected.

1.4. These are now the Court's findings into the circumstances of Mr Hunt's death. I add here that since the Court delivered its preliminary findings, nothing has arisen to suggest that the Court's original finding as to the cause of Mr Hunt's death, namely end stage dementia, requires revision. The Court here repeats its finding that the cause of Mr Hunt's death was end stage dementia.

2. The investigation into Mr Hunt's death

2.1. The investigation into the death of Mr Hunt was conducted by Brevet Sergeant Amanda Leray of the SAPOL Elizabeth Criminal Investigation Branch. Her investigation was extensive and her report is thorough and comprehensive.

2.2. It would be otiose to recite in any great detail the sad decline in Mr Hunt's mental faculties over a period of time. His decline was typical of that commonly associated with dementia. Suffice it to say that his mental incapacity was such that it necessitated the imposition of an order pursuant to section 32 of the Guardianship and Administration Act 1993 together with the special powers that mandated his detention at the Helping Hand aged care facility at Mawson Lakes.

2.3. Brevet Sergeant Leray investigated three broad issues as follows:

1) Whether the care and treatment of the deceased was appropriate whilst at Helping Hand Mawson Lakes;
2) Whether the guardianship order was valid and appropriate;
3) Whether the Guardianship Board's and Helping Hand Mawson Lakes' response to the order was appropriate.

2.4. Brevet Sergeant Leray's investigation revealed that until October 2013 Mr Hunt was living with his wife in their home at Salisbury East. Around that time he was diagnosed with vascular dementia. As a result he was admitted to the Valley View Residential Care facility for respite care.

2.5. Due to behaviour that he displayed at the Valley View facility, on 1 November 2013 Mr Hunt was admitted to Ward Q of the Royal Adelaide Hospital. On being admitted to the ward, Mr Hunt underwent a mental state examination as a result of which he was placed on an Inpatient Treatment Order.

2.6. In November 2013 an application for a guardianship order was made and this was granted by the Guardianship Board. It was this order that in effect imposed the

residential detention at the Helping Hand Mawson Lakes facility. Mr Hunt took up residence at that facility in January 2014. He remained at the facility until his death.

2.7. In November 2014 an amendment was made to the guardianship order. The amendment substituted Mrs Hunt as guardian. The detention order remained as was. On 30 March 2015 the order was confirmed by the South Australian Civil and Administrative Tribunal (SACAT) which by legislation assumed the powers of the Guardianship Board.

2.8. Mr Hunt resided in the Helping Hand facility from January 2014 until his death in February 2016. During that period, and due to his condition, Mr Hunt's behaviour unfortunately deteriorated. He was prescribed antipsychotic medication. Dr Martin Ooi, to whom I have referred in the Court's preliminary finding, was Mr Hunt's general practitioner and would visit Mr Hunt at the Helping Hand facility.

2.9. Mr Hunt's mobility started to deteriorate and from time to time he experienced falls. In December 2015 Mr Hunt suffered a fall following which he was taken to the Lyell McEwin Hospital for treatment. As a result of the fall Mr Hunt's medication regime was altered. On 16 September 2015 Mr Hunt was noted as continuing to fall due to mobility issues, mainly involving him rolling from his bed. Mr Hunt did not suffer any significant injuries. A number of measures were implemented to minimise the harm from falls. However, on 26 December 2015 there was another fall as a result of which a small intracranial bleed was sustained. A management plan was discussed and it was decided that he would be managed conservatively with no further brain scans to be conducted. The plan was implemented. On 28 December 2015 multiple non-essential medications were ceased. Further falls resulted in an increase to some of his medications.

2.10. In February 2016 Mr Hunt acutely deteriorated. He was not eating and was losing weight. A dietician assessed Mr Hunt and a protein supplement was added to his diet. Unfortunately Mr Hunt's condition continued to deteriorate and he became bedridden with very little response to stimuli and with no intake of food or fluids. It was agreed with his family that an end of life care plan should commence with the treatment of Mr Hunt being directed at relief of symptoms and promotion of comfort. This meant that no artificial measures designed to replace or support bodily function would be undertaken and that no resuscitation would be conducted in respect of him.

2.11. At 1am on 26 February 2016 Mr Hunt woke up moaning and restless. He was medicated with morphine. During the day Mr Hunt was continually monitored and medicated with morphine and pain relief. At about 3:32pm that day an enrolled nurse checked on Mr Hunt and noted that his respirations had ceased. A certification of life extinct was completed by Dr Sunil at 4:30pm. Mr Hunt died in the presence of his wife, Mrs Sylvia Hunt, his daughter and her partner.

3. Conclusions and recommendations

3.1. The investigating officer, Brevet Sergeant Leray, has expressed a number of conclusions in her report as follows; that the care of Mr Hunt at the Helping Hand Mawson Lakes facility was more than appropriate, that the orders pursuant to the Guardianship and Administration Act 1993 were appropriate and that the various responses to the orders of the Guardianship Board and SACAT were appropriate. Brevet Sergeant Leray states in her report that she has not identified any deficiency in the care and attention afforded to Mr Hunt whilst detained at the Helping Hang Mawson Lakes facility. Having examined all the evidence in this matter I agree with those conclusions and have nothing further to add.

3.2. There is no need to make any recommendations in this matter.

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 18th day of May, 2016.

Deputy State Coroner