IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 003792

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paul Lawrie
Deceased:	Paul Raymond Barnett
Date of birth:	1 March 1976
Date of death:	12 July 2023
Cause of death:	1(a) HUNTINGTON'S DISEASE AND METASTATIC BOWEL CANCER
Place of death:	14 Bowen Crescent, Burwood East, Victoria, 3149
Keywords:	In care, natural causes

INTRODUCTION

1. On 12 July 2023, Paul Raymond Barnett was 47 years old when he passed away at his specialist disability accommodation after a course of palliative care. At the time of his death, Paul lived at 15 Bowen Crescent, Burwood East, a supported living facility operated by Yooralla[1] for specialist neurological support. He had been a resident there since December 2014.

2. At age 16, Paul sustained an acquired brain injury.

3. In 2003, Paul began exhibiting the early symptoms of Huntington's Disease, and he received a formal diagnosis in 2013.

4. In April 2023, Paul was diagnosed with bowel cancer and blood tests revealed evidence of a metastatic spread.

THE CORONIAL INVESTIGATION

5. Paul'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. The death of a person in care is a mandatory report to the coroner, even if the death appears to have been from natural causes. Paul was a 'person placed in custody or care' within the meaning of section 4 of the Act, as he was 'a prescribed class of person'[2] due to his status as an 'SDA[3] resident residing in an SDA enrolled dwelling'.

6. 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.

7. 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

[1] A disability support service provider.
[2] Section 4(2)(j)(i) of the *Coroners Act 2008.*
[3] Specialist Disability Accommodation.

comments or recommendations in appropriate cases about any matter connected to the death under investigation.

8. First Constable (FC) Melissa Viers acted as the Coroner's Investigator for the investigation of Paul's death. FC Viers conducted inquiries on my behalf and compiled a coronial brief of evidence.

9. This finding draws on the totality of the coronial investigation into the death of Paul Raymond Barnett, 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.[4]

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

Circumstances in which the death occurred

10. Paul's health started to deteriorate following his bowel cancer diagnosis in April 2023. Given his poor prognosis, his father, Michael Barnett and treating physicians decided not to proceed with aggressive cancer treatment and a revised goals of care plan with a focus on comfort care was formulated and signed on 2 May 2023.

11. In June 2023, Paul began receiving palliative care support from Eastern Palliative Care.

12. On 11 July 2023, Paul was reviewed by Dr Peggy Kwok GP who noted a further deterioration in his condition and directed the cessation of regular medications and the administration of medications to manage pain and agitation.

13. On the morning of 12 July 2023, Paul was seen by a massage therapist. At 10.50am, the therapist reported that Paul had become still. Nurses immediately checked his pulse and respiration but were unable to detect either. In accordance with his care plan, resuscitation was not attempted and a nurse from Eastern Palliative Care pronounced Paul deceased shortly afterwards.

14. There is no evidence to suggest that Paul's care was anything other than appropriate.

[4] 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.

Identity of the deceased

15. On 19 July 2023, Paul Raymond Barnett, born 1 March 1976, was visually identified by his father, Michael Barnett.

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

Medical cause of death

17. Forensic Pathologist, Dr Paul Bedford from the Victorian Institute of Forensic Medicine conducted an external examination on 13 July 2023 and provided a written report of his findings dated 24 July 2023.

18. Dr Bedford noted a clinical history of advanced metastatic bowel cancer and Huntington's disease.

19. Dr Bedford provided an opinion that the medical cause of death was 1 (a) HUNTINGTON'S DISEASE AND METASTATIC BOWEL CANCER. Dr Bedford further opined that Paul's death was due to natural causes.

20. I accept Dr Bedford's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Paul Raymond Barnett, born 1 March 1976;

    b) the death occurred on 12 July 2023 at 14 Bowen Crescent, Burwood East, Victoria, 3149, from HUNTINGTON'S DISEASE AND METASTATIC BOWEL CANCER; and

    c) the death occurred in the circumstances described above.

I convey my sincere condolences to Paul's family and his carers for their loss.

I thank the Coroner's Investigator and those assisting for their work in this investigation.

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:

Michael Barnett, Senior Next of Kin

Yooralla

First Constable Melissa Viers, Coroner's Investigator

Signature:

Coroner Paul Lawrie

Date : 02 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.