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**FINDINGS of Coroner Cooper following the holding of  
an inquest under the *Coroners Act 1995* into the death  
of:**

**Ronald William Barnard**

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# Record of Investigation into Death (With Inquest)

*Coroners Act 1995*  
*Coroners Rules 2006*  
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Ronald William Barnard with an inquest held at Hobart in Tasmania, make the following findings.

## Hearing Dates

24 July 2024

## Representation

Counsel Assisting the Coroner: J Delpero

## Introduction

1. On 24 January 2023, Ronald William Barnard died at the Royal Hobart Hospital, Hobart in Tasmania. At the time of his death, he was serving an indeterminate custodial sentence, having been declared a dangerous criminal in April 2007.
2. His death is subject to the *Coroners Act 1995* (the “Act”). The Act relevantly provides that an inquest must be held where a death occurs in Tasmania and the deceased person was, immediately before their death, a person held in custody. Mr Barnard meets that definition.
3. Accordingly, an inquest was held into Mr Barnard’s death at Hobart on 24 July 2024.

## Evidence at the inquest

4. The following material was tendered at the inquest:

C1 – Police Report of Death for the Coroner;  
C2 – Royal Hobart Hospital Report of Death for the Coroner;  
C3 – Affidavit of Identification – Constable D Triffett;  
C4 – Affidavit – Dr Donald Ritchey, Forensic Pathologist;  
C5 – Affidavit – Neil McLachlan-Troup, Forensic Science Service Tasmania;  
C6 – Medical Records – Royal Hobart Hospital;  
C7 – Affidavit – G Drake;  
C8 – Affidavit – Constable C Fry;  
C9 – Affidavit – Constable D Triffett;

- C10 – Affidavit – Detective Constable W Richman;
- C11 – Comments on Passing Sentence – Justice Peter Evans’;
- C12 – Tas Conviction History – Tasmanian Prison Service;
- C13 – Records – Tasmania Prison Service;
- C14 – Property Receipts; and
- C15 – Mr Barnard’s Will dated 9 August 2021.

5. On the basis of that evidence, I make the following formal findings pursuant to section 28 (1) of the Act:
  - (a) The identity of the deceased is Ronald William Barnard;
  - (b) Mr Barnard died in the circumstances set out further in this finding;
  - (c) The cause of Mr Barnard’s death was respiratory failure; and
  - (d) Mr Barnard died 24 January 2023 at the Royal Hobart Hospital, Hobart in Tasmania

### **Background**

6. Mr Barnard was born on 21 July 1940. He was raised in Southern Tasmania. There is no evidence that he has any living relatives. His senior next of kin in terms of the Act is a man he met in prison who Mr Barnard appointed the executor of his will.

### **Mr Barnard’s health**

7. Mr Barnard was in poor health in the lead up to his death.
8. On 20 January 2023, he suffered shortness of breath and chest pain, and as a result was transported by Ambulance Tasmania from HMP Risdon to the Royal Hobart Hospital for treatment.
9. Mr Barnard was diagnosed with pneumonia and discharged back to prison with anti-biotics.
10. On 22 January 2023, Mr Barnard suffered worsening shortness of breath and vomiting, and as a result was again transported by Ambulance Tasmania to the Royal Hobart Hospital for treatment.
11. Mr Barnard was provided intravenous anti-biotics and discharged with anti-nausea medication. He was returned to prison.

12. On 23 January 2023, Mr Barnard suffered breathing difficulties, and as a result was transported for the final time by Ambulance Tasmania to the Royal Hobart Hospital for treatment.
13. Upon presentation, Mr Barnard was observed to be peri-arrest, pale, diaphoretic, weak radial pulse and drowsy.
14. Mr Barnard's treatment included venous blood gas testing, salines, salbutamol and ipratropium via IV, covid testing, and bilevel positive airway pressure trial. During treatment Mr Barnard became increasingly agitated, repeatedly telling staff to "fuck off" and "get fucked".
15. Mr Barnard's condition was determined to be type 2 respiratory failure and, as he was not considered appropriate for high dependency level of care, he was provided palliative care. On 24 January 2024, Mr Barnard was pronounced deceased at the Royal Hobart Hospital.

### **Investigation**

16. The fact of Mr Barnard's death was reported in accordance with the requirements of the *Coroners Act 1995*. On 25 January 2023, experienced Forensic Pathologist Dr Donald Ritchey, performed an autopsy on Mr Barnard at the Royal Hobart Hospital. Dr Ritchey subsequently prepared an Affidavit in relation to the autopsy in which he said:

*"The autopsy revealed a thin appearing elderly man with a hyperexpanded chest and advanced centriacinar emphysema, a lung disease caused by smoking. There was widespread, patchy inflammation (pus) filling and distending air sacs and focal areas suggestive of perimortem aspiration."*

17. I accept Dr Ritchey's opinion.
18. In addition, the general circumstances associated with Mr Barnard's death are investigated by Tasmania police. No suspicious circumstances, anomalies or inconsistencies were identified as being associated with his death.
19. The treatment he received at the Royal Hobart Hospital was entirely appropriate and of a high standard.

## **Conclusion**

20. Finally, I am satisfied on the basis of the evidence, at the inquest that the care, supervision and treatment of Mr Barnard whilst in custody in the period leading up to his death, was of an appropriate standard.

21. I wish to thank Sergeant John Delpero, Coroners Associate for his assistance in relation to this matter.

**Dated:** 10 September 2024 at Hobart in the State of Tasmania.

**Simon Cooper**

**Coroner**