IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2021 1302

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 Christopher Stone
Date of birth:	20 February 1962
Date of death:	11 March 2021
Cause of death:	1(a) Cardiomegaly and pulmonary oedema in a man with a bi-cuspid aortic valve
Place of death:	Sandringham Hospital, 193 Bluff Road, Sandringham, Victoria

INTRODUCTION

1. On 11 March 2021, Anthony Christopher Stone was 59 years old when he died of natural causes. At the time of his death, Mr Stone lived at a disability residence at Highett.

THE CORONIAL INVESTIGATION

2. Mr Stone'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 Mr Stone'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 Mr Stone'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 Stone's care was transitioned to the National Disability Insurance Scheme (**NDIS**) on 23 June 2019 (when his residence at 27 James Avenue, Highett, was transferred to Home@Scope). As Mr Stone'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 Stone 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 Stone 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 29 March 2021, Anthony Christopher Stone, born 20 February 1962, was visually identified by Benjamin O'Shannessy, Operations Manager at Home@Scope.

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

Medical cause of death

13. Forensic Pathologist, Dr Sarah Parsons, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 24 March 2021 and provided a written report of her findings dated 6 May 2021.

14. The post-mortem examination revealed cardiomegaly (enlarged heart). Dr Parsons noted that people with an enlarged heart are at increased risk of sudden death presumably due to cardiac arrhythmia. In this case, there was pulmonary oedema and histiocytes in the lungs. This would be in keeping with heart failure.

15. The most common cause of cardiomegaly is hypertension or valvular heart disease. Mr Stone was found to have a bicuspid aortic valve, which was the likely cause of his cardiac enlargement.

16. Dr Parsons provided an opinion that the medical cause of death was *"1(a) Cardiomegaly and pulmonary oedema in a man with a bi-cuspid aortic valve"*. Dr Parsons concluded Mr Stone's death was due to natural causes.

17. I accept Dr Parsons's opinion.

Circumstances in which the death occurred

18. Mr Stone had cerebral palsy, amongst other medical conditions, and was non-verbal. He required full-time assistance for all aspects of his care; he was able to eat and drink independently. He used a wheelchair to ambulate and received regular allied health and medical assessments.

19. Mr Stone had been in care for most of his life and had little contact with his family other than his Great Aunt Olive (until she passed away in 2001).

20. In 2000, he moved to a home at 27 James Avenue, Highett, which he shared with four other housemates.

21. During the day, Mr Stone attended Bayley House and enjoyed participating in community activities with the assistance of staff. He particularly enjoyed being outdoors and listening to music.

22. In the months leading to Mr Stone's death, he had begun to refuse food. On recommendation from his doctor, his meals were thereafter liquified, with which Mr Stone appeared happy. A

plan was implemented to prevent further weight loss. At about this time, Mr Stone also experienced three rolls from his low bed, which had never happened before.

23. On 11 March 2021, Mr Stone attended Bayley House. At approximately 9.30am, support workers observed Mr Stone to look unwell – his breathing was shallow, and his lips were blue. He was returned home.

24. Upon his return home, his carers also observed his lips to be blue, his eyes puffy, and he was breathing shallowly. His general practitioner assessed him shortly thereafter and found Mr Stone to be experiencing abnormal breathing and intermittent tachypnoea. He suspected Mr Stone may have pneumonia and advised that he go to hospital.

25. Mr Stone arrived at Sandringham Hospital at approximately 2.30pm, where he did not respond to supplemental oxygen and deteriorated. His family was consulted regarding appropriate care and it was decided that further medical treatment would not be provided.

26. Mr Stone passed away at 7.20pm.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was Anthony Christopher Stone, born 20 February 1962;

    (b) the death occurred on 11 March 2021 at Sandringham Hospital, 193 Bluff Road, Sandringham, Victoria, from cardiomegaly and pulmonary oedema in a man with a bi-cuspid aortic valve; and

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

I convey my sincere condolences to Mr Stone's family and friends 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:

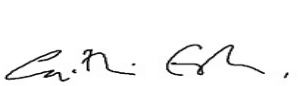
David John, senior next of kin

Alfred Health

Disability Services Commissioner

First Constable Laura Wydeman, Victoria Police, Coroner's Investigator

Signature:



Caitlin English, Deputy State Coroner

Date: 17 January 2022

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.