IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 006285

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the ***Coroners Act 2008***

Findings of:	Coroner Catherine Fitzgerald
Deceased:	Adam Richard Greaves
Date of birth:	31 May 1974
Date of death:	1 November 2022
Cause of death:	1(a) Aspiration pneumonia complicating progressive degenerative neurological disorder and frontotemporal dementia (palliated)
Place of death:	Austin Hospital 145 Studley Road, Heidelberg, Victoria, 3084
Keywords:	In care, aspiration pneumonia, progressive neurological disorder, natural causes

INTRODUCTION

1. On 1 November 2022, Adam Richard Greaves was 48 years old when he passed away at the Austin Hospital. At the time of his death, Mr Greaves lived in specialist disability care in Reservoir, Victoria. He had resided in full-time specialist disability care accommodation since 2004, when he was 30 years old. Before that, he resided in the family home and was cared for by his family. He was well-supported by his regular general practitioner (**GP**), physiotherapist, occupational therapist, disability care staff, speech pathologist and community nurses from Bolton Clarke.

2. Mr Greaves' medical history included progressive degenerative neurological disorder, congenital cerebral palsy, severe bulbar dysfunction, obstructive sleep apnoea, idiopathic spastic paraparesis, recurrent urinary tract infections, frontotemporal dementia, hypertension, depression, and sacral pressure wounds. He had severe dysphagia and therefore could not consume any food or fluids orally. He was solely fed via a percutaneous endoscopic gastrostomy (**PEG**) tube.

3. From early 2022, Mr Greaves' physical condition started to decline and he experienced frequent chest infections and choking episodes, due to his inability to clear sputum secretions on his own. His carers used a nebuliser and oral suctioning to assist with these secretions. In 2022, he was admitted to the emergency department several times in relation to choking and breathing difficulties.

THE CORONIAL INVESTIGATION

4. Mr Greaves' death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**).[1] Mr Greaves was a "*person placed in custody or care*" pursuant to the definition in section 4 of the Act, as he was "*a prescribed person or a person belonging to a prescribed class of person*" due to his status as an "*SDA resident residing in an SDA enrolled dwelling*".[2]

5. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and the circumstances in which the death occurred. The circumstances are limited to events which are sufficiently proximate and causally related to

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[1] Section 4(1), (2)(c) of the Act.

[2] Pursuant to Reg 7(1)(d) of the *Coroners Regulations 2019*, a "*prescribed person or a prescribed class of person*" includes a person in Victoria who is an "*SDA resident residing in an SDA enrolled dwelling*", as defined in Reg 5. I have received information that Mr Greaves resided at an address where the residents meet these criteria.

the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

6. 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.

7. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Greaves' death. The Coroner's Investigator conducted inquiries on my behalf and submitted a coronial brief of evidence.

8. This finding draws on the totality of the coronial investigation into the death of Adam Richard Greaves 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.[3]

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

Circumstances in which the death occurred

9. At about 2.30pm on 28 October 2022, Mr Greaves experienced an acute episode of breathing difficulties. His carers observed that he suddenly became distressed, then became pale in colour and cyanotic. His carers called 000 immediately and requested an ambulance. Mr Greaves' GP was coincidentally present at the disability home to visit another patient, so he quickly attended to Mr Greaves whilst awaiting the arrival of paramedics.

10. Upon the arrival of paramedics, Mr Greaves was assessed and transported to the Austin Hospital Emergency Department (**ED**). On arrival, he was assessed by an ED consultant, who noted Mr Greaves' recent cognitive and physical decline, with multiple recent ED presentations.

11. Mr Greaves initially received treatment with intravenous antibiotics and non-invasive ventilation, however his condition did not improve. Clinicians spoke with Mr Greaves' family

[3] 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.

and noted his poor prognosis and overall quality of life. A decision was subsequently made to transition Mr Greaves to palliative care.

12. Mr Greaves was provided with comfort care and passed away peacefully on 1 November 2022 at 4.07pm, with his family by his side.

Identity of the deceased

13. On 1 November 2022, Adam Richard Greaves, born 31 May 1974, was visually identified by his brother, Shane Greaves.

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

Medical cause of death

15. Forensic Pathologist Dr Heinrich Bouwer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 3 November 2022 and provided a written report of his findings dated 17 November 2022.

16. The post-mortem examination revealed findings consistent with the reported circumstances.

17. Examination of the post-mortem CT scan revealed cerebral atrophy (more pronounced over the frontotemporal lobes), bilateral lung consolidation with air bronchograms, small right pleural effusion, right lung scarring, fatty liver, and gallstones.

18. Toxicological analysis of post-mortem samples was not indicated and was therefore not performed.

19. Dr Bouwer provided an opinion that the medical cause of death was "*1(a) Aspiration pneumonia complicating progressive degenerative neurological disorder and frontotemporal dementia (palliated)*" and that the death was due to natural causes.

20. I accept Dr Bouwer's opinion.[4]

FINDINGS AND CONCLUSION

21. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

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[4] Pursuant to s 52(3A) of the Act, a coroner is not required to hold an inquest where the deceased was, immediately before death, a person placed in custody or care, if the coroner considers that the death was due to natural causes.

a) the identity of the deceased was Adam Richard Greaves, born 31 May 1974;

b) the death occurred on 1 November 2022 at Austin Hospital 145 Studley Road, Heidelberg, Victoria, 3084, from aspiration pneumonia complicating progressive degenerative neurological disorder and frontotemporal dementia (palliated); and

c) the death occurred in the circumstances described above.

I convey my condolences to Mr Greaves' family for their loss.

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

Janette and Ronald Miller, Senior Next of Kin

Austin Health

First Constable Alexander Finlayson (VP45808), Victoria Police, Coroner's Investigator

Signature:

Coroner Catherine Fitzgerald

Date : 16 October 2023

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.