

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 003421

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

Section 67 of the Coroners Act 2008

Inquest into the death of ROBERT JAMES BARRON

Delivered on:	30 September 2014
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street Southbank Victoria 3006
Hearing dates:	30 September 2014
Findings of:	Coroner Paresa Antoniadis SPANOS
Assisting the Coroner:	Leading Senior Constable Andrea Hibbins, Police Coronial Support Unit.

I, PARESA ANTONIADIS SPANOS, Coroner,
having investigated the death of ROBERT JAMES BARRON
and having held an inquest in relation to this death on 30 September 2014
in the Coroners Court of Victoria at Melbourne

find that the identity of the deceased was ROBERT JAMES BARRON
born on 23 June 1949
and that the death occurred on 4 August 2013
at the Thomas Embling Hospital, Fairfield Victoria 3078

from:

I (a) LUNG CANCER.

in the following circumstances:

1. Mr Barron was a 64-year-old man who, at the time of his death, was a resident at Thomas Embling Hospital at the above address.
2. At the time of Mr Barron's death, he was detained under section 12 of the *Mental Health Act 1986* as an involuntary patient at Thomas Embling Hospital, where he had been since 2000. He was also subject to supervision by the Adult Parole Board who had 'released' Mr Barron on parole in November 2012 with the condition that he continue to reside at Thomas Embling. He had been given an indefinite custodial sentence in 1974 after causing the deaths of two people in January that year.
3. Mr Barron was formally diagnosed with paranoid schizophrenia shortly after that time, but had likely been unwell for several years prior. Mr Barron's treating psychiatrist at Thomas Embling Associate Professor Andrew Carroll stated that he was compliant with treatment in general, but behavioural disturbances and his propensity for absconding were complicating factors in his management.
4. A/ Professor Carroll stated that Mr Barron generally enjoyed a good quality of life in the Canning unit of the hospital, and that he provided no major management difficulties throughout his time there. He was treated with clozapine from 2006 to 2012, when it was ceased due to neutropenia. Mr Barron was then treated with olanzapine and risperidone, and the mood stabiliser sodium valproate, as well as diazepam to treat symptoms of acute anxiety.
5. Mr Barron's medical history included heavy smoking, chronic obstructive pulmonary disease, and evidence from ECGs of a possible myocardial infarction some time prior to 2008. Mr Barron had also had a splenectomy following an episode of trauma.

6. In mid-December 2012, Mr Barron's physical health began to deteriorate and he did not respond to treatment from the hospital-based general practitioner and registrar. On 3 January 2013, he was transferred to the Austin Hospital. He spent four days in the intensive care unit until 11 January 2013. Mr Barron was diagnosed with pneumonia and underlying inoperable bronchial carcinoma. His physical condition improved slightly and he returned to Thomas Embling Hospital on 4 February 2013.
7. A physical health care plan was developed for Mr Barron by staff at the Canning unit at Thomas Embling, including A/ Professor Carroll. It included Mr Barron's views on his medical care, being that he did not wish to be transferred to a medical hospital or subject to resuscitating or other life-prolonging interventions. A/ Professor Carroll stated that Mr Barron appeared competent to make choices with respect to his future care.
8. Mr Barron's condition continued to deteriorate as was expected, and he was reviewed by the on-call consultant psychiatrist Dr Danny Sullivan on 4 August 2013 at 10.15am. He noted that Mr Barron was prescribed oral and subcutaneous opiate analgesics, and stated that the doses appeared reasonable for a patient in palliation. Dr Sullivan met with Mr Barron and noted that he was walking unassisted but accompanied by a nurse, was ashen in complexion, had pinpoint pupils and was short of breath. Mr Barron's analgesic treatment regime was continued, with subcutaneous morphine being administered throughout the morning and afternoon, and one-on-one nursing observations. Mr Barron died peacefully in the evening and was confirmed deceased at around 8.20pm on 4 August 2013.
9. Apart from a jurisdictional nexus with the State of Victoria, reportable deaths are, generally, deaths that appeared to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury. However, some deaths are reportable irrespective of the nature of the death, based on the status of the person immediately before death. Mr Barron's death was reportable as he was a *person placed in custody or care*.¹ This is one of the ways in which the *Coroners Act 2008* recognises that people in the control, care or custody of the State are vulnerable, and affords them the protection of the independent scrutiny and accountability of a coronial investigation.
10. Another protection is the requirement for mandatory inquests. While there is a discretionary power to hold an inquest in relation to any death a coroner is investigating,² this was a

¹ See section 3 for the definition of a "person placed in custody or care" and section 4(2)(c) of the definition of "reportable death".

² Section 52(1) provides that a coroner may hold an inquest into any death that the coroner is investigating.

mandatory or statutorily prescribed inquest as Mr Barron was, immediately before death, a person placed in custody or care.³

11. This finding draws on the totality of the material the product of the coronial investigation of Mr Barron's death, contained in the inquest brief compiled by First Constable Zachary Smith of the Collingwood Police Station. All this material, together with the inquest transcript, will remain on the coronial file. In writing this finding, I do not purport to summarise all evidence, but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity.
12. Mr Barron's identity, the date, place and medical cause of death were never at issue. I find, as a matter of formality, that Robert James Barron born on 23 June 1949, aged 64, late of Thomas Embling Hospital, Fairfield Victoria 3078, died at Thomas Embling Hospital on 4 August 2013.
13. Nor was the medical cause of death contentious. No autopsy was performed, as Senior Forensic Pathologist Dr Malcolm Dodd of the Victorian Institute of Forensic Medicine (VIFM) conducted an external examination of Mr Barron's body in the mortuary, reviewed his medical records and the police report of death to the coroner, and provided a written report of his findings. Dr Dodd concluded that it would be reasonable to attribute Mr Barron's death to *lung cancer*, without the need for autopsy. Dr Dodd noted Mr Barron's history of terminal lung cancer, that his death was expected and that identified no suspicious circumstances.
14. Post mortem toxicology testing of blood revealed the presence of free morphine at ~0.2mg/L, hydroxyrisperidone at ~65ng/mL, olanzapine at ~0.1mg/L and oxycodone at ~0.04mg/L, consistent with therapeutic administration.
15. The focus of the coronial investigation of Mr Barron's death was on the adequacy of clinical management and care provided to him in relation to the last months of his life. No concerns about clinical management and care were stated in the initial police report of Mr Barron's death to the Coroner.⁴ I also requested further statements from A/ Professor Carroll in order to understand Mr Barron's clinical course prior to and following diagnosis of bronchial carcinoma which caused his death.
16. I find that the cause of Mr Barron's death is lung cancer. Based on the evidence before me, I am satisfied that the health care provided to Mr Barron during his residence at Thomas Embling and at the onset of symptoms was appropriate and consistent with the care delivered in the Victorian public health care system. The evidence does not support a finding that there

³ Section 52(2) and the definition of "person placed in custody or care" in section 3.

⁴ Victoria Police Form 83 dated 4 August 2013.

was any want of clinical management and care on the part of medical and nursing staff of Thomas Embling or the Austin hospitals, or that any such want of clinical management or care caused or contributed to his death.

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

The family of Mr Barron

Dr Danny Sullivan, Consultant Forensic Psychiatrist, Thomas Embling Hospital

A/ Professor Andrew Carroll, Consultant Psychiatrist, Thomas Embling Hospital

Ms Janet Ruffles, Forensicare Legal Services

Dr Mark Oakley Browne, Chief Psychiatrist

First Constable Zachary Smith, Collingwood Police Station

Leading Senior Constable Andrea Hibbins, Police Coronial Support Unit.

Signature:



PARESA ANTONIADIS SPANOS

CORONER

Date: 30 September 2014



