MAGISTRATES COURT
TASMANIA

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CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Olivia McTaggart, Coroner, having investigated the death of Janine Mona Hunn

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that

a) The identity of the deceased is Janine Mona Hunn.

b) Ms Hunn was born on 23 May 1960 and was 59 years of age at her death. She lived in a care home operated by Nexus Inc. because she suffered significant medical conditions and disabilities. She had been under the care of the State since she was a small child. Her parents are unknown. Ms Hunn suffered a congenital genetic condition known as Angelman syndrome, a neurodevelopmental disorder characterised by severe intellectual disability, movement and balance difficulties, a short attention span and a happy and excitable personality. Ms Hunn suffered kyphoscoliosis (abnormal curvature of the spine) and club feet and mobilised using a wheelchair. She also suffered respiratory and gastrointestinal issues. Notably, Ms Hunn had a history of epilepsy and recurrent episodes of aspiration pneumonia. Despite her disabilities, the records indicate that she was happy, sociable and fun-loving. She was under the care of her general practitioner and multiple other medical personnel. Unfortunately, her health deteriorated in the months before her death, with a hospital admission in January 2019 because of pneumonia.

   At midnight on 25 June 2019, Ms Hunn was checked by a Nexus care worker and found to be her normal self. When the carer checked her again less than an hour later (just before 1.00am on 26 June), she found Ms Hunn to be experiencing a seizure. She appeared blue and was gasping for breath. The carer telephoned for an ambulance and she commenced CPR. When ambulance paramedics arrived, Ms Hunn was unresponsive. With further resuscitation efforts by paramedics, there was a return of her circulation after about 10 minutes. However, upon being

transported to the Royal Hobart Hospital and assessed, it was found that she had suffered a hypoxic brain injury. After a period of monitoring of about 24 hours, no improvement was noted and the treating medical staff were of the opinion that any further treatment would be futile. Active treatment was therefore withdrawn and Ms Hunn died at 11.50am the following day, being 27 June 2019.

c) Ms Hunn died as a result of diffuse hypoxic brain injury complicating aspiration of gastric contents that occurred during an epileptic seizure.

d) Ms Hunn died on 27 June 2019 at the Royal Hobart Hospital, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Ms Janine Mona Hunn's death. The evidence includes:

- Police and hospital reports of death;
- An opinion of the forensic pathologist regarding cause of death;
- Affidavits confirming identification and life extinct;
- Nexus care records and other care records for Ms Hunn;
- Royal Hobart Hospital records;
- Guardianship and Administration Board records;
- General practitioner records of Dr Kon Exaharkos;
- Affidavit of Adrian Scott, manager of Nexus supported living; and
- Medical review by Dr A J Bell, Coronial medical consultant.

Comments and Recommendations

I do not consider that I am required under the *Coroners Act* 1995 to hold a public inquest into Ms Hunn's death. Nevertheless, it is appropriate to comment, in light of her complete reliance upon care providers, that I have considered the quality of care of Ms Hunn both immediately before her death and more generally. In this regard, I have been assisted by a medical review undertaken by Dr A J Bell, Coronial medical consultant, who formed the view that the care provided to Ms Hunn was of a high standard, with the records reflecting attention to detail and

indicating the provision of extensive care and treatment. In particular, Dr Bell noted that the conditions causing Ms Hunn's death (namely epilepsy and episodes of aspiration) had previously been identified and properly managed. I am satisfied that Ms Hunn was provided with high quality care and that her death could not have been prevented.

The circumstances of Ms Janine Hunn's death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995.

Dated: 24 June 2021 at Hobart Coroners Court in the State of Tasmania.

Olivia McTaggart
Coroner