IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 001568

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

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

Inquest into the Death of: Nerilee Elizabeth BARFOOT

Delivered On:	31 May 2017
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street Southbank Victoria 3006
Hearing Dates:	Inquest: 26-28 October 2015
Findings of:	Coroner Paresa Antoniadis SPANOS
Representation:	Ms T. RIDDELL of Counsel, instructed by Olivia Warwick of Minter Ellison, appeared on behalf of Focus Individualised Support Services.
Police Coronial Support Unit	Leading Senior Constable J. ALLEN, assisting the Coroner
Catchwords	Lennox-Gastaut Syndrome, disability residential care, supervision, PEA arrest, cerebral ischaemic injury

I, PARESA ANTONIADIS SPANOS, Coroner,
having investigated the death of NERILEE ELIZABETH BARFOOT

and having held an inquest in relation to this death at Melbourne on 26-28 October 2015:

find that the identity of the deceased was NERILEE ELIZABETH BARFOOT

born on 9 November 1982

and that the death occurred on 13 April 2013

at Frankston Hospital, Hastings Road, Frankston, Victoria 3199
from:

I (a)GLOBAL CEREBRAL ISCHAEMIC INJURY AND BRONCHOPNEUMONIA FOLLOWING PEA ARREST IN A WOMAN WITH LENNOX-GASTAUT SYNDROME

in the following circumstances:

BACKGROUND

1. Nerilee Barfoot was the 30-year old daughter of Robin Barfoot and her ex-husband, Ray, and the younger sister of brothers, Jay and Blake. When she was about 18 months old, Ms Barfoot started to experience seizures and her developmental milestones were delayed.[1] She was diagnosed with Lennox-Gastaut Syndrome [LGS], a childhood-onset treatment-resistant form of epilepsy characterised by frequent, unpredictable seizures of different types.[2] Like many people diagnosed with LGS, Ms Barfoot had a moderately severe intellectual disability.[3]

2. Ms Barfoot was cared for at home by her family until adulthood. All family members shared in the responsibility of looking after her, though perhaps most particularly her mother. Strategies were developed, with input from her neurologist Professor Ingrid Scheffer, to minimise the risk that Ms Barfoot would be hurt during seizures. However, as she grew older and stronger, her challenging behaviours became more difficult for her

[1] Exhibit D.

[2] Exhibits A and B.

[3] Exhibit A.

family to manage and a placement at a disability shared accommodation service was arranged.[4]

3. In 2003, Ms Barfoot joined five other adults with varying levels of disability and care needs at Bungower House [Bungower] in Mornington. Bungower is a purpose-built, supported accommodation facility managed by Focus Individualised Support Services [Focus] with funding provided by the Department of Health and Human Services [DHHS].[5] The house comprises of north and south wings, each home to three residents, and Ms Barfoot lived in the north wing. Bungower is staffed during the day by three carers, one for each wing and the third 'floating' between them or otherwise deployed as needed.[6] At night, a carer sleeps at the house.

4. General practitioner, Dr Matthew Evans of Mornington Medical Clinic, coordinated Ms Barfoot's medical care. He performed annual health assessments, the last being on 4 April 2013 when she was in good health, and other consultations as required, often for soft tissue injuries sustained during seizures. He also developed care plans to maximize Ms Barfoot's health and wellbeing, which included regular consultations with a dentist, podiatrist and naturopath and blood testing to ensure her anticonvulsant medications were at therapeutic levels. He also liaised with Prof Scheffer about management of Ms Barfoot's epilepsy.

5. Ms Barfoot was reviewed by Prof Scheffer about two times a year and was ordinarily accompanied to these appointments by a Bungower carer and her mother. As she was unable to provide a history herself,[7] her carer or Robin Barfoot provided an overview of the frequency and type of seizures that had occurred in the intervening period, including provision of a seizure diary maintained at Bungower at the neurologist's request.[8]

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[4] Exhibits D and L.

[5] Foster, Letter from Thomas Kuster to Joanne Allen dated 23 November 2015 (hereinafter 'DHHS correspondence') and Transcript pages 285-290 (Foster).

[6] Exhibit L.

[7] Transcript pages 7 and 8.

[8] Exhibits B, A, D and Coronial Brief of Evidence [CB], pages 172-192 (Seizure Diaries). I note Prof Scheffer's comments about the limitations of seizure diaries due to variation in carers' proficiency and experience of identifying different seizure types and documenting them [Transcript pages 14, 17, 19, 20-21] and that this point was conceded by Ms Foster [Transcript page 291]. Records of Ms Barfoot's seizures were also maintained separately by Bungower staff, particularly so that the occurrence and type of seizures could be handed over to carers not present during a relevant shift.

6. When last reviewed by Prof Scheffer on 5 March 2013, Ms Barfoot was experiencing tonic-clonic seizures[9] lasting seven or eight minutes between three and five times each month, three-to-six atonic seizures ('drop attacks')[10] per month and some myoclonic seizures[11] involving a subtle jerk of the head or shoulder, though these were thought to be more settled overall.[12] Ms Barfoot's seizures remained unpredictable, significant, frequent and potentially injurious but were generally considered to be decreasing in frequency with age.[13]

7. Ms Barfoot was prescribed anticonvulsant medications carbamazepine, sodium valproate and topiramate, and these were administered as directed by Bungower staff.[14] Although most of the seizures she experienced were self-limiting and required no specific treatment beyond close observation, a protocol for their management was developed, and annually reviewed, by Prof Scheffer.[15] The plan[16] consisted of regular neurological and medication

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[9] Tonic-clonic seizures (previously known as grand mal seizures): a type of generalised seizure that affects the entire brain and are the kind most commonly associated with epilepsy. Such seizures are comprised of two phases, the tonic phase and the clonic phase. During the tonic phase, the patient will (ordinarily) quickly lose consciousness, and rhe skeletal muscles will suddenly tense, often causing the extremities to be pulled towards the body or rigidly pushes away from it (which can call the patient to fall if standing). The tonic phase is usually the shortest part of the seizure, lasting only a few seconds. In the clonic phase, the patient's muscles will contract and relax rapidly causing convulsions ranging in severity from exaggerated twitching of the limbs to violent shaking of the stiffened extremities. Following a tonic-clonic seizure the patient may experience confusion or total amnesia (which wears off), postical sleep (a post-seizure altered conscious state) with stertorous (gasping) breathing due to physical, mental and nervous exhaustion. See also Prof Scheffer's comments at Transcript pages 9-11.

[10] Atonic seizures, described in the CB and inquest testimony by a number of witnesses as 'drops' or 'drop attacks': a type of seizure that consists of a brief lapse in muscle tone caused by temporary alterations in brain function. The seizures are usually brief (less than 15 seconds in duration) and can occur while standing, sitting or walking and so result in injuries as a result of falls. See also Prof Scheffer's comments at Transcript pages 11-12.

[11] Myoclonic seizures: a brief involuntary twitching of a muscle of group of muscles. They may occur infrequently or many times each minute, alone of in sequence or pattern and, though experienced occasionally by everyone (eg. a myoclonic jerk when falling asleep), if they are persistent or widespread this suggests a neurological disorder. See also Prof Scheffer's comments at Transcript pages 10 and 22.

[12] There appeared – on the papers – to be a discrepancy between Prof Scheffer's assessment of the frequency of Ms Barfoot's seizures and that of Focus/Bungower. Supplementary statements were obtained (Exhibits B and P) and the apparent discrepancy was resolved. Focus agreed with Prof Scheffer's assessment of the frequency of seizure activity (and her view that frequency was decreasing with Ms Barfoot's age) but had noted an *increased frequency of injury* occurring as a result of seizures, particularly drop attacks in 2012.

[13] Exhibit A.

[14] CB, page 210 (Client Profile).

[15] CB, pages 28-29 (Statement of Dr Matthew Evans).

[16] Comprising (in short) of a Seizure Management Plan (listing apparent seizure triggers and requiring supervision, use of a helmet when mobile and directions for supporting Ms Barfoot after seizures not requiring the administration of midazolam) and a Seizure Emergency Plan (involving the administration of midazolam as required when a seizure lasts longer than 10 minutes, or to call an ambulance after five minutes if no-one trained to administer buccal midazolam is present); see CB pages 216-217 and 211.

reviews, harm minimisation through close supervision by carers, the use of a helmet when walking to minimise head injuries from a drop seizure, and an emergency seizure plan [ESP] for protracted (tonic-clonic) seizures.

8. The ESP required buccal midazolam to be administered by a qualified carer after 10 minutes of seizure activity, or for an ambulance to be called after more than five minutes of seizure activity if no midazolam-qualified carer was present.[17] If seizure activity had not ceased after midazolam was administered twice in five minutes, an ambulance would be called.[18] The ESP also required Ms Barfoot's mother to be notified when midazolam was administered.[19]

9. In addition to the supervision she required because of LGS, Ms Barfoot required a moderate level of support[20] due to her intellectual disability and some challenging behaviours. She had little or no danger awareness and was impulsive, needed help ranging from prompting[21] or supervision[22] to full assistance[23] with many activities of daily life, would intermittently act with physical or verbal aggression, and would abscond from home or while out in the community on occasions.[24] Her carers had noticed that Ms Barfoot's challenging behaviours were sometimes triggered by the presence of new staff, the absence of any seizures for a period, fatigue, hunger, and frustration or boredom.[25]

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[17] CB, page 211 and 216 (Client Profile, Seizure Management/Emergency Plan). Midazolam administration was introduced into Ms Barfoot's epilepsy management plan in 2010.

[18] CB, page 216 (Seizure Emergency Plan).

[19] CB, page 211, Exhibit D. and Transcript pages 43 and 44. Between 2010 and April 2013, midazolam was administered 10 times, more than half of these occurring in 2010 [Exhibit L].

[20] CB, page 212 (Client Profile, Level of Personal Support Required), DHHS correspondence and Transcript pages 285-287 (Foster). I will return to this matter below.

[21] Ms Barfoot needed some prompting/support brush her teeth and hair or to dress in seasonally appropriate clothing; CB pages 212-216 (Client Profile).

[22] Ms Barfoot could eat independently but sometimes required prompting to eat her meals and was supervised in case she attempted to use cutlery as a weapon; CB pages 212-216 (Client Profile).

[23] Ms Barfoot needed full assistance to take her medications and though she could bathe independently she required constant supervision and use a shower chair and seizure mat even in the adapted bathroom in case of seizures; CB pages 212-216 (Client Profile).

[24] CB pages 212-216 (Client Profile).

[25] CB page 213 (Client Profile). Ms Barfoot's Client Profile also suggests that seizures may be triggered by loud noises, hot or cold drinks, new staff and medication time.

10. Ms Barfoot's parents and siblings remained involved in her life after her move to Bungower.[26] Robin Barfoot was a strong advocate for her daughter, communicating regularly with Focus staff and was involved in all decision-making.[27] Ms Barfoot visited family members at home for celebrations, had dinner with her father when he visited Mornington, saw her mother at least weekly and spoke with her on the telephone.[28]

11. Ms Barfoot was known as a sociable and chatty young woman who liked being active and enjoyed being outside.[29] She had many interests that she pursued at home such as gardening, beading, doing puzzles, looking at magazines and sitting in the sun on her swing seat. She also enjoyed one-on-one time with family or her Bungower carers. Ms Barfoot attended a day program on weekdays from 9am to 3.30pm, operated by Focus, through which she participated in a range of activities like dancing and swimming, and developed life skills and personal goals.[30]

12. Unfortunately, due to the lower staff-to-participant ratio at the day program,[31] Ms Barfoot sustained an increasing number of minor injuries from drop seizures, particularly in late 2012. To minimise the risk of injury, Ms Barfoot was encouraged to spend more and more time in her wheelchair,[32] which limited her enjoyment of the program and had an adverse impact on her physical abilities, muscle tone and confidence.[33] Thus, in December 2012, with Prof Scheffer's endorsement, Focus successfully applied for funding for one-on-one staff support for Ms Barfoot while she attended the day program, to enhance her ability to participate in activities.[34]

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[26] Exhibit L.

[27] CB page 220 and Exhibit D.

[28] Exhibits D and L, and Transcript page 52.

[29] Transcript pages 31 and 32 (Robin Barfoot),

[30] Exhibit L. Ms Barfoot commenced at a Focus-operated day program in 2008.

[31] Exhibit L. Day program staffing was four-to-six people with a disability for each staff member.

[32] Exhibit L. It was believed that Ms Barfoot's helmet contributed to injuries she sustained to her eyebrows and chin.

[33] Exhibit L.

[34] Exhibit L.

Circumstances Proximate to Death

13. The circumstances in which Ms Barfoot died will be discussed in some detail below. It is sufficient for present purposes to say that at about 4.25pm on 7 April 2013, she was found by Bungower staff unresponsive outside the back door of the house, in an awkward position on a swing seat with her head and neck entangled in an armrest.[35] Two carers extricated Ms Barfoot from the swing seat and commenced cardio-pulmonary resuscitation while another called an ambulance.[36]

14. Paramedics arrived within minutes and found Ms Barfoot unconscious and in pulseless electrical activity [PEA][37] arrest, with a cyanosed appearance and carers performing chest compressions.[38] A tachycardic pulse was detected and following intubation and ventilation her colour improved. Intravenous fluids and adrenaline and morphine/midazolam infusions were commenced. Once her condition was stabilised, Ms Barfoot was transported to Frankston Hospital, still unconscious, with a Glasgow Coma Score of three.[39]

15. At Frankston Hospital, a computerised tomography [CT] scan of Ms Barfoot's brain and cervical spine revealed a widespread ischaemic brain injury but no evidence of trauma. She remained unconscious and on life support in the intensive care unit, with no evidence of neurological recovery and presence of decerebrate posturing.[40] There was no change in her condition over subsequent days and, following discussions with her family, treatment was withdrawn and Ms Barfoot died on 13 April 2013.[41] Ms Barfoot was an organ donor and her family consented to donation of her organs.[42]

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[35] Exhibits E, I, M and L (incident report forms).

[36] Exhibits E, I, K and M.

[37] Pulseless electrical activity [PEA], also known as electromechanical dissociation, refers to cardiac arrest in which the electrocardiogram shows a heart rhythm that should produce a pulse, but does not.

[38] CB, pages 88-99 (VACIS electronic Patient Care Report, Case #11128).

[39] Ibid. A Glasgow Coma Score of three (out of 15) is indicative of deep unconsciousness or coma.

[40] Exhibit C.

[41] Ibid.

[42] Exhibits C and D.

CORONIAL INVESTIGATION – SOURCES OF EVIDENCE

16. This finding is based on the totality of the material the product of the coronial investigation of Ms Barfoot's death. That is the brief of evidence originally compiled by Senior Constable Chris Nott of Carrum Downs Police and reconfigured by Leading Senior Constable Joanne Allen of the Police Coronial Support Unit for the inquest, the statements, reports and testimony of those witnesses who testified at inquest and any documents tendered through them, and the final submissions of Counsel. All of this material, together with the inquest transcript, will remain on the coronial file.[43] In writing this finding, I do not purport to summarise all the material and evidence, but will refer to it only in such detail as is warranted by its forensic significance and in the interests of narrative clarity.

PURPOSE OF A CORONIAL INVESTIGATION

17. The purpose of a coronial investigation of a *reportable death* is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[44] The *cause* of death refers to the *medical* cause of death, incorporating where possible the *mode* or *mechanism* of death. For coronial purposes, the *circumstances* in which death occurred refers to the context or background and surrounding circumstances, but is confined to those circumstances sufficiently proximate and causally relevant to the death, and not merely all circumstances which might form part of a narrative culminating in death.[45]

18. The broader purpose of any coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the *prevention* role.[46] Coroners are also empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health

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[43] From the commencement of the *Coroners Act 2008* (the Act), that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act.

[44] Section 67(1) of the *Coroners Act 2008*. All references which follow are to the provisions of this Act, unless otherwise stipulated.

[45] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

[46] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, cf: the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[47] These are effectively the vehicles by which the prevention role may be advanced.[48]

19. It is important to stress that coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death, and are specifically prohibited from including in a finding or comment any statement that a person is, or maybe, guilty of an offence.[49]

FINDINGS AS TO UNCONTENTIOUS MATTERS

20. In relation to Ms Barfoot's death, most of the matters I am required to ascertain, if possible, were uncontentious from the outset. Her identity and the date and place of death were not at issue. I find, as a matter of formality, that Nerilee Elizabeth Barfoot, born on 9 November 1982, late of Bungower House in Mornington died at the Frankston Hospital, Hastings Road, Frankston, on 13 April 2013, aged 30 years.

Medical Cause of Death

21. Forensic Pathologist, Dr Linda Iles of the Victorian Institute of Forensic Medicine [VIFM], reviewed the circumstance of the death as reported by the police to the coroner, the Focus incident report, Ms Barfoot's medical records and post-mortem computerised tomography scans [PMCT] of the whole body, and performed an autopsy. In the report of her findings, Dr Iles noted that Ms Barfoot was a slim woman whose body showed signs of medical intervention consistent with her clinical course, and that on external examination there were no signs of injury around the neck nor any evidence of fracture or deformity to her musculoskeletal system on PMCT.[50]

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[47] See sections 72(1), 67(3) and 72(2) regarding reports, comments and recommendations respectively.

[48] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

[49] Section 69(1).

[50] Exhibit C. Dr Iles noted that there were some minor abrasions to the bridge of the nose, left lower arm and hand, left shin and the left and right feet and small bruises on the right upper arm and left and right shins. Further, a midline sternotomy for organ retrieval was noted.

22. On internal examination, Dr Iles saw no evidence of extradural, subdural or subarachnoid haemorrhage, there was no evidence of recent or remote myocardial infarction nor of stenosis, vegetations, calcification or perforation of cardiac valves.[51] There was no sign of bruising to the tongue and no evidence of haemorrhage to the strap muscles of the neck. There was no evidence of pulmonary thromboembolism but bilateral lower lobe bronchopneumonia was apparent. The liver showed features suggestive of hepatic adenomatosis (benign liver tumour).[52]

23. Histological examination of the brain[53] demonstrated widespread recent anoxic ischaemic injury with areas of recent cerebral hemisphere infarction particularly in the frontal, mesial-temporal and mesial-occipital regions. There was cerebral swelling together with changes associated with trans-tentorial herniation and possible pre-existent Purkinje cell loss. It was noted that neuropathological changes associated with LGS are poorly understood and defined. Moreover, in this case, the extensive, widespread ischaemic cerebral injury arising from the pre-terminal event hindered any assessment of underlying pathology.

24. Toxicological analysis of blood sampled at Frankston Hospital on admission detected anticonvulsant medications valproic acid and carbamazepine, consistent with normal therapeutic use, and midazolam and morphine, likely administered during treatment.[54]

25. Dr Iles advised that Ms Barfoot's death could reasonably be attributed to *global cerebral ischaemic injury and bronchopneumonia following PEA arrest in a woman with Lennox-Gastaut Syndrome.*[55]

26. The forensic pathologist observed that the cause of the initial cardiac arrest was unclear and suggested two scenarios based on the information available to her at the time of her examination.[56] The first scenario was that in which Ms Barfoot went into cardiac arrest

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[51] Exhibit C. Dr Iles noted the absence of the distal aorta and distal inferior vena cava and that the ventricular myocardium had been sectioned (in organ retrieval).

[52] Exhibit C. Hepatic adenomatosis was an incidental finding [Transcript page 26].

[53] Neuropathologist Dr Renata Kalnins of the Austin Hospital performed a histological examination of the brain and provided a report to Dr Iles.

[54] Dr Iles commented during her evidence at inquest [Transcript page 24] that in 2013 topirmate, Ms Barfoot's other regular anticonvulsant medication, was not on VIFM's standard panel of drugs and so its presence would not have been detected.

[55] Exhibit C.

[56] Exhibit C. Dr Iles observed that no scene photographs had been available to her when preparing her report.

during a seizure, with the position in which she was found being irrelevant to the cause of her death. Equally plausible in Dr Iles' opinion was a second scenario in which during a seizure, Ms Barfoot's body became lodged beneath the armrest of the swing seat causing obstruction of her breathing and then cardiac arrest. Dr Iles noted that there were no marks on Ms Barfoot's face or neck to indicate that this had occurred but the absence of injuries was insufficient to exclude the possibility of asphyxia. Ultimately, Dr Iles was unable to determine from a pathological perspective, which of these two scenarios was more likely.

27. At the inquest, Dr Iles was invited to expand upon the comments she had made about the cause of Ms Barfoot's cardiac arrest. She confirmed that she had been aware of the position in which Ms Barfoot had been found[57] and that there were no marks found at post-mortem examination suggestive of positional asphyxia. However, the forensic pathologist observed that often in sudden unexpected deaths of epileptic individuals, even where an asphyxial component is suspected, there might be absolutely no signs of asphyxia at autopsy.[58] Moreover, as Ms Barfoot had survived for six days after the swing seat incident, any marks would potentially not be evident at the time of autopsy.[59]

28. Dr Iles testified that the type of cardiac arrest Ms Barfoot sustained – a PEA arrest – was more consistent with a seizure than a spontaneous cardiac arrest in a young woman with no cardiac history.[60] Her presentation, with a cardiac rhythm when she was found, was not typical of the sudden cardiac arrhythmias among the young with an otherwise negative autopsy who are subsequently found to have channelopathies.[61]

29. Dr Iles confirmed that she remained unable to identify as more probable one of the two scenarios she identified in her report as potentially causing Ms Barfoot's cardiac arrest.[62]

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[57] Transcript page 25.

[58] Transcript page 27. Dr Iles gave evidence the compressibility or otherwise of the cushion on which Ms Barfoot was found would not assist her to determine the likelihood of an asphyxial component to the incident [Transcript page 27].

[59] Transcript page 26.

[60] Transcript page 28.

[61] Transcript page 28.

[62] Transcript page 27. I note that Prof Scheffer was asked to comment on the two scenarios suggested by Dr Iles and she, too, considered either possibility to be feasible [Transcript page 16].

30. I find, on the basis of the advice provided by Dr Iles, that the cause of Ms Barfoot's death was global cerebral ischaemic injury and bronchopneumonia following PEA arrest in a woman with Lennox-Gastaut Syndrome.

FOCUS OF THE CORONIAL INVESTIGATION AND INQUEST

31. In common with many other coronial investigations, the primary focus of the coronial investigation and inquest into Ms Barfoot's death was on the circumstances in which she died.

32. As no issues about the adequacy of the Bungower staff response to finding Ms Barfoot unconscious, nor about the clinical management and care she received at Frankston Hospital were apparent to me on the papers or raised by Robin Barfoot during the investigation and inquest, these periods were not the focus of my investigation.

33. The primary focus of the coronial investigation and inquest into Ms Barfoot's death was on the adequacy of her supervision at Bungower and, in particular, the events of the afternoon of 7 April 2013 between 4pm and 4.25pm when she was found unconscious on the swing seat.

34. The investigation and inquest also touched upon reviews conducted following Ms Barfoot's death and the improvements implemented by Focus to identify and mitigate environmental risks to the residents of Bungower. The evidence in relation to each of these issues will be outlined below.

Supervision – The Funding Framework

35. The paradigmatic issue of the adequacy of funding for supervision of individuals with complex needs in the community is beyond the proper scope of the investigation and inquest into Ms Barfoot's death. Nonetheless, it is clear from the evidence before me both that 24-hour per day one-to-one funding may be necessary to ensure the safety of some

individuals with complex needs[63] and that, rightly or wrongly, such a funding regime is not the prevailing paradigm in Victoria and was not when Ms Barfoot died.[64]

36. The Chief Executive Officer of Focus, Gail Foster, testified that Bungower is owned and was purpose-built by DHHS.[65] The rate at which DHHS provides funding to Focus as the disability service provider managing Bungower, is determined – in broad terms – by the nature of the facility and the needs of the individuals living there at a particular point in time.[66]

37. In 2013, Focus was funded for 12,000 hours of 'service delivery' or staff hours plus 365 sleepover shifts per annum.[67] This is a rate of funding higher than the 'average' range of funding received across Focus facilities.[68] DHHS does not prescribe staffing ratios for the disability shared supported accommodation homes it funds so as to enable service providers to 'tailor' services to meet residents' needs.[69] As was mentioned above, the funding/service agreements led to there being three staff present to meet the needs of Bungower's six residents during the day.[70]

Supervision – In Practice

38. Ms Barfoot's mother, her neurologist, carers and Ms Foster unanimously acknowledged that the purpose of supervision was to make sure Bungower's residents, including Ms

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[63] It should not be inferred from this comment that I consider Ms Barfoot to have required 24-hour per day 1:1 supervision.

[64] See generally the comments of Prof Scheffer at Transcript pages 13-14 and 20, the evidence of Ms Foster at Transcript pages 285-288 and DHHS Correspondence.

[65] Transcript page 288.

[66] Transcript pages 285-286. And guided in practice by the terms of the *Disability Act* 2006, the funding/service agreements between DHHS and the disability service provider and the following DHHS documents: Policy and Funding Plan 2012-2015, Service Agreement Business Rules and Guidelines, Service Agreement Information Kit and DHHS Standards which set out 'key obligations, objectives, rights and responsibilities of the parties to the agreement and provides information on key deliverables, performance measures and targets' [DHHS Correspondence].

[67] DHHS Correspondence.

[68] Transcript page 287. Ms Foster indicated the 'average range' to be between 5-9,000 staff hours per annum.

[69] DHHS Correspondence. If a resident's needs change temporarily an application for time-limited additional funding may be submitted (such as the application on Ms Barfoot's behalf for one-to-one funding at her day program pursuant to the Regional Disability Support Fund [now known as Disability Request for Additional Funding Application]. If a resident's needs change permanently and his/her needs can no longer be supported under current funding arrangements, a Disability Support Register Application would be submitted to the DHHS seeking alternate supported accommodation to better meet the individual's needs. See also Transcript pages 285 and 288.

[70] As the incident under investigation occurred at a change of the afternoon shifts, there were actually more than three staff members at Bungower at the relevant time.

Barfoot, were safe,[71] if not absolutely then by minimising environmental hazards and the effects of dangers unique to the individual due to their medical condition(s) or disability. There was no 'blanket policy' at Bungower about how residents should be supervised or the frequency with which they should be observed because 'all residents are different'.[72]

39. Moreover, staff were expected to manage multiple residents, and the interactions between them, and so could not 'just focus on one' they had to 'balance it out'.[73] They also had to balance their supervisory role with their provision of support in activities of daily life and personal care needs, and those duties that enabled Bungower to function as a home, such as meal preparation.[74] The carers were keenly aware that they performed their roles in the residents' home – as one commented, 'it wasn't a prison'[75] – and so they had to tread a delicate balance between supervision and privacy,[76] and keep an eye out for the residents' safety 'discreetly'.[77] They reported using 'common sense' to communicate with their colleagues if they anticipated being involved in an activity with a single resident for more than a few minutes so as to facilitate the ongoing supervision of the others.[78]

40. It is self-evident that a carer's familiarity with residents' medical conditions and needs will enhance her or his ability care for and assist them. To this end, several witnesses from Focus/Bungower highlighted the extensive induction, involving skills training specific to several common complex needs (including epilepsy management) and introduction to the organisation and its policies, undertaken in advance of "buddy shifts". At Bungower, all staff acquired an overview of all six residents and their needs through review of each's 'Resident Folder'. Before commencing a shift, say in the north wing of Bungower, staff were required to review entries made since they last worked about each resident of that

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[71] Exhibit D and Transcript pages 13 (Scheffer), 108 (Chunga), 126 (Marsh), 149 (Scott), 202 (Walker), 259 (Owen) and 332 (Foster).

[72] Transcript page 308.

[73] Transcript page 74 (Chunga). Other carers made similar comments, for instance 202 (Walker) and 152 (Scott), as did Ms Foster at Transcript page 308.

[74] Transcript page 142.

[75] Transcript page 259.

[76] Transcript pages 165 (Scott), 181 and 204-205 (Walker) and Exhibit L.

[77] Transcript page 205.

[78] 109 and 115 (Chunga), 152 (Scott), 183-184 (Walker)

wing, with anything that had occurred on the day of the shift to be handed over verbally. Staff also reviewed the 'Casual Folder' outlining duties specific to their shift.[79]

41. Each of the carers who were on shift in the afternoon of 7 April 2013 gave evidence at inquest and demonstrated their familiarity with the nature of Ms Barfoot's complex needs and the strategies in place to minimise risks to her wellbeing.[80] The carers identified epileptic seizures – particularly drop attacks – as particular concerns in their management of her.[81] They were aware of the level of support Ms Barfoot required for different activities and the components of her epilepsy management plan,[82] and some were trained to administer midazolam.[83]

42. In some contrast to the evidence of Prof Scheffer[84] and Robin Barfoot,[85] the carers considered Ms Barfoot to be generally compliant with proper use of her helmet, having it on and the strap fastened when walking or not sitting or lying down at home.[86]

43. The carers acknowledged that Ms Barfoot required regular or close supervision.[87] For them, supervision encompassed 'awareness' of where she was and what she was doing, visually checking her – made relatively easy by Bungower's open plan[88] – and chatting to her, even if not face-to-face.[89] These comments accord quite closely with Robin Barfoot's expectations about the supervision of her daughter. That is, she said it was sufficient to keep an eye on her 'as you would a toddler', there was no need to be 'beside her', and one could do something else but observe her on a 'reasonably regular basis'.[90]

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[79] See generally the evidence of Ms Scott, Ms Walker, Mr Chunga and Ms Foster at inquest and Exhibits produced on behalf of Focus, in particular, L and R.

[80] See generally the evidence given at inquest by Mr Chunga, Ms Marsh, Ms Scott, Ms Owen and Ms Walker.

[81] Ibid.

[82] Transcript pages 80-82 (Chunga), 268 (Owen), 182-183 (Walker), and 144 (Scott).

[83] Transcript pages 79 (Chunga). I note Ms Foster's evidence that *all* Focus staff (Mr Chunga was an agency staff) receive mandatory midazolam administration training [Transcript page 292].

[84] Transcript page 7. Prof Scheffer thought Ms Barfoot 'wasn't mad about' wearing her helmet.

[85] Transcript page 41. Robin Barfoot stated that her daughter took her helmet off 'every opportunity she could'.

[86] Transcript pages 81 (Chunga), 133 (Marsh), 146 (Scott), 178-179 (Walker), and 258 (Owen), though Ms Owen recalled that Ms Barfoot would sometimes have to be reminded about fastening the strap [Transcript page 179].

[87] Transcript pages 99-100 (Chunga), 144 (Scott), 182 (Walker), and 258 and 269 (Owen).

[88] Transcript pages 165 (Scott), 181 and 203(Walker) and 275 (Owen).

[89] Transcript pages 100 (Chunga) 258 (Owen) 202-204 (Walker), 165 (Scott), and 126 (Marsh).

[90] Transcript page 32.

44. I note Prof Scheffer's evidence that Ms Barfoot was at risk of a convulsive seizure 'at any time' and that, in her view, given Ms Barfoot's ESP, ten minutes was the maximum time she could safely be left unsupervised.[91] Perhaps for the reasons outlined in paragraphs 38 and 39 above, the carers generally indicated the absence of any fixed frequency for supervision.[92] However, I note that while she was 'not sure,' one carer thought '15-minutely observations' had been suggested as constituting 'regular' checks.[93] Another carer said she had 'never put the midazolam protocol and supervision together'[94] to guide frequency of supervision, while a third agreed that it would be 'sensible to have a quick check' on Ms Barfoot every ten minutes given the terms of her ESP.[95]

The swing seat

45. The swing seat was constructed of tubular powder-coated metal and consisted of a frame, a seat and canopy. The swing was a three-seater, padded with firm seat, back and headrest cushions joined and covered with a polyester fabric suitable for outdoor use. The seat back appeared to be slightly reclined and the whole seat designed to swing gently back and forth. The arms at either end of the seat were U-shaped, with one straight part of each 'U' forming the outer extremity of the seat at either end, and the other forming the armrests and stopping somewhat short of the cushioning of the seatback, leaving a gap. The closed end of the 'U' aligned with the front edge of the seat and each armrest was fitted with a cushion fixed to the frame with loops of fabric.[96]

46. The swing seat was a gift from the Barfoot family to Bungower.[97] Although it was intended for use by anyone at Bungower, Ms Barfoot was its primary user.[98] She enjoyed swings and had been encouraged by her doctor to sit in the sun for half an hour each day

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[91] Transcript page 6.

[92] 99 (Mr Chunga said 10-minutely observations were not required) 182 (Ms Walker testified that there was no set time for observations).

[93] Transcript page 144 (Scott).

[94] Transcript page 183 (Walker).

[95] Transcript page 126 (Marsh).

[96] The make and model of the swing seat was not identified during the coronial investigation nor were measurements taken by the Coronial Investigator. The description provided is based on examination of photographs of the swing seat and the impressions of witnesses familiar with it.

[97] Transcript page 41.

[98] Transcript pages 41 and 41 (Robin Barfoot),

when possible.[99] For these reasons, Ms Barfoot was often involved in placement of the swing.[100] Unlike other outdoor seating at Bungower, the swing seat was moved from time to time,[101] provided there were two staff members to lift it, in accordance with occupational health and safety requirements.[102]

47. On 7 April 2013, the swing seat was in what was described by several witnesses as its usual position.[103] That is, it was positioned on concrete against the house under the pergola at back of the north wing, near to the rear sliding glass door.[104] Indeed, part of the swing seat was visible from the open-plan entry to the kitchen, a window in the meals area and from the adjacent living room's sliding door.[105] Although the swing seat was visible, anyone occupying it – however positioned – was not visible from the house due to the cushions of the seatback.[106]

Events of 7 April 2013 between 4pm and 4.25pm

48. A little before 4pm on Sunday 7 April 2013, Karen Scott was more than halfway through her 10am to 10pm shift and Lianne Owen was due to complete her shift and be relieved by Tinashe Chunga who had just arrived at Bungower.[107] Trisha Walker was nearing the end of her 9am to 4.30pm shift, at which point Rochelle Marsh would start her 4.30pm-8pm shift.[108] All six residents were at home.

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[99] Transcript pages 41 and 42.

[100] Transcript page 101. Mr Chunga testified that placement of the swing was 'up to Nerilee'. Robin Barfoot made a similar comment [Transcript page 42].

[101] Mr Chunga did not concede during his evidence that staff should determine the swing seat's location to ensure it was positioned in a safe position (ie that facilitated staff supervision of her), notwithstanding that Ms Barfoot may not be alive to safety considerations given her intellectual disability [Transcript page 102].

[102] Transcript page 102.

[103] Transcript pages 114 (Chunga), 150 (Scott) and 46 (Robin Barfoot).

[104] Transcript page 88 (Chunga).

[105] Transcript pages 88-89, 92, 114 (Chunga).

[106] Transcript page 88 (Chunga), 151 (Scott), 184 (Walker), 259 (Owen). 42 (Robin Barfoot). I note that the Focus CEO, Ms Foster conceded in her evidence at inquest that (any) swing seat should be positioned so that staff could easily monitor residents using it by glancing outside [Transcript page 319].

[107] Transcript page 68. Mr Chunga estimated that he arrived about 10 minutes before the start of his shift.

[108] Exhibits F, E, I, K, M and Q.

49. At 4pm, Mr Chunga commenced his shift with a short handover in the office and review of the Casual Folder which outlined his duties for that shift on the north wing.[109]

50. At about 4.05pm, Mr Chunga went outside at the rear of the north wing to smoke a cigarette.[110] Ms Barfoot was lying on the swing seat with her legs and feet on the seat and her head near the armrest with a missing cushion, facing the sliding back door.[111] Her helmet was on the ground next to the swing seat.[112] As she chatted with Mr Chunga, Ms Barfoot sat up in the swing seat and put on her helmet, doing up the strap.[113]

51. By around 4.10 or 4.12pm, Mr Chunga had finished his cigarette and gone inside to assist a male resident to shower in the bathroom situated at the front of the north wing of Bungower. He estimated that he was in the bathroom for not more than five minutes.[114] Mr Chunga was aware that the third resident of the north wing was wandering around the house at about that time.[115]

52. At 4.13pm,[116] Lianne Owen clocked off the Work Buddy system in the office situated near the front door of Bungower's north wing. She remained in the house for a few minutes longer to assist one of the residents in the south wing despite running late for an appointment.[117]

53. Around 4.15pm, Ms Marsh arrived at Bungower, 15 minutes ahead of the start of her shift.[118]

54. At about 4.17pm, Mr Chunga started making lunches for the following day in the kitchen.[119]

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[109] Transcript page 68 and 77.

[110] Exhibit E and Transcript page 86.

[111] Transcript pages 82-84.

[112] Transcript page 82.

[113] Transcript pages 83, 85 and 87. I note that Mr Chunga had not included this detail about Ms Barfoot sitting up and putting on her helmet while they spoke in either of his contemporaneous account in the Incident Report (completed 7 April 2013) nor his statement to police signed on 2 September 2013.

[114] Transcript page 97.

[115] Transcript page 100.

[116] Transcript page 262

[117] Transcript page 263.

[118] Transcript page 123.

55. Ms Owen called out 'goodbye' when she left the house through the north wing's front door and heard Mr Chunga and Ms Barfoot respond, their voices apparently coming from about the same place.[120] Ms Owen recalls being in her car, which was parked directly outside, at 4.20pm.[121]

56. At 4.25pm, Ms Marsh entered the north wing of the house, having already greeted the residents of the south wing.[122] Mr Chunga was in the kitchen and she asked him where she would find Ms Barfoot. He responded that she was outside on the swing.[123] They went outside together.[124]

57. Ms Barfoot was still,[125] with her neck caught in the cushion-less U-shaped arm of the swing seat and most of her body off the seat.[126] The whole of her head was on the outside of the U-shaped arm, the bar forming the armrest across her neck and her face pressed into the seat cushions,[127] and facing away from the seat back.[128] Her torso was twisted[129] and her legs and feet were on the ground.[130] She was not wearing her helmet[131] and did not respond when Mr Chunga asked if she was alright.[132]

58. Mr Chunga remained with Ms Barfoot while Ms Marsh went inside to alert other staff.[133] She returned with Ms Walker who directed her to call the emergency services.[134] Mr Chunga and Ms Walker worked to extricate Ms Barfoot from the swing seat. Their first

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[119] Transcript page 93 (time inferred from the whole of Mr Chunga's evidence).

[120] Transcript pages 267 (Owen) and 94-95 (Chunga).

[121] Exhibit Q and Transcript page 265.

[122] Transcript page 119.

[123] Transcript page 127.

[124] Exhibits E and I.

[125] Transcript page 208.

[126] Transcript page 188 (Walker), 128 (Marsh) and 105 (Chunga)

[127] Transcript pages 189, 215 (Walker), 129-130 (Marsh) and 105 (Chunga).

[128] Transcript page 106 (Chunga).

[129] Transcript pages 129 (Marsh) and 105 (Chunga).

[130] Transcript page 103 (Chunga).

[131] Transcript pages 105 (Chunga), 133 (Marsh) had no recollection of the 'position' of the helmet, implying that Ms Barfoot was not wearing it, and 196 (Walker).

[132] Exhibit E.

[133] Exhibits E and I.

[134] Exhibits M and I.

attempt, to bring her head back through the loop of the U-shaped arm to the seat, was unsuccessful. The aperture was too small and the very firm seat cushions could not be compressed to enlarge it sufficiently.[135]

59. Ms Barfoot was ultimately extricated on the second attempt. Mr Chunga lifted Ms Barfoot's lower body level with the swing seat and he and Ms Walker slid her body back toward the seat back and manoeuvred her neck up and out of the open end of the 'U', through the gap between the end of the arm and the seatback cushion.[136]

60. Mr Chunga and Ms Walker placed Ms Barfoot on the ground. She was unresponsive and not breathing but had no visible injuries on her face or neck.[137] Mr Chunga commenced cardio-pulmonary resuscitation.[138]

61. At 4.30pm, Ms Marsh telephoned for an ambulance.[139]

62. By 4.36pm, the first responding paramedics had arrived at Bungower and were with Ms Barfoot.[140]

Actions Prompted by Ms Barfoot's Death

63. Robin Barfoot and the Focus On-Call service were notified of the swing seat incident within a short time of its occurrence.[141] Ms Foster was on site by 5.20pm.[142]

64. In anticipation of compliance with the terms of Focus' funding/service agreement with DHHS, Bungower staff prepared a Client Incident Report Form used to notify DHHS that a Category One incident had occurred, involving injury to Ms Barfoot.[143] Ms Foster notified

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[135] Transcript page 216.

[136] Transcript pages 107 (Chunga) and 217 (Walker).

[137] Transcript page 208.

[138] Transcript page 108.

[139] CB pages 88-99, VACIS Electronic Patient Care Records #11128.

[140] CB pages 94-99, VACIS Electronic Patient Care Record #11128.

[141] Exhibit K. These calls were made by Trisha Walker. Once paramedics arrived, Bungower staff relocated all residents to the south end of the house and provided reassurance.

[142] Exhibit K and Transcript page 311.

[143] CB pages 100-105. Category One incidents include those involving injuries to clients or allegations of assault to staff or clients. A further Client Incident Report Form was filed following Ms Barfoot's death and this appears in the CB at pages 106-109.

DHHS of the incident by telephone on the morning of 8 April 2013, with the formal report finalised and filed later that day.[144] The swing seat was removed from use and locked in a shed on Bungower's grounds.[145]

65. As one would expect, the report of the incident initiated DHHS' Quality of Support Review [QoSR] process. Styled a 'review' not an 'investigation', the aim here is to understand what occurred, how the service provider responded to the incident and to identify opportunities for systemic practice improvements.[146] In consultation with the service provider,[147] DHHS developed a QoSR 'Action Plan' requiring Focus to address identified issues (outlined below).[148] The QoSR was 'closed' in November 2014 following Focus' completion of all actions required by DHHS.[149]

66. I note that it was clear during evidence at the inquest that prior to Ms Barfoot's entanglement in the swing seat, it had not been perceived as potentially hazardous by her family or carers.[150] That swing seat was the only one used at any Focus property that was not positioned so as to facilitate visual monitoring by staff and this was attributed to it being the only swing seat that was ever moved, and moved to meet the resident's (Ms Barfoot's) wish for it to be positioned in the sun.[151]

67. Since then, Focus has had all swing seats on its properties examined by an occupational rehabilitation specialist who determined that if used in accordance with a manufacturer's instructions, swing seats posed no additional risks to a disabled adult or child that would not apply to the general population.[152]

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[144] Transcript page 311.

[145] Transcript page 162.

[146] Transcript pages 224-228 and CB pages 110-111 (Memorandum dated 26 August 2013 concerning the Quality of Support Review conducted following Ms Barfoot's death).

[147] Transcript page 233 (Di Masi) and 315 (Foster). There was a meeting between DHHS and Focus in May 2013.

[148] I have referred to only those issues/responses of relevance to the coronial investigation.

[149] CB pages 133-134 (Memorandum dated 21 November 2014 concerning Closure of the Quality of Support Review conducted following Ms Barfoot's death).

[150] Witnesses expressed the view that only with hindsight did they perceive the potential hazard of the swing seat [Transcript page 195 (Walker) and 273 (Owen)]. The exception was perhaps Prof Scheffer who noted that 'anything can be a risk when having a tonic-clonic seizure, how you fall, where you fall …' [Transcript page 9].

[151] Exhibit O.

[152] Exhibit O. I note that 'Ms Barfoot's' swing seat was assessed as fit for purpose and being used in accordance with the manufacturer's instructions on 7 April 2013.

68. In addition, Focus has extended its risk assessment policy so that it includes the assessment of risks posed by the use of garden furniture, including swing seats, not only 'activities' in which clients might be involved. Thus, the Occupational Health and Safety [OH&S] Team are consulted about the purchase of new recreational or occupational seating and prior to installation of any item that is gifted to Focus or one of the facilities it operates.[153]

69. Focus' Asset Register had not captured gifts prior to Ms Barfoot's death. Since then, a new Asset Register (Reckon Asset Manager) has been introduced and is synchronised with the finance system to ensure that any gifted or purchased item with a value in excess of $500 is identified so that it can form part of the OH&S checking system to review potential hazards to clients or staff. The hazard identification process is enhanced by a suite of new OH&S policies relating to hazard identification and control, purchase of furnishings, manual handling, and workplace inspection procedures.[154]

CONCLUSIONS

70. 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 explication.[155] The effect of the authorities is that Coroners should not make adverse findings against or comments about individuals in their professional capacities, unless the evidence provides a comfortable level of satisfaction that they departed materially from the standards of their profession and in so doing, caused or contributed to the death.

71. Having applied the applicable standard to the available evidence, I find that:

    a. I am unable to determine whether Ms Barfoot simply went into cardiac arrest during a seizure, or whether she had a seizure became entangled in the arm rest, experienced a period of hypoxia and then went into cardiac arrest.

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[153] Exhibit O and Transcript pages 302-303.

[154] Exhibit O and Transcript pages 300-303.

[155] *Briginshaw v Briginshaw (1938) 60 C.L.R. 336 esp 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..."

b. There was no regime in place at Bungower for strictly timed regular observations or visualisation of Ms Barfoot (or other residents) but such supervision as was in place was flexible, in keeping with their staffing levels, the residents' needs and the desire to provide as homelike an environment as possible.

c. At about 4.05pm on 7 April 2013, Ms Barfoot was lying on the swing seat outside the rear of the north wing.

d. Ms Barfoot was last seen alive by Mr Chunga around 4.10pm when she was sitting on the swing seat with her helmet on and fastened.

e. Some time before 4.20pm, Ms Barfoot responded audibly to Ms Owen's 'goodbye' as she left Bungower after her shift.

f. At a time between 4.10 and 4.25pm, Ms Barfoot must have removed her helmet, possibly intending to lie down again.

g. Some time before about 4.25pm when she was found unresponsive by Mr Chunga and Ms Marsh, Ms Barfoot experienced a seizure.

h. The supervision of Ms Barfoot by Bungower staff between about 4.00pm and 4.25pm that afternoon was reasonable and appropriate in all the circumstances.

i. Sensible improvements in practice and procedures at Bungower were made as a result of the DHHS Quality of Support Review and Focus/Bungower's consideration of the circumstances in which Ms Barfoot died.

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

Robin Barfoot

Focus Individualised Support Services, c/- Minter Ellison

Thomas Kuster, Department of Health and Human Services

Prof Ingrid Scheffer

Mia Jansen, Peninsula Health

Signature:

PARESA ANTONIADIS SPANOS
Coroner
Date: 31 May 2017