



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 14th day of May and the 11th day of June 2020, by the Coroner's Court of the said State, constituted of Simon James Smart, Deputy State Coroner, into the death of Hugh Keightly Grundy.

The said Court finds that Hugh Keightly Grundy aged 65 years, late of St Paul's Lutheran Homes, 7 Braun Drive, Hahndorf, South Australia died at the Repatriation General Hospital, 216 Daws Road, Daw Park, South Australia on the 16th day of May 2017 as a result of general inanition on a background of advanced fronto-temporal dementia. The said Court finds that the circumstances of his death were as follows:

1. Introduction

1.1. Hugh Keightly Grundy was born on 7 February 1952 and died on 15 May 2017 at the Repatriation Hospital in Daw Park. He was 65 years old. Mr Grundy was formally identified by his wife, Wendy Rae Grundy, at Daw Park on 16 May 2017¹.

2. Cause of death

2.1. A pathology review was conducted by Dr Iain McIntyre from Forensic Science South Australia on 19 May 2017². Dr McIntyre found Mr Grundy died as a result of general inanition with advanced fronto-temporal dementia, and I so find. Dr McIntyre noted a history including tonic-clonic seizures, post-traumatic stress disorder, anxiety and depression, cerebrovascular accident, cholelithiasis and falls.

¹ Exhibit C1

² Exhibit C2, Pathology Review by Dr Iain N McIntyre dated 19 May 2017

3. Reason for Inquest

- 3.1. The South Australian Civil and Administrative Tribunal (SACAT) authorised a Level 3 Inpatient Treatment Order³ (ITO) in relation to Mr Grundy on 22 December 2016. That order was due to expire on 22 June 2017⁴. Mr Grundy was subject to a Level 3 ITO at the time he was moved to Ward 18 at the Repatriation General Hospital. Ward 18 is an Older Person's Mental Health inpatient facility at the hospital. In the terminal phase of his illness Mr Grundy was palliated with appropriate pain relief and medication and he was transferred to the Daw House Hospice at Repatriation General Hospital. When transferred the ITO was revoked on 12 May 2017 as Mr Grundy was moved for end of life care rather than mental health treatment⁵. Despite the death not occurring whilst under an ITO, Mr Grundy's death is still regarded as a death in custody as 'the death occurred, or the cause of death, or possible cause of death, arose, or may have arisen' whilst Mr Grundy was subject to an ITO. As such this is a mandatory inquest pursuant to Section 21(1)(a) of Coroners Act, 2003.

4. Background

- 4.1. Mr Grundy was married to Wendy Grundy and had been since 1983. They both had two children prior to their marriage. Mr Grundy was employed in educating farm trainees at Roseworthy College and TAFE. He involved himself in committees and Boards of clubs.
- 4.2. In 2002 the Grundy family moved to Callington and built a wind and solar powered house. Mr Grundy started the Alternative Technology Association of South Australia. On moving to that house Mr Grundy took a redundancy package. Mrs Grundy stated Mr Grundy became depressed and lacked motivation⁶. Mrs Grundy noted a decline in concentration and organisation.
- 4.3. In 2010 Mr Grundy was employed at Big W and a hatchery. Mrs Grundy said after a period at the hatchery it was clear something was not right. Mr Grundy was forgetful and had a short concentration span.

³ Pursuant to S.29 of the *Mental Health Act, 2009*.

⁴ Exhibit C7, Statement of Tahnee Harvey dated 25 August 2017

⁵ Exhibit C4, Statement of Doctor Alexandra Goldsworthy dated 31 October 2017

⁶ Exhibit C1, Statement of Wendy Rae Grundy dated 27 September 2017

- 4.4. In 2013 Mr Grundy went to his general practitioner and was diagnosed with frontal temporal lobe dementia. In 2015 Mr Grundy had his first seizure. Mrs Grundy considered Mr Grundy's aggression became worse.
- 4.5. On New Years 2015/2016 Mr Grundy suffered a stroke and required formal care. He was placed into an aged care facility at Karoonda. His aggression toward aged care staff was considered unacceptable. He was detained a number of times under the Mental Health Act and admitted to different hospitals.
- 4.6. Mr Grundy was not allowed to return to the aged care home in Karoonda. He was admitted to St Pauls Lutheran Residential Care Facility in a specialist secure dementia wing. He deteriorated further and his aggression and violence required his transfer to Ward 18 of the Repatriation General Hospital which is a secure high dependency ward. Mr Grundy was not communicative. He had no drive. He was moved to Daw House which is the hospice attached to the Repatriation General Hospital. On 16 May 2017, one week after his admission, he passed away. Mrs Grundy stated that over 400 people attended Mr Grundy's funeral⁷.

5. Mr Grundy's decline in health

- 5.1. Mr Grundy was a resident of St Paul's Lutheran Home Hahndorf from 16 August 2016. He had been diagnosed with early onset dementia. He was initially placed in the secure memory support unit. His initial gentle behaviour began to deteriorate around 20 September 2016. He would become upset once he realised he was being aggressive. A staff safety issue arose for the first time on 1 October 2016. Mr Grundy became physically aggressive on 8 October 2016. Mr Grundy was assessed at the Royal Adelaide Hospital and returned to St Paul's on 10 October 2016. On 13 October 2016 dementia behaviour specialists were engaged by St Paul's to assess Mr Grundy. Mr Grundy was transferred to the Flinders Medical Centre that day and remained there until 24 October 2016. On his return Mr Grundy became aggressive and was transferred to the acute mental health ward at Repatriation General Hospital on 25 October 2016⁸.
- 5.2. On 12 May 2017 Mr Grundy was transferred to Daw House after a long period of treatment at Flinders Medical Centre and Ward 18 at the Repatriation General Hospital. Mr Grundy's admission to Daw House was solely for end of life care. Mr Grundy was

⁷ Ibid

⁸ Exhibit C6, Statement of Melissa Pagliarulo dated 1 September 2017

unresponsive on admission to Daw House. Mr Grundy died on 16 May 2017⁹. Mr Grundy's death was certified by Doctor Luke Duffy at 4:15am.

6. Coronial investigation

- 6.1. Detective Brevet Sergeant James Page¹⁰, Senior Constable Lambert and probationary Constable Tobi Rienerts attended Daw House in the early afternoon on 16 May 2017 following Mr Grundy's death in accordance with standard procedures¹¹. Brevet Sergeant Craig Robertson attended Daw House at 1:38pm on 16 May 2017 and undertook a photographic examination in line with standard procedures¹².
- 6.2. Detective Brevet Sergeant Bradley Molony investigated the death in custody of Mr Grundy and prepared a comprehensive report¹³ for the State Coroner. Nothing of concern was noted during the police involvement and investigation.
- 6.3. I note that no concerns have been raised by the family members of Mr Grundy.

7. Conclusion and recommendations

- 7.1. I find that Mr Grundy's care and treatment at the Repatriation General Hospital and Daw House was considered and appropriate. I further find that the imposition and revocation of an Inpatient Treatment Order was appropriate.
- 7.2. I have no need to make recommendations in relation to the death of Mr Grundy.

Key Words: Death in Custody; Natural Causes; Inpatient Treatment Order

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

Seal the 11th day of June, 2020.

Deputy State Coroner

Inquest Number 30/2020 (0896/2017)

⁹ Exhibit C5, Statement of Doctor Timothy To dated 28 September 2017

¹⁰ Exhibit C9, Statement of James Lee page dated 16 May 2017

¹¹ Exhibit C8, Statement of Probationary Constable Tobi Reinert's dated 16 May 2017

¹² Exhibit C10, Statement of Brevet Sergeant Craig Robertson dated 7 August 2017

¹³ Exhibit C11, Detective Brevet Sergeant Bradley Molony dated 30 April 2018 and Final report dated 12 November 2018