IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 6991

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Katherine Lorenz
Deceased:	John Paul Barnett
Date of birth:	5 December 1943
Date of death:	25 December 2020
Cause of death:	1(a) Complications of chronic obstructive airways disease and ischaemic heart disease
Place of death:	St Vincents Hospital, 41 Victoria Parade, Fitzroy, Victoria, 3065

INTRODUCTION

1. On 25 December 2020, John Paul Barnett was 77 years of age when he died in St Vincent's Hospital.

2. Mr Barnett had a significant and complex medical history including chronic obstructive pulmonary disease, ischaemic heart disease, cardiomyopathy, congestive cardiac failure, hypertension, chronic kidney disease, chronic anaemia and diffuse large B-Cell lymphoma.

3. At the time of his death, Mr Barnett was serving a sentence of imprisonment at Port Phillip Prison. He required multiple hospital visits and admissions during his term of incarceration. Since 19 January 2012, he had been assigned an 'M2' risk rating denoting a medical condition requiring regular ongoing treatment.

4. Mr Barnett was diagnosed with diffuse large B-Cell lymphoma, a fast-growing cancer, in about June 2020. He commenced chemotherapy but his prognosis was considered poor with a life expectancy of less than 12 months.

5. On 14 December 2020, he was admitted to St Vincent's Hospital with increasing shortness of breath secondary to cardiac failure. On 22 December 2020, he was returned to St John's sub-acute unit at Port Phillip Prison and, following a consultation between Mr Barnett and his medical treating team, a plan was made to institute palliative care measures.

6. By 24 December 2020, Mr Barnett's condition had further deteriorated. His observations were unstable, he was drowsy with limited ability to respond to questions and had poor oral intake.

THE CORONIAL INVESTIGATION

7. Mr Barnett'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.

8. 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.

9. 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.

10. Following Mr Barnett's death, the Justice Assurance and Review Office (**JARO**) of the DJCS conducted a review of the custodial management and healthcare provided to Mr Barnett. I have reviewed the information and material provided by JARO including a Death in Custody Report prepared by Justice Health, a business unit within the DJCS responsible for delivering health services to Victorian prisoners.

11. This finding draws on the totality of the coronial investigation into the death of Mr Barnett. 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]

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

Circumstances in which the death occurred

12. On Thursday, 24 December 2020, at approximately 2:10pm, Mr Barnett was admitted to the St Augustine's secure ward of St Vincent's Hospital.

13. On 25 December 2020, at approximately 2:10am, he was found unresponsive by a nurse attending on him to conduct observations. A second nurse attended minutes later and advised the two present Correctional Officers that Mr Barnett appeared deceased. This was formally confirmed by a doctor at 2:25am.

14. Following Mr Barnett's death, JARO conducted a review and found that his management met the standards prescribed by Corrections Victoria. Justice Health reviewed Mr Barnett's health records and found nothing to suggest that the healthcare afforded to Mr Barnett was not in accordance with the *Justice Health Quality Framework 2014*. Justice Health made no recommendations for systemic improvements arising from Mr Barnett's death.

[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.

Identity of the deceased

15. On 31 December 2020, John Paul Barnett, born 5 December 1943, was identified via fingerprint identification.

16. Identity was not in dispute and required no further investigation.

Medical cause of death

17. Forensic Pathologist Professor Noel Woodford, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 28 December 2020 and provided a written report of his findings dated 15 January 2021. In preparing his report, Professor Woodford reviewed the medical deposition, Victoria Police Report of Death (Form 83) and post-mortem computed tomography (**CT**) scan.

18. The post-mortem examination did not show any injuries of a kind likely to have caused or contributed to death.

19. A routine post-mortem CT scan revealed small irregular kidneys, implanted pacemaker, coronary artery calcification, lung opacities and hiatus hernia.

20. Professor Woodford opined that the death was due to natural causes which he formulated as 1 (a) *complications of chronic obstructive airways disease and ischaemic heart disease*.

21. I accept Dr Woodford's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was John Paul Barnett, born 5 December 1943;

    b) the death occurred on 25 December 2020 at St Vincents Hospital, 41 Victoria Parade, Fitzroy, Victoria, 3065, from natural causes formulated as *complications of chronic obstructive airways disease and ischaemic heart disease*; and

    c) the death occurred in the circumstances described above.

23. Having considered all the available evidence, I am satisfied that Mr Barnett's custodial and healthcare management was appropriate and met the required standards in accordance with the *Justice Health Quality Framework 2014*.

24. 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.

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

Carlene Grills, Senior Next of Kin

Allison Will, Director, Justice Assurance and Review Office

Donna Filippich, Legal Counsel, St Vincent's Hospital Melbourne

Signature:

Coroners Court of Victoria

Coroner Katherine Lorenz

Date : 28 March 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.