IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2020 5991

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Caitlin English, Deputy State Coroner
Deceased:	Anthony Swaney
Date of birth:	10 March 1962
Date of death:	3 November 2020
Cause of death:	1(a) Acute renal failure in the setting of pneumonia and acute bronchitis
Place of death:	Monash Medical Centre, 246 Clayton Road, Clayton, Victoria

INTRODUCTION

1. On 3 November 2020, Anthony Swaney was 58 years old when he died of natural causes. At the time of his death, Mr Swaney lived in a group home at Springvale.

THE CORONIAL INVESTIGATION

2. Mr Swaney's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent, or result from accident or injury. The death of a person in care or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes.

3. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

4. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

5. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of My Swaney's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

6. This finding draws on the totality of the coronial investigation into My Swaney's death, including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

Deaths of persons placed in custody or care

7. I note that Mr Swaney's care was transitioned to the National Disability Insurance Scheme (**NDIS**) in 2018 and his group home was transferred to Home@Scope on 23 June 2019. As Mr Swaney's care was not funded by the Department of Health and Human Services, he did not meet the definition of 'person placed in custody or care' under the Act.

8. Despite the Coroners Court of Victoria providing an independent death review function of persons placed in custody or care at the time of their death, the Act does not currently capture persons who were previously under the care of the Department of Health and Human Services and have transitioned to the NDIS.

9. Section 17(1)(b) of the Act provides that where a medical investigator has provided a report to the coroner that includes an opinion that the death was due to natural causes, the coroner is not required to continue an investigation into a reportable death. Further, section 67(2) of the Act provides that I do not have to make a finding with respect to the circumstances in which a death occurred if the deceased was not, immediately before the person died, a person placed in custody or care and there is no public interest in making a finding regarding those circumstances.

10. But for the lacuna in the coronial legislation occasioned by the NDIS and the transfer to privately run facilities, Mr Swaney would have met the definition of 'person placed in custody or care' at the time of his death. I have therefore chosen to provide a written finding despite his death being attributable to natural causes. For the same reason, I have chosen to publish this finding – section 73(1B) of the Act would have required me to do so had Mr Swaney been defined as a person placed in custody or care.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the deceased

11. On 3 November 2020, Anthony Swaney, born 10 March 1962, was visually identified by his doctor, Dr Brett Potter.

12. Identity is not in dispute and requires no further investigation.

Medical cause of death

13. Forensic Pathologist, Dr Paul Bedford, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 9 November 2020 and provided a written report of his findings dated 10 March 2021.

14. The post-mortem examination revealed lung changes consistent with pneumonia, acute bronchitis, and pleural effusions. Acute renal failure was noted, and the heart was mildly enlarged but without recent damage and without significant coronary artery disease.

15. Toxicological analysis of post-mortem samples identified the presence of acetone.

16. Dr Bedford provided an opinion that the medical cause of death was *"1(a) Acute renal failure in the setting of pneumonia and acute bronchitis".* He was of the opinion that the cause of death was due to natural causes.

17. I accept Dr Bedford's opinion.

Circumstances in which the death occurred

18. Mr Swaney's medical background included Trisomy 18 (Edwards' syndrome) and cerebral palsy, resulting in intellectual disability, spastic quadriplegia, and swallowing issues. He was non-verbal. Mr Swaney's medical history also included epilepsy, type 2 diabetes, osteoporosis, hypertension, gastro-oesophageal reflux, and he had had previous bouts of aspiration pneumonia.

19. From 2005, he resided in a group home in Springvale. Prior to this, he had resided at Kew Cottages since childhood. Mr Swaney was reported to have enjoyed spending time in the garden at his group home and enjoyed listening to music and spending time with others.

20. Due to Mr Swaney's swallowing issues, he was at a high risk of aspiration and choking while eating or drinking. A speech pathologist had developed a mealtime support plan, which was in place at the time of his death.

21. In the months preceding his death, Mr Swaney's health began to deteriorate, which meant he had required multiple hospital admissions and medical interventions due to respiratory concerns and abdominal swelling.

22. Mr Swaney's sister, Michelle, declined to provide a statement but noted to the coroner's investigator that her brother had always lived in a state of ill health, he had never been independent in terms of care, and had been living in assisted facilities since the age of 10 years. His health had deteriorated in the last one to two years, which had required multiple hospital admissions.

23. On 30 October 2020, Mr Swaney's doctor referred him to the Monash Medical Centre on the background of four days of abdominal distension, thought to be due to constipation. That morning, he had been noted to be more breathless and had low oxygen saturation.

24. On presentation to hospital, Mr Swaney was noted to have acute kidney injury and hyperkalaemia, extensive peripheral oedema to all four limbs, faecal loading, and respiratory acidosis.

25. He was initially reviewed by the surgical team who did not identify a bowel obstruction or other surgical pathology.

26. Mr Swaney continued to deteriorate throughout his admission. He suffered sever heart failure, causing pulmonary oedema (fluid in his lungs), hypotension (low blood pressure), severe peripheral oedema (swelling due to fluid), and hepatic congestion (liver congestion).

27. He also had acute renal failure (kidney failure) with high potassium levels. This was exacerbated by the heart failure and hypotension. The renal team was of the opinion that Mr Swaney's renal failure was due to multi-organ failure rather than being the cause of his decline.

28. Mr Swaney had severe respiratory failure with respiratory acidosis (lung failure causing carbon dioxide retention), which caused severe drowsiness. He had not tolerated non-invasive ventilation previously, so it was not attempted during this admission.

29. Mr Swaney also experienced hypothermia (low temperature of about 35 degrees Celsius). This was likely due to his severe systemic unwellness but may have also been due to an infection and he was treated with antibiotics as a precautionary measure.

30. Dr Christina Johnson, consultant in general and geriatric medicine at Monash Health, noted that Mr Swaney's health rapidly declined with worsening of multi-organ failure. A primary cause could not be identified despite multiple investigations. He was transitioned to comfort care on 2 November 2020.

31. Mr Swaney passed away at 6.29pm on 3 November 2020.

REVIEW BY THE DISABILITY SERVICES COMMISIONER

32. The Disability Services Commissioner conducted an investigation under the *Disability Act 2006* into disability services provided by Home@Scope to Mr Swaney. I was advised in March 2021 that the Commissioner had finalised her investigation and had not made any adverse findings regarding the services provided by Home@Scope.

FINDINGS AND CONCLUSION

33. Pursuant to section 67(1) of the Act I make the following findings:

    (a) the identity of the deceased was Anthony Swaney, born 10 March 1962;

    (b) the death occurred on 3 November 2020 at Monash Medical Centre, 246 Clayton Road, Clayton, Victoria, from acute renal failure in the setting of pneumonia and acute bronchitis; and

    (c) the death occurred in the circumstances described above.

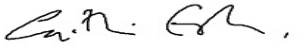
I convey my sincere condolences to Mr Swaney's family for their loss.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

I direct that a copy of this finding be provided to the following:

Michelle Zele, senior next of kin
Monash Health
Disability Services Commissioner
First Constable Ayla Gray, Victoria Police, Coroner's Investigator

Signature:



Caitlin English, Deputy State Coroner
Date : 16 September 2021

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.