IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 005419

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Sarah Anne Swallow
Date of birth:	1 August 1988
Date of death:	11 September 2024
Cause of death:	1a: Peripheral T-cell lymphoma not otherwise specified 2: Trisomy 21, hyperparathyroidism, hypothyroidism
Place of death:	39 Leigh Street Huntingdale Victoria 3166

INTRODUCTION

1. On 11 September 2024, Sarah Anne Swallow was 36 years old when she died from natural causes.

2. Sarah received funded daily independent living support due to her diagnosis of Down syndrome and intellectual disability, which was provided by disability service provider OC Connections. Sarah lived at a Specialist Disability Accommodation (**SDA**) dwelling enrolled under the National Disability Insurance Scheme (**NDIS**). She attended the Bayley House day service for 18 years, which she absolutely loved and thrived at.

3. Sarah was the youngest of three siblings in a close-knit family and she was loved by everyone, *'the light of everyone's lives'*. She was extremely sociable and happy-go-lucky and enjoyed spending time outdoors and swimming. She loved attending her weekly dance class with Emotion 21 and was part of their performance group, performing at large events including the World Down Syndrome Congress in India.

THE CORONIAL INVESTIGATION

4. Sarah's death fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**) as she was a 'person placed in custody or care' within the meaning of the Act, as a person with disability who received funded daily independent living support and resided in an SDA enrolled dwelling immediately prior to her death.[1] This category of death is reportable to ensure independent scrutiny of the circumstances leading to death given the vulnerability of this cohort and the level of power and control exercised by those who care for them. The coroner is required to investigate the death, and publish their findings, even if the death has occurred as a result of natural causes.

5. 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.

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

[1] This class of person is prescribed as a 'person placed in custody or care' under the *Coroners Regulations 2019* (Vic), r 7(1)(d).

comments or recommendations in appropriate cases about any matter connected to the death under investigation.

7. This finding draws on the totality of the coronial investigation into the death of Sarah Anne Swallow including evidence contained in the coronial brief and information from the National Disability Insurance Agency (**NDIA**) and the NDIS Quality and Safeguards Commission. 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.[2]

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

Circumstances in which the death occurred

8. Sarah was diagnosed with Peripheral T-Cell Lymphoma in April 2024. She was commenced on chemotherapy but sadly showed no response to that treatment, and so it was ceased in June 2024. Possible treatments including clinical trials were discussed, but palliative care management was agreed as being in Sarah's best interest.

9. Sarah moved in with her parents and was under the care of the Cabrini Home Palliative Care Team. Support workers from OC Connections regularly picked Sarah up so that she could visit her friends.

10. Sarah died peacefully at home on 11 September 2024.

Identity of the deceased

11. On 16 September 2024, Sarah Anne Swallow, born 1 August 1988, was visually identified by her mother, Lesley Swallow, who completed a Statement of Identification.

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

Medical cause of death

13. Forensic Pathologist Dr Melanie Archer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination of the body of Sarah Swallow on 18 September

[2] 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.

2024. Dr Archer considered the Victoria Police Report of Death (Form 83), post mortem computed tomography (**CT**) scan and medical records from Ashwood Medical Group and provided a written report of her findings dated 30 September 2024.

14. The external examination showed no remarkable features.

15. Dr Archer provided an opinion that the cause of death was due to natural causes and ascribed the medical cause of death as 1(a) PERIPHERAL T-CELL LYMPHOMA NOT OTHERWISE SPECIFIED, 2 TRISOMY 21, HYPERPARATHYROIDISM, HYPOTHYROIDISM.

FINDINGS AND CONCLUSION

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

   a) the identity of the deceased was Sarah Anne Swallow, born 1/08/1988;

   b) the death occurred on 11 September 2024 at 39 Leigh Street, Huntingdale, Victoria 3166;

   c) I accept and adopt the medical cause of death ascribed by Dr Melanie Archer and I find that Sarah Anne Swallow, a woman with Trisomy 21, hyperparathyroidism and hypothyroidism died from peripheral T-cell lymphoma;

2. AND, I find that Sarah Anne Swallow was 'a person placed in custody or care' until the time that she moved into her parent's address for palliative care. There is no evidence of any causal connection between the care she received and her cause of death.

3. AND FURTHER, having considered all the available evidence, I find that Sarah Anne Swallow's death was from natural causes and that no further investigation is required. As such, I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into her death and to finalise the investigation of Sarah's death in chambers.

I convey my sincere condolences to Sarah's family, friends and carers for their loss.

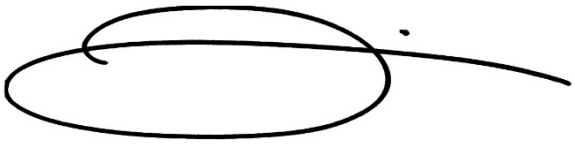
Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Lesley and Jeffrey Swallow, Senior Next of Kin

Senior Constable Jerome de Mink, Coronial Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 6 October 2025

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.