IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004868

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge John Cain, State Coroner
Deceased:	Catherine Barker
Date of birth:	25 April 1962
Date of death:	13 March 2023
Cause of death:	1(a) Tachyarrthmia leading to sudden cardiac death 1(b) Hyperkalaemia leading to sudden cardiac death 2(a) Atrial Fibrillation
Place of death:	Colac Hospital, Colac Area Health, Colac VIC 3250
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 13 March 2023, Catherine Barker (**Ms Barker**) was 60 years old when she died at Colac Hospital, Colac from tachyarrthmia and hyperkalaemia leading to sudden cardiac death in the setting of atrial fibrillation.

2. At the time of her death, Ms Barker was a National Disability Insurance Scheme (**NDIS**) participant. She received funding to reside in a Specialist Disability Accommodation (**SDA**) enrolled dwelling[1] provided by genU. Ms Barker had been born with an intellectual disability arising from genetic chromosomal abnormalities.

3. Ms Barker had a very supportive family, having ten siblings whom she called and spoke with most weeks with her sister, Bernadette, her main family support. Whilst she used to live at home with her family, her mother passed away in 1990 and her father passed away in 2015. From 7 July 2022 Ms Barker was living in genU SIL accommodation in Warnambool however on 12 March 2023 she moved into genU SIL accommodation in Colac. Ms Barker was looking forward to these new accommodation arrangements as she would be much closer to her sister who would be close by. Ms Barker spent most of her holidays with her family both in Victoria and interstate which she thoroughly enjoyed. She would also spend time in Point Lonsdale with her sisters Frances and Loretta and at times her family would visit her at home and take her out.

THE CORONIAL INVESTIGATION

4. Ms Barker's death fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**) as she was a 'person placed in custody or care' within the meaning of the Act, as a person receiving funding for Supported Independent Living (**SIL**) and residing in an SDA enrolled dwelling immediately prior to her death. 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

[1] SDA enrolled dwelling is defined under the *Residential Tenancies Act 1997* (Vic). The definition, as applicable at the time of Ms Barker's death, is a permanent dwelling that provides long-term accommodation for one or more SDA residents, that is enrolled as an SDA dwelling under relevant NDIS (Specialist Disability Accommodation) Rules in force at the relevant time. An SDA resident means a person who is a NDIS participant funded to reside in an SDA enrolled dwelling, or who receives continuity of supports under the Commonwealth Continuity of Support Program in respect of specialist disability services for older people (from 1 July 2021, the Disability Support for Older Australians program). The definition of SDA resident was amended on 1 July 2024 pursuant to the *Disability and Social Services Regulation Amendment Act 2023* to extend to include persons who are residing, or propose to reside, in an SDA dwelling under an SDA residency agreement or residential rental agreement.

coroner is required to investigate the death, and publish their findings, even if the death has occurred as a result of natural causes.

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. This finding draws on the totality of the coronial investigation into the death of Catherine Barker, including information from the National Disability Insurance Agency (**NDIA**) and the NDIS Quality and Safeguards Commission, as well as a Medical Certificate Cause of Death (**MCCD**) completed by a medical practitioner at Colac Hospital. 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]

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

Circumstances in which the death occurred

8. Ms Barker was born with an intellectual disability due to a genetic chromosomal abnormality and had had her mastoid bone removed from her left ear resulting in a hearing impairment. Approximately six months prior to her passing, Ms Barker experienced a decline in function resulting from a fall in her supported accommodation home and fracturing her leg for which she continued to experience pain and mobility issues.

[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.

9. Approximately six months prior to her passing, Ms Barker had been diagnosed with atrial fibrillation and had a cardiologist appointment scheduled at the Cardiac Rhythm Clinic, Barwon Health on 4 April 2023 for further follow up in respect of ongoing shortness of breath.

10. On 12 March 2023 having moved into her new genU SIL accommodation in Colac, Ms Barker was reported to have had a fall without injury approximately 6.30pm while on her way to her bedroom using her walking frame. She was reported to have another fall when getting out of bed at 7.30am the following morning, 13 March 2023 and was observed to be short of breath, confused and had limited mobility. Ms Barker's sister, Bernadette arrived to visit her at 10.30am who discussed the recent falls and observations made by staff with the Team Leader. Following these discussions, it was decided to seek medical treatment for Ms Barker and Bernadette drove her to Colac Hospital Accident & Emergency.

11. Upon assessment it was determined that Ms Barker's heart was enlarged, and her heart rate was slowing. Consideration was given to transferring Ms Barker to Geelong University Hospital however before this could occur, Ms Barker's condition deteriorated, and she went into cardiac arrest and subsequently passed away.

Identity of the deceased

12. On 13 March 2023, Catherine Barker, born 25 April 1962, was identified by Medical Practitioner Dr Shruthi Venkatesh via medical records review and visual identification.

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

Medical cause of death

14. On 13 March 2023, Medical Practitioner Dr Shruthi Venkatesh reviewed Ms Barker's complete medical history, conducted an examination on the body and completed a MCCD. Dr Venkatesh provided an opinion that the medical cause of death was tachyarrthmia and hyperkalaemia leading to sudden cardiac death in the setting of atrial fibrillation.

15. On 18 August 2024, a Medical Liaison Nurse (**MLN**) at the Victorian Institute of Forensic Medicine, reviewed the MCCD at my direction and confirmed that the cause of death was due to natural causes.

16. I accept Dr Venkatesh's opinion and am satisfied that the death was due to natural causes.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Catherine Barker, born 25 April 1962;

    b) the death occurred on 13 March 2023 at Colac Hospital, Colac in Victoria from tachyarrthmia and hyperkalaemia leading to sudden cardiac death in the setting of atrial fibrillation;

    c) the death occurred in the circumstances described above.

18. The available evidence does not support a finding that there was any want of clinical management or care on the part of the SIL provider, or clinical staff at Colac Hospital that caused or contributed to Ms Barker's death.

19. Having considered all the available evidence, I find that Ms Barker's death was from natural causes and that no further investigation is required. As such, I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into her death and to finalise the investigation of Ms Barker's death in chambers.

20. I convey my sincere condolences to Ms Barker's family, friends and carers for their loss, and acknowledge the distress caused by the delay in the reporting and investigation of Ms Barker's death.

21. 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.

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

    a) Bernadette Conron, Senior Next of Kin

    b) genU

    c) Colac Health Service

Signature:

Date : 11 November 2024

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.