IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 1844

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of: CHRISTOPHER BARCA

Delivered On:	10 October 2012
Delivered At:	Coroners Court Of Victoria Level 11, 222 Exhibition Street Melbourne
Hearing Dates:	10 October 2012
Findings of:	HEATHER SPOONER, CORONER
Police Coronial Support Unit	Leading Senior Constable King Taylor

I, HEATHER SPOONER, Coroner having investigated the death of CHRISTOPHER BARCA

AND having held an inquest in relation to this death on 10 October 2012
at MELBOURNE

find that the identity of the deceased was CHRISTOPHER BARCA
born on 7 March 1954
and the death occurred on 21 May 2011
at 8 Botanic Drive, Kew, Victoria 3101

from:

1a. ASPIRATION OF GASTRIC CONTENT
1b. DOWN'S SYNDROME
2. EPILEPSY

in the following circumstances:

1. Mr Barca was aged 57 when he died. He resided in a Department Of Human Services (DHS) group home situated at 8 Botanic Drive, Kew. Mr Barca had a past medical history that included down's syndrome, intellectual disability, hepatitis B and epilepsy. He had also suffered a '*complete heart block*' requiring the insertion of a permanent pacemaker.

2. A police investigation was conducted into the circumstances surrounding his death and as Mr Barca was deemed to be '*in care*' immediately prior to his demise, a mandatory inquest was convened pursuant to s.52ss.(2)(b) *Coroners Act 2008*.

3. A summary that was prepared by the investigating member was read to the inquest:

"The deceased, Christopher Barca, was born on 7 March 1954. At the time of his death, the deceased was aged 57 years and 2 months.

The deceased was the fourth born of seven children to his mother Dorothy (Dec) and father Vincent (Dec). He had four sisters and two brothers.

The deceased was born with Down Syndrome and an intellectual disability.

It is understood that on doctor's recommendation at the time, that shortly after his birth, the deceased was placed in full time care due to his disability.

The deceased resided at various facilities during the course of his life ending up at a facility located at 8 Botanic Drive, Kew. It was at this residence where the deceased was to later pass.

During his life the deceased developed a number of complex health issues including epilepsy, hip dysplasia, chronic Hepatitis B and mild to moderate oropharyngeal dysphagia. The deceased was also prone to chest infections, pneumonia and pressure sores. The deceased also had a pacemaker implanted in 2005 due to an abnormal heart rhythm.

During the months leading up to his death, the deceased also began to develop problems with mobility resulting in him requiring a wheelchair to be moved around.

The deceased was also seeing a speech pathologist where his mealtime profiles and guidelines were developed. These guidelines were prepared in October 2010 and later updated in April 2011. The guidelines include the preparation of the deceased's food and drinks, equipment used and the supervision and assistance required whilst eating. The profile also includes a 'warning' and 'signs to watch out for' whilst the deceased was eating.

On 2 May 2011, the deceased was seen by his GP due to a moist cough for which he was prescribed antibiotics.

On 16 May 2011, his condition was re-assessed where it was concluded his cough was improving and his chest was clear.

On 21 May 2011 at approximately 4.45pm, the deceased was being supported by staff with his evening meal when he began to shake. Shortly after he started to cough and jerk.

Staff applied three thrusts to his upper back in order to clear any food substances blocking his throat.

The deceased was non-responsive and his face began to turn pale and his lips blue. He was moved to the floor and placed in the recovery position where some food substances were cleared from his mouth.

The deceased was still shaking and remained unresponsive. Staff called '000' Emergency Services.

Staff commenced CPR on the deceased, which was continued by ambulance paramedics on their arrival.

A number of attempts were made to revive the deceased however were unsuccessful.

Revival attempts ceased on the deceased at approximately 5.30pm where it was deemed that he had passed away."

4. A post mortem autopsy was performed by Dr Malcolm Dodd, Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM). He formulated the cause of death and made the following comments:

"The immediate cause of death in this case is one of extensive aspiration of gastric content into both major and minor airways.

The summary of circumstances report indicates that Christopher Barca was a fifty seven year old male suffering from an intellectual disability (Down's Syndrome) and is also diagnosed as having epilepsy.

In addition, a pacemaker was fitted for a cardiac condition.

The deceased resided in a DHS care facility for persons with disabilities and had been in that facility for two years.

The report indicates that the deceased appeared to choke and possibly had suffered a form of seizure.

The staff had immediately checked the airways and when deemed to be clear, the deceased was then moved to the floor. The deceased soon lost consciousness and was refractory to resuscitation.

The post mortem examination revealed dysmorphic features in keeping with Down's Syndrome.

The pacemaker was identified; all leads from the pacemaker were correctly sited.

Internal examination showed extensive aspiration of gastric content throughout the trachea, right and left main bronchi and into small bronchial ramifications.

Furthermore, gastric material was readily expressed from minor bronchial lumens within the periphery of all pulmonary lobes.

Histological examination confirmed the presence of gastric material within bronchiolar lumens and alveolar air space.

No other significant naturally occurring disease was disclosed.

Toxicological analysis of body fluid was noncontributory.

Although the diagnosis of epilepsy is acknowledged, it would appear that the deceased has, in all probability, choked on food and suffered an agonal seizure as a response to this rather than an epileptic seizure being a primary event."

5. It is apparent that Mr Barca unfortunately died from aspiration following an incident involving him choking on his food.

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

The family of Mr Christopher Barca;
Investigating Member, Victoria Police;
Interested parties.

Signature:

HEATHER SPOONER
CORONER
Date: 17 October 2012