IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 002586

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Deborah Christine Barker
Date of birth:	2 June 1958
Date of death:	13 May 2022
Cause of death:	1(a) Unascertained (natural causes)
Place of death:	70 Kawarren Street, Balwyn North, Victoria, 3104

INTRODUCTION

1. On 13 May 2022, Deborah Christine Barker was 63 years old when she died at her home. At the time of her death, Deborah lived at a Specialist Disability Accommodation (**SDA**) residence in Balwyn North.

2. Deborah was born premature and was deprived of oxygen during her birth. This impeded her development, and she was later diagnosed with an intellectual disability.

3. Deborah attended Pascoe Vale Primary School for two or three years before attending a special needs school in Broadmeadows until she was 15 years old.

4. She lived with her family and regularly attended special needs workshops until 2005, when her parents admitted her as a ward of the state due to their advancing age.

5. In 2009 Deborah moved to the Balwyn North residence where she lived with four other residents. She received support for all activities of daily living. Her carers described her as a 'great resident'.

6. In addition to her intellectual disability, Deborah was diagnosed with depression, anxiety and Obsessive Compulsive Disorder (**OCD**). Her conditions were well managed, and her carers did not notice any decline in her health leading up to her death.

THE CORONIAL INVESTIGATION

1. Deborah'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. Additionally, Deborah's circumstances were analogous to "a person placed in care" as it is defined in sections 3 and 4 of the *Coroners Act 2008* (Vic) ("the Act").

2. Since 2019, funding for disability services in Victoria has shifted from the Department of Families, Fairness and Housing to the National Disability Insurance Scheme. This shift meant that the definition of *person placed in custody or care* in section 3(1) of the *Coroners Act 2008* to include 'a person under the control, care or custody of the Secretary to the Department of Human Services or the Secretary to the Department of Health' was no longer sufficient to capture the group of vulnerable people in receipt of disability services that the legislature had intended.

3. The Coroners Regulations 2019 were amended on 11 October 2022 to create a new category of person considered to be 'in care' under Regulation 7 of the Coroners Regulations 2019, being a 'person in Victoria who is an SDA resident residing in an SDA enrolled dwelling'. The amendments also introduce an associated reporting obligation under Regulation 8 for a person who: (i) is funded to provide an SDA resident with daily independent living support; and (ii) has reasonable grounds to believe that the resident's death has not been reported to a coroner or the Institute.

4. While Deborah Christine Barker was not formally 'in care' at the time of her death on 13 May 2022, she was an SDA resident in an SDA-enrolled dwelling. If reported today, her death would be considered to be an 'in care' death that requires additional steps be taken in the coronial process, including that an inquest be held unless the Coroner considers the death was due to natural causes, and that the present Findings be published on the Internet. It is of significance that the Coroners Regulations have now been updated to capture the passings of potentially vulnerable persons such as Deborah, with these enhanced investigative processes, to ensure that any issues associated with their care are appropriately and independently canvassed by the coroners of this state.

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. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Deborah's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

8. This finding draws on the totality of the coronial investigation into the death of Deborah Christine Barker 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.[1]

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

Circumstances in which the death occurred

9. At approximately 7pm on Friday 13 May, Deborah went to use the toilet after finishing dinner. Around 10 minutes later, her carer noticed she was not in her room and checked the toilet, finding her unresponsive.

10. Deborah's carers immediately commenced cardiopulmonary resuscitation (CPR) and called Triple Zero. Paramedics arrived shortly thereafter, though she remained unresponsive. Deborah was sadly declared deceased at 7:32pm.

Identity of the deceased

11. On 13 May 2022, Deborah Christine Barker, born 2 June 1958, was visually identified by her carer, Rosie Milanese, who completed a Statement of Identification.

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

Medical cause of death

13. Forensic Pathologist Registrar Dr Jagbir Grewal from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on the body of Deborah Barker on 17 May 2022, supervised by Senior Forensic Pathologist Dr Matthew Lynch. Dr Grewal considered the Victoria Police Report of Death (Form 83), post mortem computed tomography (**CT**) scan, VIFM contact log and medical records from Dr Leong Lim and provided a written report of his findings dated 21 December 2022.

14. The findings at autopsy included severe hepatic macrosteatosis, a heart weight of 423 grams, foreign material in the trachea and distal airways, scant myocardial inflammation and focal pancreatic haemorrhage. There was no evidence of any injuries which may have caused or contributed to the death.

[1] 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.

15. Dr Grewal commented that a higher, albeit normal, heart weight and severe fatty liver disease synergistically increase the risk of potentially fatal arrythmia. This was favoured to be the mechanism of sudden cardiac death.

16. Toxicological analysis of post mortem blood samples identified the presence of citalopram, mirtazapine and quetiapine at levels consistent with therapeutic use.

17. Dr Grewal provided an opinion that the medical cause of death was 1 (a) UNASCERTAINED (NATURAL CAUSES).

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Deborah Christine Barker, born 02 June 1958;

    b) the death occurred on 13 May 2022 at 70 Kawarren Street, Balwyn North, Victoria, 3104;

    c) I accept and adopt the medical cause of death ascribed by Dr Jagbir Grewal and find that Deborah Christine Barker died from unascertained natural causes;

2. AND, having previously determined that Deborah Christine Barker was equivalent to "a person in care" at the time of her death, I find that there is no relationship between the cause of her death and the care she received.

I convey my sincere condolences to Deborah's family for their loss.

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.

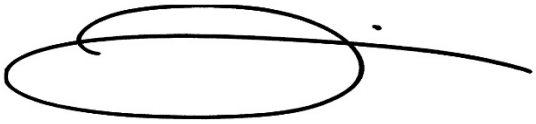
I direct that a copy of this finding be provided to the following:

Marjorie & Robert Barker, Senior Next of Kin

NDIS Quality and Safeguards Commission

Senior Constable Ty Christy, Coroner's Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 16 October 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.