IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 002933

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Barry Robert Johnson
Date of birth:	1 October 1953
Date of death:	31 May 2022
Cause of death:	1(a) Metastatic colorectal carcinoma
Place of death:	55-57 Swan Street, Blackburn South, Victoria, 3130

INTRODUCTION

1. On 31 May 2022, Barry Robert Johnson was 68 years old when he died at home of natural causes. At the time of his death, Barry lived in a Specialist Disability Accommodation (**SDA**) home in Blackburn South.

2. Barry grew up with his parents and brother, William. In 2000 he moved to the SDA home in Swan Street, Blackburn South, where he lived until his death. Barry's mother was involved in Barry's care and visited weekly until her death in 2012, at which time William assumed the role of financial administrator and medical decision maker.

3. Barry lived with intellectual disability, Autism Spectrum Disorder, Cerebral Palsy and dysphagia. He required one to one support for all activities of daily living, including meal preparation and mealtime supervision, personal care, medication administration and community access. Barry was able to ambulate on his own.

4. In March 2020 Barry was diagnosed with ascending colon adenocarcinoma. His condition and prognosis were discussed with William and the decision was made that Barry was not for active treatment, given his quality of life. He remained relatively stable following his diagnosis, aside from well-managed iron deficiency anaemia.

Recent health decline

5. In April 2022, Barry was accepted under the care of the Eastern Palliative Care Team (**EPCT**) after a short stay in hospital related to his cancer diagnosis.

6. During April and May, Barry's blood tests showed low haemoglobin, and a mildly elevated white cell count but he was generally well, aside from sleeping more and appearing more tired than usual. He was treated with antibiotics.

7. On 27 May 2022, Barry's general practitioner Dr Shirley Tang reviewed his recent blood tests which indicated that his inflammatory markers had increased. He was commenced on a new course of antibiotics.

8. That evening after returning from day service, Barry was noted to have a temperature of 37.5 degrees and was given paracetamol. Night shift staff provided a repeat dose of paracetamol on the advice of EPCT, as he appeared to be sweating.

9. At around midnight, night shift staff found Barry pale and cold. They called NURSE-ON-CALL who called Triple Zero and requested an ambulance. Around 45 minutes later paramedics called the Swan Street residence and advised that there would be significant delays in Barry being attended to, and as he had improved by this time, the decision was made for paramedics to not attend unless staff called Triple Zero again and requested priority attendance. Barry remained stable throughout the night.

10. Barry spent most of the 28 and 29 May 2022 resting in bed and declined some meals. He was visited by family on 29 May. He was assessed by Dr Tang on 30 May 2022 who prescribed treatment for constipation and recommended an urgent review by EPCT, given his presentation in the previous days.

THE CORONIAL INVESTIGATION

11. Barry's death was reported to the Coroner as he was a vulnerable person whose 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").

12. 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.

13. 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: (ii) 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.

14. While Barry Robert Johnson was not formally 'in care' at the time of his death on 31 May 2022, he was an SDA resident in an SDA-enrolled dwelling. If reported today, his 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 Barry, 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.

15. 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.

16. 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.

17. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Barry'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.

18. This finding draws on the totality of the coronial investigation into the death of Barry Robert Johnson 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]

[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.

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

Circumstances in which the death occurred

19. Barry slept through the night on 31 May 2022. He was observed to have a distended abdomen in the morning, and he refused food and fluid before returning to bed for the rest of the day. Barry was checked on regularly throughout the day. He was comfortable, and his temperature remained in the normal range.

20. At around 5pm he ate a small amount of dinner and a cup of cordial, before returning to bed. At 7:30pm he was given his evening medications and ate a small amount of yoghurt.

21. At 8pm, staff located Barry unresponsive in bed. They commenced cardiopulmonary resuscitation (**CPR**) and called Triple Zero. Paramedics arrived shortly after and took over CPR, to no avail. Barry was sadly declared deceased at 8:18pm.

Identity of the deceased

22. On 31 May 2022, Barry Robert Johnson, born 1 October 1953, was visually identified by his carer, Alice Toe, who completed a Statement of Identification.

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

Medical cause of death

24. Forensic Pathologist Dr Joanne Ho from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on the body of Barry Johnson on 1 June 2022. Dr Ho considered the Victoria Police Report of Death (Form 83), post mortem computed tomography (**CT**) scan, VIFM contact log and scene photographs and provided a written report of her findings dated 15 June 2022.

25. The external examination was unremarkable. The post mortem CT scan was reviewed by Forensic Radiologist Dr Chris O'Donnell who reported numerous cortical and subependymal nodules consistent with tuberous sclerosis. There was also a perforated bowel with free air in the abdomen, fluid around the liver, and bilateral renal cysts.

26. Dr Ho provided an opinion that the medical cause of death was 1 (a) METASTATIC COLORECTAL CARCINOMA.

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 Barry Robert Johnson, born 1 October 1953;

   b) the death occurred on 31 May 2022 at 55-57 Swan Street, Blackburn South, Victoria, 3130;

   c) I accept and adopt the medical cause of death ascribed by Dr Joanne Ho and find that Barry Robert Johnson died from metastatic colorectal carcinoma;

2. AND having previously determined that Barry Robert Johnson was equivalent to "a person in care" at the time of his death, I find that there is no relationship between the cause of his death and the care he received.

I convey my sincere condolences to Barry'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:

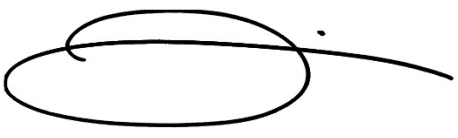
William Johnson, Senior Next of Kin

Avant Law on behalf of Dr Shirley Tang

NDIS Quality and Safeguards Commission

Senior Constable Andrew Duffin, Coroner's Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 17 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.