IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 2296

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of: ANTHONY MAHONEY

Delivered On:	2 July 2014
Delivered At:	Coroners Court of Victoria
	Level 11, 222 Exhibition Street
	Melbourne 3000
Hearing Date:	2 July 2014
Finding Of:	AUDREY JAMIESON, CORONER
Police Coronial Support Unit	Leading Senior Constable Andrea Hibbins

I, AUDREY JAMIESON, Coroner having investigated the death of **ANTHONY MAHONEY**

AND having held an inquest in relation to this death on 2 July 2014

at MELBOURNE

find that the identity of the deceased was **ANTHONY MAHONEY**

born on 8 February 1955

and the death occurred between 26 and 27 May 2013

at 49 Jacka Street, Macleod 3085

from:

1 (a) HAEMOPERICARDIUM

1 (b) RUPTURED RIGHT CORONARY ARTERY ANEURYSM

in the following circumstances:

1. On 2 July 2014, a mandatory inquest under section 52(2)(b) of the *Coroners Act 2008* (Vic) (the Act) was held into the death of Mr Anthony Mahoney, because immediately before his death, Mr Mahoney was "a person placed in....care" as it is defined in the Act. Mr Mahoney had an intellectual disability and had been a client of the Department of Human Services (DHS) Disability Services for most of his life.

2. Mr Mahoney was 58 years of age at the time of his death. He had been adopted out by his birth parents when he was 16 months of age, and became a ward of the state at age 13 when his adoptive parents could no longer look after him. Since 2006, he lived at a Community Residential Unit (CRU) operated by the DHS for people with intellectual disabilities located at 49 Jacka Street, Macleod (the residence). The CRU was a shared accommodation house for people with behaviour problems requiring general supervision and specific assistance with some activities of daily living. Mr Mahoney was never engaged in full-time employment but would occasionally travel to the city to sell copies of 'The Big Issue'. He received a Disability Support Pension and his finances were managed by the State Trustees.

3. Mr Mahoney had a past medical history that included an intellectual impairment, postural hypotension, pulmonary embolism (2008), chronic obstructive pulmonary disease, iron deficiency, Barrett's oesophagus, Schizoaffective disorder, smoking and a right coronary

artery aneurysm seen on a 2012 abdominal CT scan, for which he was undergoing further investigation at the time of his death.

4. On 26 May 2013, Mr Mahoney, a co-resident and two DHS direct care workers went on a day trip to Woodend and Gisborne, returning to the residence at approximately 5.00pm. During the evening, the residence supervisor noticed that Mr Mahoney appeared tired, but assumed that his fatigue was due to the outing. Mr Mahoney went to sleep at approximately 9.30pm.

5. At approximately 6.45am on 27 May 2013, the residence supervisor entered Mr Mahoney's room and found him to be unresponsive. The manager and Emergency Services were contacted, and attending Paramedics confirmed that Mr Mahoney was deceased.

FORENSIC PATHOLOGIST EXAMINATION AND EVIDENCE

6. Dr Gregory Young, Forensic Pathology Registrar at the Victorian Institute of Forensic Medicine (VIFM), supervised by Dr Jacqueline Lee, Forensic Pathologist at VIFM, performed a post mortem examination upon the body of Mr Mahoney, reviewed a post mortem CT scan and reviewed the Victorian Police Report of Death, Form 83. Anatomical findings included a giant fusiform right coronary artery aneurysm (2.3cm distal to right coronary orifice and 7.5cm in maximum dimension), which was ruptured anteriorly into epicardial fat and into the pericardial sac, with a focal dissection into the wall of the aneurysm and associated haemopericardium.[1] The aneurysm showed evidence of long-standing change as well as acute haemorrhage.

7. Dr Young explained that an aneurysm is an abnormal outpouching of a blood vessel (or the heart), and can be fusiform (involving the full circumference of the blood vessel) or saccular (involving only a portion of the vessel). Coronary artery aneurysm is an uncommon condition, usually seen with atherosclerosis, as was identified in Mr Mahoney. Dr Young further noted that coronary artery aneurysms can cause death due to rupture or thrombosis.

8. Other anatomical findings included incidental pituitary adenoma, multi-nodular goitre of the thyroid, pulmonary emphysema, benign nephrosclerosis of the kidneys and severe calcific

[1] Haemopericardium refers to the presence of blood in the pericardial sac surrounding the heart. It can occur from rupture of a coronary artery aneurysm, as in Mr Mahoney's case. This in turn leads to cardiac tamponade, which is where the blood in the pericardial sac causes increased pressure around the heart, restricting the heart from filling and subsequently beating.

atherosclerosis including coronary arteries and the aorta. No evidence of injuries that may have caused or contributed to Mr Mahoney's death was identified.

9. Toxicological analysis of blood retrieved post mortem identified the presence of Amisulpride and Clozapine, which Dr Young explained are both used in the treatment of Schizophrenia, in concentrations consistent with therapeutic use. No alcohol was detected. Dr Young ascribed the cause of Mr Mahoney to haemopericardium secondary to a ruptured right coronary artery aneurysm.

POLICE INVESTIGATION

10. The circumstances of Mr Mahoney's death have been the subject of investigation by Victoria Police. No evidence of third party involvement was identified. Police obtained statements from various staff members at the residence, General Practitioner Dr Huyen Le and treating Psychiatrist Dr Akshay Ilango.

11. The Police investigation indicated that the Mr Mahoney had consulted with Dr Le since 2002. He attended Psychiatrists at the North East Continuing Care Service for a monthly review as a voluntary case managed patient. He was admitted to hospital in December 2011 for treatment of an aspiration pneumonia, and an abdominal and pelvic CT scan showed a large aneurysm arising from the right coronary artery. A Cardiology opinion was sought and the episode of inpatient care lasted three months, until February 2012.

12. In January 2013, Mr Mahoney had an electrocardiogram and a transthoracic echocardiogram (TTE) arranged by his Psychiatrist for annual Clozapine monitoring. The TTE showed normal left ventricular function and a 5cm cystic lesion anterior to the right coronary artery, thought to be a pericardial cyst. There was no recommendation for follow up and he was monitored by Dr Le.

13. Dr Le last consulted with Mr Mahoney on 1 May 2013 for a review of his annual Health Assessment management plan. Dr Le was subsequently informed that Mr Mahoney had been referred to the Valve Clinic for further Cardiology assessment.

14. Mr Mahoney did not express any physical complaints prior to his death and his mental health was stabilised on medication.

FACTORS CAUSING OR CONTRIBUTING TO DEATH

15. The evidence supports a conclusion that Mr Mahoney died sometime between 26 and 27 May 2013 and that the cause of his death was haemopericardium secondary to a ruptured right coronary artery aneurysm. The circumstances under which Mr Mahoney died were, according to the pathologist, consistent with Mr Mahoney's relevant past medical history. There was no evidence to suggest any other cause or contribution to his death. Mr Mahoney died from natural causes related to his underlying natural disease process.

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death:

In all the circumstances, I am satisfied that there would be no benefit from conducting a full inquest into Mr Mahoney's death or obtaining any further medical or other evidence, as neither would assist me to further understand the medical issues before me or the cause of Mr Mahoney's death which resulted from natural causes in the context of his underlying naturally occurring disease.

FINDING

I accept and adopt the medical cause of death as ascribed by Dr Gregory Young and I find that Anthony Mahoney died from natural causes being haemopericardium secondary to a ruptured right coronary artery aneurysm.

AND I further find that there is no relationship between the cause of Mr Mahoney's death and the fact that he was "a person placed in care".

Pursuant to section 73(1) of the **Coroners Act 2008**, I order that the following be published on the internet.

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

Mrs Gwyneth Mahoney

Dr Oakley Browne, Chief Psychiatrist

Dr Huyen Le, Preston Family Medical Practice

Mr Shane Beaumont, Department of Human Services

Ms Pauline Chapman, Austin Health

Detective Senior Constable M Argentino

Signature:

AUDREY JAMIESON
CORONER
Date: **2 July 2014**