IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 3941

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
*Section 67 of the **Coroners Act 2008***

I, CAITLIN ENGLISH, Coroner having investigated the death of Baher Kondos

without holding an inquest:
find that the identity of the deceased was Baher Kondos
born on 11 September 1981
and the death occurred on 3 August 2014
at Yooralla Disability Services residential unit, 72 Millawa Avenue, St. Albans, Victoria
from:

1 (a) Sudden Unexpected Death in Epilepsy

Pursuant to section 67(1) of the **Coroners Act 2008**, there is a public interest to be served in making findings with respect to **the following circumstances**:

1. Baher Kondos was 33 years of age at the time of his death. He lived in supported accommodation at Yooralla residential unit, at Millawa Avenue, St. Albans, with two other male clients.

2. Mr Kondos is survived by his parents and sibling.

3. Victoria Police conducted an investigation into the circumstances of Mr Kondos' death. The Coroner's investigator prepared a coronial brief, which includes statements obtained from Mr Kondos' disability support workers, Victoria Police investigators and the forensic pathologist who examined Mr Kondos. I have drawn on all of this material as to the factual matters in this finding.

Health History

4. Mr Kondos was generally physically fit but had a medical history that included schizophrenia, intellectual disability, depression, hypertension, mood swings and epilepsy.[1] He repeatedly suffered from self-inflicted injuries, agitation and aggression and catatonic behaviour.

5. At the time of his death, Mr Kondos was taking prescription medications, including clozapine and olanzapine (anti-psychotic drugs), atenolol (anti-hypertensive medication) and sodium valproate (a drug used in the management of seizures and behavioural issues). The doses of some of these medications had been adjusted in June 2014.[2]

Events Proximate to Death

6. On 3 August 2014, Mr Kondos, who suffered from epilepsy and had an intellectual disability, had breakfast and medications in the morning before attending an outing to the airport to watch the planes with carers from Yooralla Disability Services ("Yooralla").

7. Mr Kondos had resided at Yooralla for approximately 15 years.

8. On returning from the outing at approximately 12.30pm, Mr Kondos was left to himself, having become unsettled following the outing. This was not unusual for Mr Kondos. Carers encouraged Mr Kondos to spend some time alone to calm down and to have a nap. That afternoon, carers noted Mr Kondos watching television in his unit and sitting on the couch in the lounge room.

9. At approximately 3.30pm, carers noted Mr Kondos had returned to his unit.

10. At approximately 4.40pm, carers checked on Mr Kondos through the window of his unit. They noted that the room was dark and Mr Kondos was in bed with the covers over him. The carers then went in to check him in person.

11. Mr Kondos was found to be lying on his side with his head turned face down on the mattress. Carers attempted to wake Mr Kondos and then, noting that he was pale and not breathing, called emergency services and commenced CPR.

12. Paramedics arrived at approximately 4.58pm and took over CPR for approximately 30 minutes before declaring him deceased.

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[1] Statement of Dr Nabil Moussa dated 18 January 2015 and Patient Health Summary from St Luke Medical Centre.
[2] Patient Health Summary from St Luke Medical Centre.

13. Police attended the scene and commenced investigations. Police and medical investigations determined that there was no evidence of any injury that could have led to the death and that Mr Kondos' cause of death appeared unascertained.

Post Mortem Examination

14. Dr Michael Burke, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted a post mortem inspection. Dr Burke completed a report, dated 15 September 2014, formulating the cause of death as unascertained. However, on receiving further information regarding Mr Kondos' medical history, Dr Burke noted the history of intellectual disability, documented history of epilepsy, schizophrenia and mood swings and completed a supplementary report, dated 13 August 2015, formulating a reasonable cause of death as 'Sudden Unexplained Death in Epilepsy' ('SUDEP'). In a further supplementary report dated 12 September 2017 he noted there was no evidence to suggest the death was anything other than natural causes.

15. I accept Dr Burke's opinion as to the medical cause of death.

Finding

16. I find that:

    a. The identity of the deceased was Baher Kondos; and

    b. Mr Kondos died on 3 August 2014 from 'Sudden Unexplained Death in Epilepsy', at Yooralla residential unit at 72 Millawa Avenue, St. Albans, Victoria.

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death:

17. Pursuant to section 52(2)(b) of the *Coroners Act 2008* ('the Act'), a coroner must hold an inquest where the deceased was, immediately before the death, a person placed in custody or care. However, pursuant to section 52(3A) of the Act, a coroner is not required to hold an inquest if the coroner considers that the death was due to natural causes.

18. SUDEP is the sudden, unexpected death of an otherwise healthy person who suffered from epilepsy, where no other cause of death is found at autopsy. It is the leading cause of death in young adults with uncontrolled seizures.[3]

[3] Epilepsy Australia - http://www.epilepsyaustralia.net/epilepsy-sudep/.

19. I note that police investigations into Mr Kondos' care did not identify any concerns or deficiencies in the care or management by staff and carers at Yooralla. Mr Kondos' family had no concerns with regard to Mr Kondos' care at Yooralla over a 15 year period. Mr Kondos' family reported that carers contacted them daily to notify them of Mr Kondos' state and condition and that staff were notably distressed at his passing.

20. I am satisfied that Mr Kondos' death was due to natural causes and that I am, therefore, not required to hold an inquest into Mr Kondos' death.

21. Section 73(1B) of the Act provides that findings made following an investigation of a death of a deceased who was, immediately before the death, a person placed in custody or care that the death was due to natural causes must be published on the internet in accordance with the rules. As such, this finding will be published on the Court's website.

I convey my sincere condolences to Mr Kondos' family at his untimely death in 2014.

I direct that a copy of this finding be provided to the following:
Mr and Mrs Sohan and Boshra Kondos, Senior Next of Kin
FC Josh McCabe, Coroner's Investigator, Victoria Police
Dr Mark Oakley Browne, Office of the Chief Psychiatrist
Mr Jeffrey Chan, Yooralla Disability Services
Mr Peter Kelly, North Western Mental Health

Signature:

CAITLIN ENGLISH
CORONER
Date: 31 October 2017