IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2023 003324

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the ***Coroners Act 2008***

Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Deceased:	Patrick Anthony Barry
Date of birth:	29 April 1951
Date of death:	20 June 2023
Cause of death:	1(a) Aspiration pneumonia and small bowel obstruction 1(b) Metastatic bowel cancer
Place of death:	Colac Area Health, 2-28 Connor Street, Colac, Victoria
Key words:	Aspiration pneumonia, small bowel obstruction, metastatic bowel cancer, person placed in custody or care

INTRODUCTION

1. On 20 June 2023, Patrick Anthony Barry was 72 years old when he passed away in hospital. At the time, Mr Barry lived in Colac.

2. Mr Barry had an intellectual disability. He lived in supported residential facilities from a young age, moving to Specialist Disability Accommodation located in Colac in 2019 where he lived with two other residents.

3. Mr Barry required support with his activities of daily living, including medical care. He was non-verbal and in later life used a wheelchair to mobilise. He enjoyed participating in activities at his day program run by GenU in Colac. However, in the months leading to his death, he retired from group activities due to declining health.

4. Mr Barry had severe dysphagia, which meant he was at high risk of choking and developing aspiration pneumonia. He was therefore provided with pureed foods and thickened liquids to reduce this risk. His medical history also included scoliosis, recurrent chest infections, congestive heart failure, and epilepsy.

5. In early May 2023, Mr Barry was diagnosed with aspiration pneumonia, and he was admitted to Colac Area Health for one week. He was discharged home on 11 May 2023 with oral antibiotics.

6. On 16 May 2023, Mr Barry returned to Urgent Care at Colac Area Health with shortness of breath and aspiration. He was not admitted on this occasion and discharged home with antibiotics.

7. On 15 June 2023, Mr Barry's general practitioner diagnosed him with an upper respiratory tract infection and prescribed prednisolone to assist. He was due to have a follow-up medical review in one week.

8. Mr Barry was supported by his parents who visited him regularly until their respective deaths. He thereafter received ongoing love and support from his sisters who noted that he was very happy in his Colac home and loved his carers.

THE CORONIAL INVESTIGATION

9. Mr Barry'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. Generally, reportable deaths include deaths that are unexpected, unnatural or violent, or result from accident or injury. However, if a person satisfies the definition of a person placed in care immediately before death, the death is reportable even if it appears to have been from natural causes.[1]

10. 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.

11. 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.

12. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Barry'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.

13. This finding draws on the totality of the coronial investigation into Mr Barry'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.[2]

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[1] See the definition of "reportable death" in section 4 of the *Coroners Act 2008* (**the Act**), especially section 4(2)(c) and the definition of "person placed in custody or care" in section 3 of the Act. Regulation 7(1)(d) of the Coroners Regulations 2019 provides that a 'person placed in custody or care' now includes *"a person in Victoria who is an SDA resident residing in an SDA enrolled dwelling".* 'SDA resident' has the same meaning as in the *Residential Tenancies Act 1997* (Vic) and captures a person who is an SDA recipient (that is, an NDIS participant who is funded to reside in an SDA enrolled dwelling). 'SDA enrolled dwelling' also has the same meaning as in the *Residential Tenancies Act 1997* and is defined as a: *"long term accommodation for one or more SDA resident and enrolled as an SDA dwelling under the National Disability Insurance Scheme (Specialist Disability Accommodation) Rules 2016 of the Commonwealth as in force from time to time or under other rules made under the National Disability Insurance Scheme Act 2013 of the Commonwealth."*

[2] 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.

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

Identity of the deceased

14. On 21 June 2023, Patrick Anthony Barry, born 29 April 1951, was visually identified by his nurse, Pauline Wheeler, who signed a formal Statement of Identification to this effect.

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

Medical cause of death

16. Forensic Pathologist, Dr Paul Bedford, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection on 22 June 2023 and provided a written report of his findings dated 29 June 2023.

17. The post-mortem examination was consistent with the reported circumstances.

18. Dr Bedford provided an opinion that the medical cause of death was *"1(a) Aspiration pneumonia and small bowel obstruction"* secondary to *"1(b) Metastatic bowel cancer". He noted the death was due to natural causes.*

19. I accept Dr Bedford's opinion.

Circumstances in which the death occurred

20. On 18 June 2023, Mr Barry presented to Urgent Care at Colac Area Health with shortness of breath and abdominal distension. There was suspicion of bowel obstruction, so a CT scan of the pelvis and abdomen was performed.

21. The CT scan revealed multifocal small bowel obstruction with a possible stenosing lesion in the transverse colon. There were also probable chest wall and spinal metastases and a possible pulmonary embolus.

22. Following discussion with his family, Mr Barry was treated for pneumonia and possible pulmonary embolus, but it was understood that there was no surgical cure for his malignancy.

23. Mr Barry was kept comfortable until he passed away peacefully at 6.00pm on 20 June 2023.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was Patrick Anthony Barry, born 29 April 1951;

    (b) the death occurred on 20 June 2023 at Colac Area Health, 2-28 Connor Street, Colac, Victoria;

    (c) the cause of Mr Barry's death was aspiration pneumonia and small bowel obstruction secondary to metastatic bowel cancer; and

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

25. The available evidence does not support a finding that there was any want of clinical management or care on the part of those caring for Mr Barry at his home or on the part of clinicians involved in his care that caused and contributed to his death.

I convey my sincere condolences to Mr Barry's family and community 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:

Kaye Lovett, senior next of kin
Colac Area Health
Senior Constable Toby Cameron, Victoria Police, Coroner's Investigator

Signature:

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Deputy State Coroner Paresa Antoniadis Spanos

Date: 12 April 2024

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.