IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 4763

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: HARRY BARKAS

Findings of:	**AUDREY JAMIESON, CORONER**
Delivered on:	**20 February 2019**
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street, Southbank 3006
Hearing date:	20 February 2019
Police Coronial Support Unit:	Leading Senior Constable Darren Cathie

I, AUDREY JAMIESON, Coroner having investigated the death of **HARRY BARKAS**

AND having held an inquest in relation to this death on 20 February 2019

at MELBOURNE

find that the identity of the deceased was **Harry Barkas**

born on 22 March 1962

and the death occurred on 7 October 2016

at Marngoneet Correctional Facility, 1200 Bacchus Marsh Road, Lara, Victoria 3212

from:

1 (a) ISCHAEMIC HEART DISEASE

(b) CORONARY ARTERY ATHEROSCLEROSIS AND ANEURYSM

in the following summary of circumstances:

1. Harry Barkas was 54 years of age at the time of his death. He was an inmate at the Karreenga Annexe, Marngoneet Correctional Centre in Lara, and had been incarcerated for approximately nine years. Mr Barkas had a history of type two diabetes, high blood pressure and high cholesterol. He was treated for a number of co-morbidities during his imprisonment.

2. At 7.37am, Mr Barkas was sighted by prison staff during a head count inside his accommodation unit, Johanna B cottage. At approximately 8.20am, Mr Barkas went to the bathroom. At around 8.50am, during a "Work Count", other prisoners advised the prison officers that Mr Barkas was in the bathroom. A prison officer knocked on the toilet door but received no response. The toilet door was locked from the inside; prison officers opened the door and located Mr Barkas lying face down, between the toilet and the basin. He was not breathing and had no pulse.

3. A 'Code Black' was initiated, prison officers placed Mr Barkas in the recovery position, moved him onto his back and commenced cardiopulmonary resuscitation (CPR). Prison nurses attended with emergency equipment and ambulance paramedics arrived at 9.07am and continued to administer CPR. Resuscitation efforts were deemed futile, and at 9.38am, Mr Barkas was declared to be deceased.

CORONIAL JURISDICTION

4. Mr Barkas' death was reportable pursuant to section 4 of the Coroners Act 2008 (Vic) ('the Act') because he was immediately before his death a person placed in custody, as defined by section 3 of the Act.

PURPOSE OF THE CORONIAL INVESTIGATION

5. The Coroners Court of Victoria is an inquisitorial jurisdiction.[1] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[2] The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances but is confined to those circumstances sufficiently proximate and causally relevant to the death and not merely all circumstances which might form part of a narrative culminating in death.[3]

6. The broader purpose of coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by Coroners, generally referred to as the 'prevention' role.[4] Coroners are also empowered to report to the Attorney-General on a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[5] These are effectively the vehicles by which the prevention role may be advanced.[6]

7. It is not the Coroner's role to determine criminal or civil liability arising from the death under investigation. Nor is it the Coroner's role to determine disciplinary matters.

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[1] Section 89(4) Coroners Act 2008.

[2] Section 67(1) of the *Coroners Act 2008*.

[3] See for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy v West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).

[4] The "prevention" role is explicitly articulated in the Preamble and Purposes of the Act.

[5] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations respectively.

[6] See also sections 73(1) and 72(5) of the Act which requires publication of Coronial Findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a Coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

8. Section 52(2) of the Act provides that it is mandatory for a Coroner to hold an Inquest into a death if the death or cause of death occurred in Victoria and a Coroner suspects the death was as a result of homicide, or the deceased was, immediately before death, a person placed in custody or care, or the identity of the deceased is unknown.

STANDARD OF PROOF

9. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining whether a matter is proven to that standard, I should give effect to the principles enunciated in Briginshaw v Briginshaw. [7] These principles state that in deciding whether a matter is proven on the balance of probabilities, in considering the weight of the evidence, I should bear in mind:

    - the nature and consequence of the facts to be proved;
    - the seriousness of any allegations made;
    - the inherent unlikelihood of the occurrence alleged;
    - the gravity of the consequences flowing from an adverse finding; and
    - if the allegation involves conduct of a criminal nature, weight must be given to the presumption of innocence, and the court should not be satisfied by inexact proofs, indefinite testimony or indirect inferences.

10. The effect of the authorities is that Coroners should not make adverse findings against or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

CORONIAL INVESTIGATION

Forensic Pathology Investigation

11. Associate Professor (A/Prof) David Ranson, Deputy Director – Head of Forensic Services at the Victorian Institute of Forensic Medicine, performed a full post mortem examination upon the body of Mr Barkas, reviewed a post mortem computed tomography (CT) scan and referred to the Victoria Police Report of Death, Form 83.

12. At autopsy, A/Prof Ranson observed severe coronary artery atherosclerosis with fusiform and dissecting aneurysm formation; cardiomegaly; ischaemic heart disease; acute and subacute

[7] (1938) 60 CLR 336.

myocardial infarction; and hypertensive renal changes. A/Prof Ranson reported that the degree of Mr Barkas' coronary artery atherosclerotic disease meant that Mr Barkas would have been at very high risk of further ischaemic myocardial events and at high risk of sudden cardiac death associated with ischaemia related arrhythmia.

13. A minor injury was observed to the left side of Mr Barkas' head, including the bone ridge in the vicinity of his left eyebrow and upper left cheek. A/Prof Ranson opined that it would be possible for such an injury constellation to be seen after a fall to the ground. This injury was not associated with any intracranial trauma.

14. Toxicological analysis of Mr Barkas' post mortem blood did not detect any common drugs or poisons.

15. A/Prof Ranson ascribed Mr Barkas' death to natural causes, being ischaemic heart disease secondary to coronary artery atherosclerosis and aneurysm.

Police Investigation

16. Senior Constable (SC) Jeffrey Hempton was the nominated coroner's investigator.[8] At my direction, SC Hempton conducted an investigation of the circumstances surrounding Mr Barkas' death, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by four Senior Prison Officers and five Prison Officers.

17. Police ascertained that Mr Barkas had a room within the Johanna B cottage of the Karreenga Annexe. The unit is self-contained, and comprises six individual bedrooms, with communal living and kitchen facilities.

18. Upon attending the Johanna B cottage at Marngoneet Correctional Centre, police did not identify evidence of third-party involvement in Mr Barkas' death. Detective Senior Constable (DSC) Steven Robinson of the Wyndham Crime Investigation Unit (CIU) inspected the scene and identified Mr Barkas had small cuts to the left side of his face. DSC Robinson observed small blood smears on the floor of the bathroom, which he believed were consistent with the cuts, suggesting that Mr Barkas had fallen face first after being on the toilet.

[8] A coroner's investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the coroner to assist the coroner with his/her investigation into a reportable death. The coroner's investigator takes instruction from a coroner and carries out the role subject to the direction of a corner.

19. Prison Officer Ashlee Feeney stated that she observed Mr Barkas during a 'Let Out' count at 7.37am. She said that he was standing in the common area of Johanna B cottage, with no indication that there was a health issue.

20. In his summary to the coronial brief, SC Hempton advised that Mr Barkas was well regarded among prison staff and was considered to be polite and co-operative. SC Hempton added that there was no intelligence to suggest Mr Barkas had any conflict with other prisoners and all information indicated he was well regarded by other prisoners.

Department of Justice and Regulation – Office of Correctional Services Review

21. By way of letter dated 16 January 2017, Emma Catford, Director of the former Office of Correctional Services, (now the Justice Assurance and Review Office), provided the court with a report (OCSR) containing an overview of Mr Barkas' management in custody and the circumstances of his death. The OCSR also included a review conducted by Justice Health of Mr Barkas' health management.

22. The OCSR advised that, on 11 September 2007, Mr Barkas was received into custody in connection with charges relating to sexual offences. On 12 May 2010, Mr Barkas was sentenced to a total of 13 years and six months' imprisonment, with a non-parole period of nine years. He was placed on the Sex Offenders Register on 13 May 2010.

23. From 23 August 2007, a placement alert or "protection placement" was assigned to Mr Barkas, given the nature of his offences. On 6 October 2016, a medical alert was assigned, due to Mr Barkas having a medical condition requiring regular or ongoing treatment.

24. It was reported that Mr Barkas' Individual Management File revealed he was consistently described as polite, courteous and cooperative. During his nine years of imprisonment, there was only one recorded minor incident of unauthorised smoking on 2 February 2008.

25. The OCSR stated that the review had concluded Mr Barkas' custodial management by Corrections Victoria was appropriate and the prison's response to his death met required standards.

26. The Justice Health review identified that Mr Barkas had a medical history of type 2 diabetes controlled by diet, high blood pressure and high cholesterol. It was noted that Mr Barkas was prescribed medication to manage his blood pressure, but throughout his time in prison had continually refused to take medications to improve his diabetes control or cholesterol. This

was reportedly despite medical and health staff explaining the risks of not accepting treatment.

27. The review indicated that Mr Barkas attended regular reviews with medical, health and allied health staff while in prison. He self-monitored his diabetes on an infrequent basis but had regular blood tests as requested by the medical officers. Comprehensive chronic healthcare plans were in place to manage his various health issues. It was identified that Mr Barkas had developed poor dental health and had declined dental treatment that had been recommended on several occasions.

28. The Justice Health review indicated that Mr Barkas was transferred between prisons on several occasions throughout his incarceration. After 5 March 2014, Mr Barkas was held at Langi Kal Kal, and later at Port Phillip Prison and Marngoneet. On 19 September 2016, Mr Barkas was transferred to the Karreenga Annexe. A health assessment was conducted on transfer, noting he had type 2 diabetes, high cholesterol, high blood pressure and dental pain.

29. On 20 September 2016, Mr Barkas was reviewed by a medical officer after he reported experiencing pain and coughing. Upon examination his chest was clear. Mr Barkas was prescribed ibuprofen for pain relief. On 29 September 2016, Mr Barkas presented to the medical centre, and reported being short of breath the previous evening. His chest was clear, and he was afebrile. Pathology tests indicated Mr Barkas' diabetes and cholesterol were both poorly controlled. No changes were made to the management of his diabetes or hypertension. On 6 October 2016, Mr Barkas was reviewed by a medical officer, as he reported inflammation under his left armpit. Upon examination, signs of infection were evident, but he was afebrile. Mr Barkas was prescribed antibiotic therapy and pain relief.

30. Justice Health's review of Mr Barkas' custodial health records concluded that Mr Barkas' healthcare met the required standards, in accordance with Justice Health Quality Framework 2011.

31. There were no recommendations arising from either the OCSR or the Justice Health review of Mr Barkas' death.

Family Concerns

32. On 11 October 2016, the Court received a letter of concern from Mr Barkas' sister Estella Barkas, on behalf of his family. Estella stated that, while incarcerated, Mr Barkas had repeatedly voiced concerns about the medical treatment he was receiving. In particular, the

family's concerns related to treatment pertaining to Mr Barkas' dental issues, diabetes, high cholesterol and sleep apnoea. Other issues related to Mr Barkas' treatment by others at the facility, and whether or not he had been sexually assaulted. Estella also raised concerns about bruising the family had observed on Mr Barkas' face, following his death.

33. By way of letter dated 29 May 2017, Mr Barkas' mother Helen Barkas wrote to the Court. Mrs Barkas advised that she and her daughter visited Mr Barkas approximately two weeks prior to his death. She said that he looked the same as usual but seemed fearful and could not breathe well. Mrs Barkas expressed a desire to know the exact cause of her son's death and alleged that the prison had been negligent in his care. She queried if her son had died from natural causes, and if so, whether his treatment was delayed or neglected.

Coroners Prevention Unit Investigation

34. In light of the concerns raised by Mr Barkas' family, I requested that the Coroners Prevention Unit (CPU)[9] review Dr Ranson's autopsy report and records pertaining to his medical management in the Victorian Corrections system.

Cause of Death

35. The CPU reviewed Dr Ranson's Medical Examiners Report and noted that Mr Barkas died of ischaemic heart disease and that the most likely mode of death was an acute rhythm disturbance in the setting of poor circulation to the conducting area of the heart. The CPU stated that this may have been a complication of the heart attack that had occurred within the preceding days to weeks. However, it may equally have been an acute disturbance of blood flow to the conducting system that occurred at the time of death. The CPU explained that the latter cause would not be evident prior to his time of death.

Injuries to Mr Barkas' face

36. The CPU noted that Mr Barkas suffered injuries to his face proximate to his time of death, including some mixed bruise abrasions above the left eyebrow and the upper part of the left cheek and some mottled reddening of the front of the nose. The CPU concurred with Dr Ranson's conclusions that it is likely these injuries were sustained when Mr Barkas collapsed, especially given no further evidence of injury to the face or brain.

[9] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations, as well as assisting in monitoring and evaluating the effectiveness of the recommendations. The CPU comprises a team with training in medicine, nursing, law, public health and the social sciences.

Assessment of healthcare over the period of imprisonment

37. The CPU reviewed the OCSR of Mr Barkas' death, which outlined Mr Barkas' health assessments and interventions whilst he was incarcerated. This document and medical records evinced frequent relevant reviews of Mr Barkas by medical officers and specialists. However, Mr Barkas continued to decline treatment especially with respect to medication for his diabetes and cholesterol despite frequent advice and evidence that his diabetes was worsening and damaging his kidneys (protein in urine) and blood tests indicating poor diabetic control.[10]

38. Mr Barkas underwent a number of dental reviews during imprisonment. On 11 August 2016, a dental clinic review was conducted. Multiple other appointments were arranged that Mr Barkas failed to attend, including on: 31 May 2016, 28 April 2016, 17 March 2016 and 9 February 2016. He had an optometry review on 16 August 2016 and several medical reviews for minor problems of possible allergic reactions and skin rashes.

Assessment of healthcare in the weeks prior to death.

39. Mr Barkas' autopsy indicated scarring of the heart muscle sustained over some time. Dr Ranson commented there was also recent myocardial infarction of some days' duration affecting the papillary muscles of the heart valves, and healing myocardial infarction of several weeks' duration, on a background of more remote myocardial infarction and severe coronary artery disease. The CPU reviewed Mr Barkas' medical records to determine if there was any indication of the ischaemic events identified by Dr Ranson in days and weeks prior to death.

40. Following transfer to Marngoneet Correctional Centre in May 2016, Mr Barkas was reviewed on the following occasions:

    a. On 15 September 2016, Mr Barkas was seen by the medical officer with neck and shoulder pain. There was a normal range of movement, no skin or bony abnormalities and no neurological findings and a musculoskeletal condition was diagnosed. Treatment was an anti-inflammatory medication.

    b. On 19 September 2016, Mr Barkas had a review of his general health as part of his transfer from another facility in May 2016. The assessment was performed by a registered nurse who documented Mr Barkas' medical history as including

[10] Please see the *Office of Correctional Services Review into the death of Harry Barkas at Karreenga Annex on 7 October 2016*, dated 16 January 2017 part 3.1, 3.2 and 3.4.

hypertension, diabetes and tooth pain. He complained of on-going tooth pain during this assessment. A diabetes/endocrine review was also completed with Mr Barkas. A review by the medical officer was scheduled for the following day for both the general issues (tooth pain) and endocrine review and all appropriate blood tests were ordered.

c. On 20 September 2016, Mr Barkas was seen by Dr Hossain Mirza, medical officer. The notes recorded:

Lots of pain issues --on naproxen which is not available this week. Has ibuprofen as prn--can have that at his room which he preferred to get. Coughing for a while --feels like wet cough. On exam--chest clear, O2 98% RA Mx: Routine blood test as requested by staff.

d. These blood tests were taken on 27 September 2016. Dr Mirza stated that Mr Barkas had no known history of ischaemic heart disease and that he did not complain of chest pain during this consultation.[11] Routine follow up of chronic conditions was organised.

e. At 12.26pm on 29 September 2016, Mr Barkas was seen by Leanne Hallworth as he had experienced breathlessness during the night. Ms Hallworth was a registered nurse and had also completed a Cardiac Specialist Nurse program at Barwon Health.[12]

f. Nurse Hallworth recorded Mr Barkas' vital signs: blood pressure 102/71 mmHg, pulse rate 108 beats per minute (elevated), temperature 36.6 degrees Celsius and oxygen saturation 95%. During the assessment, Mr Barkas said he did not feel light headed but he did feel wheezy. On examination of his chest, Nurse Hallworth did not identify a wheeze or any other abnormality. She noted that he was expectorating green or yellow sputum which could be indicative of an infection. However, Nurse Hallworth did not identify any formulation or cause for his symptoms and no specific treatment was given. Nurse Hallworth stated that she organised a routine review of Mr Barkas for 7 October 2016.

[11] Coronial File, *Statement of Dr Mirza Hossain dated 2 August 2018*, provided the Coroners Court 6 August 2018.

[12] Coronial File, *Statement of Registered Nurse Leanne Hallworth dated 5 September 2018*, provided the Coroners Court on 6 September 2018.

INQUEST

41. Pursuant to section 52(1) of the Act, a coroner may hold an Inquest into any death he/she is investigating. Section 52 of the Act mandates the holding of an Inquest if the deceased was, immediately before death, a person placed in custody. However, an Inquest is not mandatory where the person is deemed to have died from natural causes, pursuant to section 52(3A).

42. In light of the concerns raised by his family, I considered it appropriate to use my discretion to hold a Summary Inquest into Mr Barkas' death on 20 March 2019. However, I did not deem it necessary to hear from any witnesses.

COMMENTS

1. I acknowledge the grief endured by Mr Barkas' family in the wake of his passing, and the concerns expressed by Mrs Helen Barkas and Ms Estella Barkas in their letters to the Court. However, the investigation has not identified a link between the family's concerns relating to Mr Barkas' treatment for dental issues, diabetes, high cholesterol and sleep apnoea, alleged bullying or post mortem bruising on his face, and the cause of his death. Moreover, the investigation has not elicited any evidence to substantiate the family's claims in this regard. In particular, I note the evidence of Justice Health that Mr Barkas had steadfastly refused to adhere to recommendations that he take medication to control his diabetes at a number of different facilities over the years.

2. Eight days before death, Mr Barkas complained of shortness of breath. It is possible that this represented a presentation of myocardial ischaemia. However, his clinical presentation was more likely due to another cause, such as respiratory infection, as Mr Barkas complained of a wheeze and was expectorating green and yellow sputum. While the Nurse Hallworth's assessment was limited, her notes indicated that Mr Barkas' breathing had returned to normal, there was no chest pain and there were symptoms suggestive of a non-cardiac issue. There was no clear indication, based on the information available, for an ECG or urgent medical review.

3. The medical management of Mr Barkas over many years leading up to his death was reasonable. There was evidence that Mr Barkas' other health concerns regarding his teeth and eyes were also addressed.

FINDING

Mr Barkas was suffering from multiple co-morbidities during his imprisonment. Moreover, A/Prof Ranson's report has indicated that Mr Barkas was afflicted by significant cardiac disease, including: severe coronary artery atherosclerosis with fusiform and dissecting aneurysm formation; cardiomegaly; ischaemic heart disease; and acute and subacute myocardial infarction.

On the evidence available to me, I find that the provision of care to Mr Barkas while he was imprisoned was appropriate, given his longstanding medical co-morbidities. I further find that there was no causal connection between the fact that Mr Barkas was a person placed in custody and the cause of his death.

I accept and adopt the medical cause of death as identified by A/Prof David Ranson and find that Harry Barkas died from natural causes, being ischaemic heart disease secondary to coronary artery atherosclerosis and aneurysm.

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:

Ms Helen Barkas

Ms Michelle Gavin, Acting Director at the Justice Assurance and Review Office

Ms Kellie Dell'Oro, Meridian Lawyers on behalf of Correct Care Australasia Pty Ltd

Senior Constable Jeffrey Hempton

Signature:

AUDREY JAMIESON
CORONER
Date: **20 February 2019**