IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 002724

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Adam Barry
Date of birth:	6 May 1972
Date of death:	17 May 2024
Cause of death:	1a: Perforation of a hollow viscus complicating oesophageal cancer in a man with cerebral palsy
Place of death:	Monash Medical Centre 246 Clayton Road Clayton Victoria 3168
Keywords:	In care, Specialist Disability Accommodation, SDA, supported independent living, disability, natural causes

INTRODUCTION

1. On 17 May 2024, Adam Barry[1] was 52 years old when he died while receiving inpatient palliative care at the Monash Medical Centre in Clayton.

2. Adam's medical history included cerebral palsy, dysphagia and epilepsy. In February 2024, he was diagnosed with metastatic oesophageal cancer.

3. At the time of his death, Adam had been living in Specialist Disability Accommodation (**SDA**) in Mount Waverly. The SDA was enrolled under the National Disability Insurance Scheme (**NDIS**) and operated by disability service provider Scope. Adam had been a resident of this home for 27 years where he was affectionally known as 'Boz'. Staff at Scope supported Adam in activities of daily living and with his personal care needs.

4. Owing to his disabilities, Adam had limited mobility in his limbs and he used a motorised wheelchair to get around. Adam communicated by using an iPad which he would use to spell out words.

5. Adam was a disability advocate and was once the face of Public Transport Victoria's disability brochures and he also appeared as part of a television commercial for them. Adam also assisted the Victoria Police Academy, Metro Trains and Government House in training staff and new recruits on how to best work with people with disabilities.

6. Adam was a passionate supporter of St Kilda Football Club and enjoyed also watching WWE wrestling and the Melbourne Renegades Cricket team. Adam also participated in the Balloon Football League, a sport for persons in wheelchairs that is played with a balloon on basketball courts. He was known to love cooking and good food as well as travelling with his family.

7. Adam was initially cared for by his father Warren Barry and his step-mother Pamela Crees until Warren's death in 2017, after which Pamela cared for Adam. In 2022 Adam's cousin Kathryn Nichols (**Kathryn**), along with her husband Dennis Nichols, took over Adam's care and were his enduring power of attorney and medical treatment decision makers until the time of his death.

[1] Referred to throughout my finding as 'Adam' unless more formality is required.

THE CORONIAL INVESTIGATION

8. Adam's death 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. Adam was a person in care at the time of his death and he was an SDA resident living in an SDA dwelling pursuant to Regulation 7 of the *Coroners Regulations 2019* (Vic).

9. This category of death is reportable to ensure independent scrutiny of the circumstances leading to death given the vulnerability of this cohort and the level of power and control exercised by those who care for them. The coroner is required to investigate the death, and publish their findings, even if the death has occurred as a result of natural causes.

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. This finding draws on the totality of the coronial investigation into the death of Adam Barry, including evidence contained in the coronial brief and information from the National Disability Insurance Agency (**NDIA**). 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]

[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

Circumstances in which the death occurred

13. On 30 January 2024, Adam presented to hospital with vomiting. Clinical investigations discovered a lower oesophageal mass and he was subsequently diagnosed with metastatic oesophageal cancer on 1 February 2024.

14. The oncological opinion at the time was that Adam was not a candidate for radiotherapy or chemotherapy treatment owing to his clinical condition, making the treatments difficult. After admission to hospital, clinical discussions were had with Adam and Kathryn regarding the course of treatment for Adam. It was determined that Adam did not want invasive treatment and instead preferred to manage the symptoms of his disease.

15. Clinicians offered Adam treatment via a palliative oesophageal stent (**POS**). The POS is inserted via surgical procedure with the aim to open a blockage in Adam's oesophagus to enable him to continue to tolerate food and fluids and assist him with breathing and swallowing which were made difficult due to the cancerous mass. Through consultation with Adam and Kathryn, the POS was not inserted at the time of diagnosis.

16. On 6 March 2024, Adam returned to his home and was supported as an outpatient by the Eastern Health Palliative care team.

17. On 29 March 2024, Ambulance Victoria were called by Scope staff to the home after Adam was found to be experiencing acute pain in the abdomen. Paramedics assessed Adam and recommended he be transferred to hospital, but Adam declined. Ambulance Victoria advised Adam's palliative care team of what had occurred who later contacted Scope staff to advise that Adam should be monitored closely.

18. After the cancer diagnosis, Adam's clinical presentation deteriorated with progressive difficulty with swallowing, a reduced appetite, vomiting and weeks of cough. He was admitted to the Monash Medical Centre on 13 April 2024 an x-ray revealed a potential aspiration pneumonia.

19. At this time Adam continued with non-invasive treatment including antibiotics for the suspected pneumonia and a referral to the gastroenterology team. Adam was reviewed by gastroenterology on 19 April 2024, and he was again offered a POS procedure, but Adam declined to undertake the procedure.

20. On 21 April 2024, Adam had a further clinical deterioration with acute abdominal pain. A computed tomography (**CT**) scan was conducted that revealed Adam's cancer had further progressed and metastasised.

21. On 24 April 2024, following further clinical decline with cough, hypoxia and tachycardia, Adam was reviewed by the Monash Health palliative care team where end of life care was discussed with Adam. Adam expressed a wish to go home but the doctors at Monash Health explained that it would be difficult for that to occur due to his requirement for acute care and medication that could not be facilitated at the Scope home.

22. On 25 April 2024, Adam was admitted to Monash Health's McCulloch House for end-of-life care. There it was determined that Adam wished to continue to explore the possibility of continuing end-of-life care at his home and he also expressed a desire to attend one last St Kilda football match. While at McCulloch house Adam's treatment included pain management, anti-nausea medication and seizure prophylaxis.

23. On Adam's 52nd Birthday on the 4 May 2024 clinicians were able to stabilise Adam, and despite concerns for ongoing aspiration, Adam was able to attend the first half of the St Kilda Football club game at Marvel Stadium in Melbourne. The outing was organised by Kathryn who was able to arrange a Corporate Box for Adam. Adam was unable to stay for the whole match and later returned to McCulloch House for care.

24. In the days after, Adam's condition continued to decline where he was noted to be increasingly fatigued and less alert. On 15 May 2026 clinicians identified he was approaching terminal phase. He was supported by medication to manage his pain.

25. On 17 May 2024 at 4.10am, Adam died peacefully at McCulloch house.

Identity of the deceased

26. On 17 May 2024, Adam Barry, born 6 May 1972, was visually identified by his cousin, Kathryn Nichols.

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

Medical cause of death

28. On 20 May 2024, Forensic Pathologist Dr Judith Fronczek from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination and provided a written report

of her findings, which were consistent with Adam's stated history. Toxicological analysis was not undertaken.

29. Dr Fronczek provided an opinion that the medical cause of death was '*1(a) perforation of a hollow viscus complicating oesophageal cancer in a man with cerebral palsy.'* Dr Fronczek provided an opinion that the cause of death was due to natural causes.

30. I accept Dr Fronczek's opinion.

FURTHER INVESTIGATION

31. In the course of my investigation, I received a statement from Kathryn as part of the coronial brief that outlined concerns regarding Adam's care by Scope. Kathryn offered that Adam was wanting to move from the facility as he was not provided with appropriate recreational activities outside the home and that he felt he needed a change for his physical and mental health.

32. The coronial brief also included medical records that outlined a concerning incident where Adam was overdosed with pain medication following a dental procedure and incidences of pressure sores which were reported to be present for 'years'.

33. As a result, I determined to seek further information from Scope as to the care provided to Adam.

34. Scope provided me a statement of Chief Operating Officer Nicole Standfield dated 24 July 2026. Scope also provided further records in support of their statement.

35. The materials revealed that Adam had a structured plan of activities outside the home that involved a visiting the Scope 'Social Connections' day program in Carnegie two days a week. Adam was also further supported by the Blue Heart Community Care team to access the community for activities a further two days per week. Activities that were facilitated included cooking classes, shopping, cultural excursions, watching movies, crafts, and work experience and training. On days that Adam did not visit the community, he engaged in self-paced activities such as participating in household tasks, socialising with other residents, and watching sport on television. In April 2024, Adam became too unwell to participate in his day program.

36. In April 2023, Adam received an overdose of pain medication following a dental procedure whereby the wrong medication was provided to Adam owing to an error by the dispensing

pharmacist and the error was not picked up by Scope staff at the time. As a result, Adam was hospitalised. Scope investigated the incident and identified that there were opportunities to improve internal systems to ensure medication is appropriately checked and administered. As a result, Scope implemented systems changes including an updated medication administration procedure and improvements in medication storage, checking and staff training.

37. Scope outlined that Adam had experienced pressure sores whilst residing in the SDA and appropriate referrals were made to his treating general practitioner and nurse practitioner care provided by Bolton Clark to manage these concerns.

38. I identified no further concerns of care. While I acknowledge the concerns of Adam's family, I note that Scope's care of Adam appeared to be considered and appropriate, and that there is no evidence that any reported incident in the period before his death (such as the medication error) had a contributory role in his death.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Adam Barry, born 6 May 1972;

    b) the death occurred on 17 May 2024 at Monash Medical Centre, 246 Clayton Road, Clayton, Victoria from perforation of a hollow viscus complicating oesophageal cancer in a man with cerebral palsy; and

    c) the death occurred in the circumstances described above.

40. Having considered all the available evidence, I find that Adam's death was due to natural causes. As such, I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into his death and to finalise the investigation of Adam's death by way of a written finding.

41. The available evidence does not support a finding that there was any want of clinical management or care on the part of Scope, or the clinical staff at Monash Medical Centre that caused or contributed to Adam's death. The factual matrix of Adam's death does not, therefore, support a conclusion that him being 'in care' at the time of his death – according to the Act – had a causal relationship with his death. In such circumstances, I have not identified any opportunities for prevention.

I convey my sincere condolences to Adam's family, friends and carers for their loss and note that Adam was clearly loved and well supported in life.

ORDERS AND DIRECTIONS

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:

Kathryn Nichols, Senior Next of Kin

Monash Health

Scope (Aust) Ltd

First Constable Jerome de Mink, Coronial Investigator

Signature:

Coroner Ingrid Giles

Date: 21 August 2026

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.