IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 003111

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Elizabeth Helen Barber
Date of birth:	16 September 1946
Date of death:	15 June 2021
Cause of death:	1(a) Metastatic duodenal carcinoma
Place of death:	Thomas Embling Hospital, 201 Yarra Bend Road, Fairfield, Victoria, 3078
Keywords:	Death in custody; natural causes

INTRODUCTION

1. On 15 June 2021, Elizabeth Helen Barber was 74 years old when she died of natural causes at the Thomas Embling Hospital. At the time of her death, Ms Barber resided at the Thomas Embling Hospital on a Custodial Supervision Order.

2. Ms Barber had a secure childhood and grew up in Brighton with her parents and two sisters. According to her sister Rosemary, she was a 'vaguely annoying or wilful child' who was naughty and would have been quite difficult to parent.[1]

3. Ms Barber finished secondary school and studied a secretarial course before moving overseas until she was around 27 years old. She was brave and courageous. On her return to Melbourne, she studied nursing at the Alfred Hospital and worked as an Enrolled Nurse in aged care facilities until she was in her fifties.[2]

Medical and forensic history

4. Ms Barber was diagnosed with schizophrenia in the mid-1970s. Early in her diagnosis, Ms Barber spent time between inpatient psychiatric wards and boarding houses and was cared for by her mother and Rosemary. According to Rosemary, Ms Barber was very intelligent, had a lot of insight into her illness and was able to 'play the system'.[3]

5. In the later years of her life, Ms Barber became 'totally institutionalised'. Her cry for help was to light fires. At one stage, in protest of being discharged from St Vincent's Hospital, Ms Barber set fire to her bed and was subsequently sentenced to nine months at the Rosanna Psychiatric Hospital.[4]

6. On 9 November 2009, Ms Barber was found not guilty by reason of mental impairment on a charge of arson, having set fire to her apartment. She was placed on a Non-Custodial Supervision Order under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*.[5]

7. On 16 October 2013, Ms Barber was apprehended and admitted to the Barossa Unit, an acute women's unit, at Thomas Embling Hospital (**Thomas Embling**). A year later, her

[1] Coronial Brief (**CB**), Statement of Rosemary McLeish, dated 8 November 2021.
[2] Ibid.
[3] Ibid.
[4] Ibid.
[5] CB, Statement of Dr Oladipo Surungbe, dated 9 December 2021.

Non-Custodial Supervision Order was varied to a Custodial Supervision Order. On 28 January 2018, Ms Barber was transferred to the Daintree Unit, a rehabilitative unit Thomas Embling.[6]

8. Ms Barber's placement at Thomas Embling was for the treatment and rehabilitation of her schizophrenia, as well as to address her offending and risk of violence. She received 24-hour monitoring and care from a multidisciplinary team of medical and allied health staff.[7]

9. Ms Barber's other medical history included pulmonary emboli, breast cancer, and goitre. She had a family history of breast cancer and pulmonary embolus.[8]

THE CORONIAL INVESTIGATION

10. Ms Barber's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). 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.

11. 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.

12. 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.

13. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Ms Barber'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.

14. This finding draws on the totality of the coronial investigation into the death of Elizabeth Helen Barber including evidence contained in the coronial brief. Whilst I have reviewed all

[6] Ibid.
[7] Ibid.
[8] CB, Statement of Dr Danielle Ko, dated 24 January 2022.

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.[9]

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

Circumstances in which the death occurred

15. On 26 April 2021, Ms Barber was transferred by ambulance from Thomas Embling to the Emergency Department at the Austin Hospital for assessment and management of a two-month history of worsening postural hypotension, fainting, dizziness and generalised weakness.[10]

16. On 27 April 2021, Ms Barber was admitted under the respiratory medical unit. She was found to have chronic and occlusive pulmonary emboli, which she had ceased medication for two weeks prior, and duodenal adenocarcinoma with metastases to the lungs and lymph nodes. She advised doctors that she did not want treatment and requested a palliative care referral.[11]

17. Ms Barber was reviewed by the Palliative Care Unit on 30 April and 3 May. She continued to decline further investigation and treatment. Ms Barber was recommenced on apixaban for pulmonary emboli and commenced pain management.

18. On 8 May 2021, Ms Barber was transferred to the Palliative Care Unit for symptom management and likely end of life care. She remained in the Palliative Care Unit for assessment and symptom management whilst the most appropriate discharge destination was decided.

19. On 12 May 2021, Ms Barber was discharged back to Thomas Embling. She was to remain at Thomas Embling with the support of Melbourne City Mission Palliative Care unless her symptoms could not be well managed.

20. The Melbourne City Mission Palliative Care team reviewed Ms Barber several times between 17 May 2021 and her death on 15 June 2021. Clinicians provided advice to her treating team

[9] 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.
[10] CB, Statement of Dr Danielle Ko, dated 24 January 2022.
[11] Ibid.

at Thomas Embling, including to increase her pain relief dosage in response to her reports of increasing pain and nausea.[12]

21. At 10:30pm on 15 June 2021, Registered Nurse Novuyiso Gumede took over observation of Ms Barber. She observed Ms Barber looking visibly uncomfortable, struggling to breathe and groaning. She became unresponsive and Nurse Gumede called a Code Blue. Ms Barber was declared deceased at 10:54pm.[13]

Identity of the deceased

22. On 15 June 2021, Elizabeth Helen Barber, born 16 September 1946, was visually identified by nurse Dr Novuyiso Gumede, who completed a Statement of Identification.

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

Medical cause of death

24. Forensic Pathologist Dr Brian David Beer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on the body of Elizabeth Barber on 16 June 2021. Dr Beer reviewed the Victoria Police Report of Death (Form 83), E-Medical Deposition Form of Thomas Embling Hospital and post mortem computed tomography (**CT**) scan and provided a written report of his findings dated 2 July 2021.

25. The external examination showed findings in keeping with the clinical history. The post mortem CT scan showed multiple "secondary" masses in both lungs. A duodenal mass was not clearly identified.

26. Dr Beer provided an opinion that the medical cause of death was 1 (a) METASTATIC DUODENAL CARCINOMA.

FINDINGS AND CONCLUSION

1. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Elizabeth Helen Barber, born 16 September 1946;

[12] CB, Statement of Associate Professor Brian Le, dated 7 December 2021.
[13] CB, Statement of Novuyiso Gumede

b) the death occurred on 15 June 2021 at Thomas Embling Hospital, 201 Yarra Bend Road, Fairfield, Victoria, 3078;

c) I accept and adopt the medical cause of death as ascribed by Dr Brian David Beer and I find that Elizabeth Helen Barber died from metastatic duodenal carcinoma;

2. AND, having considered all of the circumstances, I find that Elizabeth Helen Barber died from natural causes. There is no evidence of any causative link between her cause of death and the fact that she was a person in custody, as defined in the *Coroners Act 2008*. Accordingly, I was not required to hold an Inquest into her death.[14]

I convey my sincere condolences to Ms Barber's family 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.

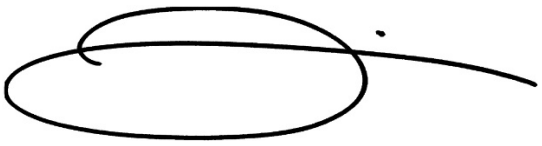
I direct that a copy of this finding be provided to the following:

Rosemary McLeish, Senior Next of Kin

Austin Health

Senior Constable Alexander Urano, Coroner's Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 13 December 2023

[14] Section 52(3A) of the *Coroners Act 2008* (Vic).

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.