IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 001633

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the Death of Barry Arthur Seaton

Delivered On:	17 September 2026
Delivered At:	65 Kavanagh St, Southbank, Victoria, 3006
Hearing Dates:	17 September 2026
Findings of:	Coroner Simon McGregor
Counsel Assisting the Coroner:	Nicholas Ngai, Senior Solicitor
Keywords	SDA resident; In care death; Disability

I, Coroner Simon McGregor, having investigated the death of Barry Arthur Seaton, and having held an inquest in relation to this death on 17 September 2026, make findings as follows.

INTRODUCTION

1. On 21 March 2024, Barry Arthur Seaton was 66 years old when he died in the Palliative Care Centre at the Frankston Community Rehabilitation Centre at 125 Golf Links Road, Frankston, which is operated by Peninsula Health.

2. At the time of his death, Barry resided in Supported Disability Accommodation (**SDA**) operated by Scope (Aust) Ltd at 15 Coolibah Crescent, Bayswater. Barry received full assistance for daily living activities including meal preparation, personal care and medication administration.[1]

3. Barry had a medical background that included cerebral palsy, epilepsy and recurrent aspiration pneumonia, and was wheelchair-bound.[2] Barry attended Scope's Ringwood Social Connections program, a daily program for social outings. Barry was a long-term powered wheelchair user who required full assistance with activities of daily living but had demonstrated significant independence in operating his wheelchair within the community.[3]

THE CORONIAL INVESTIGATION

4. 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. Because Barry was an SDA resident residing in an SDA enrolled dwelling at the time of his death, his passing was determined to be 'in care'[4] and, as such, is subject to a mandatory inquest, pursuant to section 52(2) of the Act.

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[1] *Coronial Brief*, Statement of Shirley Marshallsea (Scope).
[2] Ibid.
[3] Ibid.
[4] See Regulation 7(1)(d) of the *Coroners Regulations 2019*.

5. 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.

6. 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.

7. At my direction, Victoria Police assigned Senior Constable Brooke Jeffrey to be the Coronial Investigator for Barry's death. Senior Constable Jeffrey conducted inquiries and took statements from witnesses before compiling and submitting a coronial brief of evidence.

8. This finding draws on the totality of the coronial investigation into the death of Barry Arthur Seaton 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.[5]

9. In considering the issues associated with this finding, I have been mindful of Barry's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

[5] 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, pursuant to section 67(1)(c) of the Act

10. On 18 March 2024, Barry attended a community outing to Frankston Pier with eight other participants and four Disability Support Workers.[6] During the outing, Barry drove his powered wheelchair towards the end of the pier before subsequently falling down an unprotected stairway onto the lower platform.[7] Barry sustained a head strike in the fall and was unconscious.[8]

11. Barry was taken by ambulance to the Frankston Hospital Emergency Department, where he was found to be in respiratory distress, to have a left scalp laceration, bilateral pneumothoraxes, a right first rib fracture, bilateral subcutaneous emphysema and a possible right kidney laceration.[9]

12. After discussion between the medical team and Barry's family about the likely poor outcome of active medical intervention, Barry was transitioned to comfort care and he passed away around 2:00 am on 21 March 2024.[10]

13. A member of the Victoria Police Collision Reconstruction and Mechanical Investigation Unit (**CRMIU**) inspected Barry's electric motorised wheelchair. The CRMIU findings confirmed that:[11]

    a) Electric motors were operational and within their limits;

    b) The brakes were functional as intended by the manufacturer; and

    c) The wheels and suspension were functional and performed to manufacturer's specification.

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[6] *Coronial Brief*, Statements of Georgia Krueger and Sharon DeBonde-Foley.
[7] Ibid.
[8] Ibid.
[9] *Coronial Brief*, Statement of Dr Cherelynn Holmes (Peninsula Health).
[10] Ibid.
[11] *Coronial Brief*, CRMIU report of Senior Constable Daniel Pierce.

Identity of the deceased

14. On 21 March 2024, Barry Arthur Seaton, born 6 February 1958, was visually identified by their disability worker, Andrew Margrave.

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

Medical cause of death

16. Forensic Pathologist Dr Victoria Francis from the Victorian Institute of Forensic Medicine conducted an external examination on 22 March 2024 and provided a written report of her findings dated 5 April 2024.

17. Post-mortem examination revealed evidence of an adult male with fixed limb flexion with wasting in his lower limbs. There was evidence of bruising over his hip and chest region and a bandage was noted over his right scalp.

18. Post-mortem CT scans revealed evidence of no obvious intracranial haemorrhage. The cervical spine appeared intact and the bladder was distended with urine containing contrast. There was no definite renal injury identified and there was a right pneumothorax with increased lung markings, as well as bilateral subcutaneous emphysema. A right rib fracture was also confirmed.

19. Toxicological analysis of post-mortem blood samples identified the presence of Acetone (~20 mg/L), Morphine (~0.07 mg/L), Amitriptyline (~0.07 mg/L), Nortriptyline (~0.1 mg/L), Carbamazepine (~7.1 mg/L), Lamotrigine (~8.0 mg/L), Levetiracetam (~22 mg/L), Valproic Acid (~12 mg/L) and Ondansetron (~0.09 mg/L).

20. Dr Francis provided an opinion that the medical cause of death was 1 (a) Complications of chest injuries following a fall in the setting of recurrent aspiration pneumonia, cerebral palsy and epilepsy and I accept her opinion.

CPU REVIEW

21. As a result of receiving the family's concerns relating to medical care and management of Barry's falls risk, I referred this case to the independent practitioners in the Mental Health and Disability Team of the Coroners Prevention Unit (**CPU**)[12] to review the adequacy of care provided by workers from Scope (Aust) Ltd.

22. In the weeks prior to his death, Barry was not ordinarily subject to continuous one-to-one supervision and had independently navigated public environments, including railway stations, trains, transport interchanges and streets. The CPU formed the view that the supervision arrangements at Frankston Pier were consistent with his established support model, with staff responsible for general observation and responding to emerging risks rather than providing constant close physical supervision.

23. An Occupational Therapy (**OT**) assessment was undertaken by Better Rehab on 24 October 2022, with a subsequent Functional Capacity Assessment and Plan Review Report completed on 23 February 2023.[13] The assessment concluded that Barry was not safe to independently access the community due to his increased risk of falls and reduced control of his then-powered wheelchair.[14] Consequently, for most of 2023, Barry did not undertake unescorted community access and instead participated in community activities under supervision. However, Barry's powered wheelchair was subsequently replaced, and by September 2023, he had been provided with a new wheelchair incorporating customised modifications designed to improve its operation and accommodate his functional needs.[15]

24. The restrictions on Barry's independent community access during 2023, reflected concerns regarding his previous wheelchair rather than his underlying functional capacity. Following the provision of a new customised powered wheelchair in September 2023, Barry's ability

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[12] 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. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.
[13] *Coronial Brief,* Statement of Shirley Marshallsea (Scope).
[14] Ibid.
[15] Ibid.

to safely mobilise within the community was reassessed. An OT travel assessment undertaken by Better Rehab on 11 January 2024, concluded that he was capable of independently travelling unaided in the community.[16]

25. The available evidence confirms that in the weeks preceding the incident, Barry regularly undertook independent community travel, including train journeys between Ringwood and Bayswater, travel to Melbourne's CBD and independent mobility within his local community.[17]

FINDINGS AND CONCLUSION

26. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[18] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

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

    a) the identity of the deceased was Barry Arthur Seaton, born 6 February 1958;

    b) the death occurred on 21 March 2024 at Golf Links Road Rehabilitation Centre, 125 Golf Links Road, Frankston, Victoria, 3199, from 1(a) complications of chest injuries following a fall in the setting of recurrent aspiration pneumonia, cerebral palsy and epilepsy; and

    c) the death occurred in the circumstances described above.

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[16] Ibid.
[17] Ibid.
[18] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

28. The available evidence confirms that in the lead up to the fatal incident, Barry had been permitted to access the community without direct staff accompaniment. There is no evidence to suggest that inadequate supervision by Scope staff contributed to the fatal incident. The incident occurred within an established support model that permitted Barry a degree of independent community access, consistent with balancing his autonomy and independence against the foreseeable risks associated with community participation. I am satisfied that the care provided to Barry by Scope (Aust) Ltd was reasonable and appropriate in all the circumstances.

Pursuant to section 73(1) 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:

John Taylor, Senior Next of Kin

Jeremy Ryan and David Guthrie, HWL Ebsworth

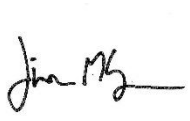
Noemi Baquing, Scope (Aust) Ltd

Kathleen Jansen, Peninsula Health

National Disability Insurance Scheme Quality and Safeguards Commission

Senior Constable Brooke Jeffrey, Coroner's Investigator

Signature:



Date: 17 September 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

inquest. 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.