



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 18th day of August and the 22nd day of December 2011, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Matthew Tyson Swavley.

The said Court finds that Matthew Tyson Swavley aged 39 years, late of 1/117 Yorketown Road, Elizabeth Park, South Australia died at the Lyell McEwin Health Service, Haydown Road, Elizabeth Vale, South Australia on the 16th day of October 2009 as a result of cardiomegaly. The said Court finds that the circumstances of his death were as follows:

1. Introduction and reason for Inquest

- 1.1. Matthew Tyson Swavley, aged 39 years, died suddenly from natural causes on 16 October 2009 at the Lyell McEwin Health Service (LMHS). At the time of his death Mr Swavley had been detained pursuant to section 12 of the Mental Health Act 1993 (the Act). His death was therefore a death in custody within the meaning of section 21(1)(a) of the Coroners Act 2003 and this Inquest was held as required by that section.

2. Cause of death

- 2.1. Following Mr Swavley's death, a post-mortem examination was conducted by Professor Roger Byard, a senior specialist forensic pathologist at Forensic Science South Australia. In his post-mortem report dated 23 March 2010¹, Professor Byard expresses the cause of death as 'cardiomegaly'.

¹ Exhibit C2a

- 2.2. Professor Byard further stated that the death was attributed to cardiomegaly due to the presence of a markedly enlarged heart which weighed 827 grams. He stated that there was no significant coronary atherosclerosis and there was no evidence of acute or chronic ischaemic myocardial damage. There were no other underlying organic diseases or any evidence of trauma.
- 2.3. A significant feature of Mr Swavley's post mortem examination was the fact that he was morbidly obese with a weight of 154 kilograms and a Body Mass Index of 46. However, I do not understand that Mr Swavley had ever been diagnosed with any physical disease or ailment involving the heart. To that extent, Mr Swavley's death in LMHS was quite unexpected.
- 2.4. A toxicological analysis was performed by Mr Chris Kostakis of Forensic Science South Australia. In his report² he identified therapeutic levels of the anti-psychotic medications olanzapine and haloperidol in Mr Swavley's blood. Both of those medications had been prescribed for Mr Swavley.
- 2.5. I find the cause of Mr Swavley's death to have been cardiomegaly.

3. Background

- 3.1. Mr Swavley's parents have both provided statements³ to the Inquest. They stated that Mr Swavley was a quiet child that appeared normal. Mr Swavley's parents separated when he was quite young and he remained with his mother and his two siblings. When Mr Swavley was about 12 years old he wanted to live with his father and moved to Gawler and began to attend Gawler High School. When Mr Swavley was 17 years old he moved back to his mother's house. It was at this time that his mother suspected that he had begun to smoke marijuana. Mrs Swavley stated that he displayed a few instances of violence but that they were only directed at property and not directed at her or his siblings. While living with his mother at this time, Mr Swavley worked with his father restoring houses and also had other small jobs, including pruning. This involved Mr Swavley getting up at 7am to go to work which was something that was seen as a huge achievement. During the time Mr Swavley worked with his father, his father noticed a difference in his behaviour but could not put it down to anything.

² Exhibit C3a

³ Exhibits C13a and C14a

- 3.2. When Mr Swavley was 21 he moved out on his own into a place in Gawler West. Mrs Swavley stated that this is when she noticed his mental illness and she was aware that he had been seeing doctors and was being prescribed medication. Mr Swavley Snr stated that he found Mr Swavley smoking hash once and they argued about it. He stated that on this day he saw information on mental illnesses and became aware that Mr Swavley was being treated for a mental illness.
- 3.3. Mr Swavley Snr stated that he disagreed with how his son was living his life but would still keep in contact with him several times a year. Mr Swavley Snr stated that he would normally attend the Guardianship Board hearings. Mrs Swavley stated that she lived in the country and she tried to get down to the suburbs to see Mr Swavley monthly or every six weeks as he tended to reside in the Gawler and Elizabeth area over the years. She would take him coca cola and cigarettes and home cooked meals. Mr Swavley would also let her know when he had been detained and she would visit him in hospital.
- 3.4. Mrs Swavley stated that over the last year of Mr Swavley's life she had noticed that he gained a large amount of weight and was quite untidy and not looking after himself. She thought he had put on weight due to the drugs he was being given.

4. Mr Swavley's involvement with Mental Health Services

- 4.1. Mr Swavley first came to the attention of the mental health services in 1993 when he was 23 years of age. He thereafter underwent a number of hospital admissions, both voluntary and while subject to detention. He was ultimately to be diagnosed with schizophrenia. It is evident that he had issues with the consumption of cannabis. He was prescribed anti-psychotics.
- 4.2. Mr Swavley was also placed on community treatment orders due to poor compliance with medication and resultant poor mental health. Mr Swavley appears to remain for the most part more on community treatment orders until the time that he died.
- 4.3. He was eventually placed onto an administration order, the first being granted on 14 July 1995.
- 4.4. Mr Swavley continued to live independently in the community although he seemed to experience some level of psychotic and delusional symptoms most of the time. He

appeared to struggle with functioning in the community. He remained connected to the mental health services due to the ongoing community treatment orders.

- 4.5. Mr Swavley had the same mental health nurse from Northern Mental Health for the last three years, Mr Mick Hynes⁴. Mr Hynes stated that there had been a few incidents of violence with Mr Swavley where he had become abusive and pushed Mr Hynes around. After the first few times of this happening, the police would attend the home address with Mr Hynes. Mr Hynes stated that there was a time in April 2008 when Mr Swavley was required to be held down by five police officers in order to be given his injection.
- 4.6. Dr Nagesh is a Senior Consultant Psychiatrist who worked with the Northern Mental Health Service⁵. He stated that he had been Mr Swavley's treating psychiatrist for the last 10 years. He stated that he would attend upon Mr Swavley every 6-8 weeks in the office, but he would always keep abreast of what was happening with Mr Swavley in the community. He would also visit Mr Swavley in his home.
- 4.7. Dr Nagesh stated that Mr Swavley had a long history of schizophrenic disorder, paranoid subtype. Despite the provision of the depot neuroleptics, Mr Swavley had required multiple hospital admissions. Dr Nagesh felt that these admissions appeared to be attributable to lack of compliance with oral medication, a lack of insight into his illness and to the adverse effects of medications. Mr Swavley had refused to go on clozapine as it had generated adverse effects and required weekly bloods tests. He had an aversion to needles and was becoming increasingly hostile towards them. Mr Swavley's personal hygiene was also reportedly problematic.
- 4.8. Dr Nagesh stated that Mr Swavley's care was complicated by the numerous challenges he presented being managed in the community. Mr Swavley was reported to have significant negative symptoms, including agitation and hostility towards staff on occasions.

5. The events leading to Mr Swavley's death

- 5.1. In the months leading up to his death, Mr Swavley put on a large amount of weight and his treating psychiatrist felt that this may have been due to reaction to his medication. As Mr Swavley did not have a regular general practitioner, it was very difficult to have this verified.

⁴ Exhibit C10a

⁵ Exhibit C11a

- 5.2. In February 2009 Mr Swavley was detained at the Modbury Hospital for 9 days after he had allegedly assaulted a friend. He was brought in by the police. It was felt that his presentation was precipitated by non-compliance with medication and marijuana use, which made him experience delusions and aggression. On arrival he was floridly psychotic but responded well to olanzapine, valproate and lorazepam. On discharge he appeared to have some level of insight but then he was again detained in May 2009. He was reported to have become more belligerent, paranoid and hostile to the workers since his community treatment order was renewed. He experienced a delusion. He was discharged back into the community after a week.
- 5.3. On his discharge he was again managed in the community with the assistance of the Northern Mobile Assertive Care team. On 1 October 2009 Mr Swavley was reported to be abusive, angry and threatening. He was required to be held down by police officers in order to have his depot injection administered. The following day Dr Nagesh wrote to the Psychiatry Department at the LMHS and detailed his history and involvement with Mr Swavley. He stated that at that time Mr Swavley was receiving a monthly haloperidol injection with police presence due to his level of aggression. He stated that although Mr Swavley had been on haloperidol for 3 to 4 months by this time, there had been no reduction in symptoms, no better engagement, no progress in getting him to a general practitioner and no potential rehabilitation work. Dr Nagesh observed that Mr Swavley posed numerous challenges as far as safely managing him in the community was concerned. He also observed that increasing his level of community support was not considered to be feasible as he would not engage and would pose real risk of aggression towards staff. Administering his medications in a community setting was described as a 'battle'. Dr Nagesh said:

'One is left wondering as to what is being achieved through his being on CTO (community treatment order) receiving treatment that is not helping him in any way and if at all making the disease and side effect burden exponentially worse.'

Dr Nagesh recommended that Mr Swavley undergo an extended placement in the LMHS of perhaps between 3 months and 18 weeks of initial clozapine treatment with close monitoring. This was recommended in order to more thoroughly assess his schizophrenic disorder and physical co-morbidities and to assess the possible use of electroconvulsive therapy. As well, Mr Swavley's possible discharge into a community transition program to a facility where he could be taught independent living skills before returning to his own accommodation needed to be considered. Dr Nagesh wrote:

'These measures will ensure that Matthew is given the benefit of receiving best possible treatment in a safe setting so as to sufficiently recover from his psychopathology so that further recovery + rehab could be better planned.'

A bed became available in ward 1G in the LMHS approximately one week after this recommendation was made.

- 5.4. On 15 October 2009 the Northern mental health team attended Mr Swavley's address. Mr Hynes was there in addition to Dr Sujeeve⁶, who was filling in for Dr Nagesh. Dr Sujeeve stated that he assessed Mr Swavley's mental state to be quite poor, he spoke of dying three times and of having 'powers'. His general health had deteriorated with poor self care and central obesity. Mr Hynes stated that Mr Swavley seemed his normal self on that day, talking about spiders in his brain and that he was connected to computers. Dr Sujeeve detained Mr Swavley and he was transported to the LMHS for admission. Dr Sujeeve completed a Form 1 under the Mental health Regulations that described the reasons for Mr Swavley's detention. There can be no suggestion other than that this detention was both lawful and appropriate.
- 5.5. On presentation to the Emergency Department of the LMHS Mr Swavley was medically assessed by a Consultant, Dr Chu⁷. Dr Chu performed an ECG on Mr Swavley and found him to be experiencing sinus tachycardia which he felt was consistent with mild dehydration. Dr Chu checked Mr Swavley's urine for any sign of infection, of which there was none. A chest X-ray and a blood test were performed, with the blood result displaying slightly high haemoglobin which was also consistent with dehydration. Mr Swavley was admitted to Ward 1G at about 4:00pm under the condition that he drink fluids regularly.
- 5.6. On the ward Mr Swavley was subjected to 15 minute observations by staff. One of the nurses, Mr Alcorn⁸, stated that he started his shift at 6.50pm that day and maintained observations of Mr Swavley at 15 minute intervals. He stated that Mr Swavley was responsive and had taken a shower. Mr Alcorn stated that at 11:40pm he gave Mr Swavley a cigarette and some medication to help him settle for the night. Mr Swavley then went to bed and appeared to sleep until 2:00am when he presented at the nurses desk asking for another cigarette. Mr Alcorn refused and gave him a drink of water and encouraged him to go back to bed, which he did. Mr Alcorn

⁶ Exhibit C9a

⁷ Exhibit C8a

⁸ Exhibit C4a

continued with 15 minutes checks, with the last one being at 4:20am when he noted that Mr Swavley was asleep in bed and snoring.

- 5.7. On the next check, at approximately 4:35am, Mr Alcorn walked into Mr Swavley's room as it appeared he was not in bed. He found him lying face down on the floor next to the bed and could not find any evidence of breathing. Mr Alcorn called a code blue and the Medical Emergency Team were called. Mr Alcorn commenced CPR along with another nurse. On arrival of the MET team they took over CPR and administered medications, they intubated Mr Swavley and obtained intravenous lines. This continued until after 5:00am. Unfortunately Mr Swavley could not be resuscitated. The MET team then ceased CPR and Mr Swavley was certified deceased.

6. Conclusions

- 6.1. Mr Swavley at all material times had a serious and intractable mental illness that did not respond well to treatment. His detention on 15 October 2009 and thereafter was lawful, appropriate and undertaken in his best interests. His collapse and death from natural causes could not be foreseen. There is no suggestion that his detention and hospitalisation contributed to his death. Resuscitation efforts were satisfactory.

7. Recommendations

- 7.1. I have no recommendations to make in this matter

Key Words: Death in Custody; Psychiatric/Mental Illness

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 22nd day of December 2011

Deputy State Coroner