IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 4149

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the Coroners Act 2008

Findings of:	**CORONER DARREN J BRACKEN**
Deceased:	**Antonia Victoria Lourandos**
Date of Birth:	11 January 1993
Date of death	17 August 2015
Cause of death:	Complications of megacolon due to chronic constipation in a woman with cerebral palsy
Place of death:	737 Gilbert Road, Reservoir, Victoria

TABLE OF CONTENTS

HER HONOUR:

BACKGROUND

1. On 17 August 2015, Antonia Victoria Lourandos **(Ms Lourandos)** was 22 years old when she died at her family home. Immediately prior to her death, Ms Lourandos lived in Reservoir with her parents, Pauline and Andrew Lourandos (**Mr and Mrs Lourandos**) and younger sister, Adrianna.

2. Ms Lourandos was severely disabled, having been diagnosed with epilepsy and cerebral palsy at 11 months of age.[1] She was medicated all her life, immobile, non-verbal and entirely dependent on other people for her care. Although non-verbal, Ms Lourandos was described as friendly and engaging and could communicate through facial expressions and vocalising various noises.

3. Ms Lourandos' parents were her carers throughout her life and were very dedicated to her health, care and happiness. Although she lived in the family home, Ms Lourandos would attend Able Australia during the day. Every six to eight weeks she would attend respite care located at 108 Vincent Drive, South Morang (**the Scope Facility**).[2] The Scope Facility was operated by Scope Australia Limited (**Scope**) through funding from the Department of Health and Human Services (**DHHS**).[3]

4. Ms Lourandos suffered from chronic constipation throughout her life and took a powdered laxative every second day.[4] She was admitted to hospital twice due to her constipation. She also underwent several surgical procedures as a child, including spinal surgery. Apart from constipation, Ms Lourandos' health was reportedly generally good.[5]

5. Ms Lourandos was fed orally for breakfast and dinner and was fed through a percutaneous endoscopic gastrostomy (**PEG**) tube for lunch. Breakfast or dinner could also be fed through the PEG tube if she was unwell. All of Mr Lourandos' medications were given orally via a medication cup.

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[1] Statement of Pauline Lourandos, Coronial Brief, p.39.
[2] Statement of Maggy Samaan, Coronial Brief, p.68.
[3] Service Agreement between DHHS and Scope, dated 30 June 2015.
[4] Statement of Pauline Lourandos, Coronial Brief, p.40.
[5] Statement of Pauline Lourandos, Coronial Brief, p.40.

6. On 14 August 2015, Mrs Lourandos dropped her daughter at the Scope Facility for respite care over the weekend.[6]

7. At 1.00pm on Saturday 15 August 2015, Colin Eldridge, a disability support worker, noticed Ms Lourandos appeared pale and very still.[7] He rang the On-call service coordinator, Peter Brown, who advised he should monitor her and to call again if there were any issues. Mr Eldridge handed over to Matt Meekken and believed he informed him to monitor Ms Lourandos for any changes in her appearance.[8]

8. That evening, Mr Meekken noted Ms Lourandos was laughing and smiling; she was not pale or still.[9]

9. On Sunday 16 August 2015 at 4.30pm, Jo-Anne D'Urso, a support worker, noticed a sore on Ms Lourandos' heel that had formed a scab.[10] She asked Mr Eldridge to call Mr Brown.[11] Mr Eldridge told Mr Brown that they were having difficulty getting Ms Lourandos' feed to flow through her PEG tube.[12] Mr Brown advised Mr Eldridge to call Mrs Lourandos.

10. Mr Eldridge contacted Mrs Lourandos between 5.00pm and 6.00pm that afternoon and stated that Ms Lourandos had not eaten her dinner properly and that she had a pressure sore on her right heel.[13] Mrs Lourandos enquired as to whether Ms Lourandos had completed a bowel movement. Mr Eldridge replied that Ms Lourandos had two large bowel movements the previous day.[14]

11. Contrary to what Mr Eldridge informed Ms Lourandos, documentation contained in the Coronial Brief outlines Ms Lourandos had a large sized bowel movement on 15 August 2015 and an average sized bowel movement on 16 August 2015.[15]

12. Mrs Lourandos told Mr Eldridge that Ms Lourandos probably needed to pass wind or a bowel motion. She suggested that staff lie Ms Lourandos down and make her comfortable and that they should release the build-up of air from her PEG site.[16]

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[6] Statement of Pauline Lourandos, Coronial Brief, p.41.
[7] Scope Incident Data Collection Form, Coronial Brief, p.202.
[8] Statement of Colin Eldridge, Coronial Brief, p.30.
[9] Scope Client Notes Form, Coronial Brief, p.193.
[10] Scope Incident Data Collection Form, Coronial Brief, p.206.
[11] Statement of Jo-Anne D'Urso, Coronial Brief, p.35.
[12] Statement of Colin Eldridge, Coronial Brief, p.31.
[13] Statement of Pauline Lourandos, Coronial Brief, p.41.
[14] Statement of Pauline Lourandos, Coronial Brief, p.41.
[15] Bowel chart, Coronial Brief, p.178.
[16] Statement of Colin Eldridge, Coronial Brief, p.31.

13. Approximately one to one-and-a-half hours later, Mr Eldridge telephoned Mrs Lourandos and said that Ms Lourandos was happy and resting.[17]

THE CORONIAL INVESTIGATION

Coroners Act 2008

14. Ms Lourandos' death was a "*reportable death*" pursuant to section 4 of the *Coroners Act 2008* (Vic) (**the Act**) because of one or more of her death having occurred in Victoria, was unexpected and was not from natural causes.[18]

15. The Act requires a coroner to investigate reportable deaths such as Ms Lourandos' and, if possible, to find:

    (a) The identity of the deceased;

    (b) The cause of death; and

    (c) The circumstances in which death occurred.[19]

16. For coronial purposes, "*circumstances in which death occurred*",[20] refers to the context and background to the death including the surrounding circumstances. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death relevant circumstances are limited to those which are sufficiently proximate to be considered relevant to the death.

17. The Coroner's role is to establish facts, rather than to attribute or apportion blame for the death.[21] It is not the Coroner's role to determine criminal or civil liability,[22] nor to determine disciplinary matters.

18. One of the broader purposes of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through comments made in findings and by making recommendations.

19. Coroners are also empowered to:

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[17] Statement of Pauline Lourandos, Coronial Brief, p.41.
[18] *Coroners Act 2008* (Vic) s 4.
[19] *Coroners Act 2008* (Vic) preamble and s 67.
[20] *Coroners Act 2008* (Vic) s 67(1)(c).
[21] *Keown v Khan* [1999] 1 VR 69.
[22] *Coroners Act 2008* (Vic) s 69 (1).

(a) Report to the Attorney-General on a death;[23]

(b) Comment on any matter connected with the death investigated, including matters of public health or safety and the administration of justice;[24] and

(c) Make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[25]

Standard of Proof

20. Coronial findings must be underpinned by proof of relevant facts on the balance of probabilities, giving effect to the principles explained by the Chief Justice in *Briginshaw* v *Briginshaw*.[26] The strength of evidence necessary to so prove facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[27] The principles enunciated by the Chief Justice in *Briginshaw* do not create a new standard of proof; there is no such thing as a "*Briginshaw Standard*" or "*Briginshaw Test*" and use of such terms may mislead.[28]

21. Facts should not be considered to have been proved on the balance of probabilities by inexact proofs, indefinite testimony, or indirect inferences,[29] rather such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[30] Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved and the content of the finding based on those facts.[31]

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[23] *Coroners Act 2008* (Vic) s 72(1).
[24] *Coroners Act 2008* (Vic) s 67(3).
[25] *Coroners Act 2008* (Vic) s 72(2).
[26] (1938) 60 CLR 336, 362-363. See *Domaszewicz v State Coroner* (2004) 11 VR 237, *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152 [21]; *Anderson v Blashki* [1993] 2 VR 89, 95.
[27] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J but bear in mind His Honour was referring to the correct approach to the standard of proof in a civil proceeding in a federal court with reference to section 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at pp170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.
[28] *Qantas Airways Ltd v Gama* (2008) 167 FCR 537, [123]-[132].
[29] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.
[30] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.; *Cuming Smith & CO Ltd v Western Farmers Co-operative Ltd* [1979] VR 129, at p. 147; *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at pp170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.
[31] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336, referring to *Barten v Williams* (1978) 20 ACTR 10; *Cuming Smith & Co Ltd v Western Farmers' Co-operative Ltd* [1979] VR 129; *Mahon v Air New Zealand Ltd* [1984] AC 808 and *Annetts v McCann* (1990) 170 CLR 596.

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

Identity of the Deceased pursuant to section 67(1)(a) of the *Coroners Act 2008*

22. On 17 August 2015, Pauline Lourandos identified the deceased as her daughter, Antonia Victoria Lourandos, born 11 January 1993.

23. Ms Lourandos' identity is not in dispute in this matter and requires no further investigation.

Medical cause of death pursuant to section 67(1)(b) of the *Coroners Act 2008*

24. On 20 August 2015, Dr Victoria Francis, a Forensic Pathologist, practising at the Victorian Institute of Forensic Medicine, conducted an autopsy of Ms Lourandos' body. Dr Francis provided a written report, dated 23 December 2015, which concluded that a reasonable cause of death was '*complications of megacolon due to chronic constipation in a woman with cerebral palsy*'.

25. Dr Francis made the following comments:

    (a) the large bowel mucosa showed chronic ulceration but there was no evidence of perforation or peritonitis;

    (b) focal acute inflammatory infiltrates were seen in the lungs;

    (c) post mortem biochemistry showed:

        (i) a mild increase in urea and decreased creatinine; and

        (ii) *Escherichia coli* in the blood enrichment culture, but this is a common post mortem contaminant and normal upper respiratory tract flora was detected in the lungs;

    (d) c-reactive protein, a molecule that increases in the blood stream in response to inflammation, particularly infections, was mildly elevated most likely due to the inflammatory infiltrates in her lungs;

    (e) megacolon is defined as gross atonic distension of the large bowel in the absence of obstruction. It is a rare but recognised complication of chronic constipation. Potential complications of megacolon include raised intra-abdominal pressure causing major vessel obstruction and compression of other major organs such as the lungs. Ms Lourandos' abdominal issues would have been exacerbated by her scoliosis. The exact mechanism of

her death is uncertain, as these complications cause functional issues that are not able to be determined during the post mortem examination; and

(f) on the basis of the information available, she was of the opinion that Ms Lourandos' death was due to natural causes.

26. Toxicological analysis of post mortem specimens taken from Ms Lourandos identified the presence of diazepam and its metabolite, nordiazepam at low therapeutic levels. Glucose was detected in the vitreous humour (1.8 mmol/L). Dr Francis noted that glucose levels normally decrease in the post mortem period and therefore no clinical significance can be attached to this level.

27. On 24 August 2015, Dr Linda Iles, a Forensic Pathologist, practising at the Victorian Institute of Forensic Medicine, conducted an examination on Ms Lourandos' brain. Dr Iles provided a neuropathology report, dated 3 November 2015, in which she advised that no acute changes were identified that might account for Ms Lourandos' death. Dr Iles commented that the neuropathological findings indicate a severe disruption to normal cortical development which is a substrate for Ms Lourandos' cerebral palsy.

Circumstances in which the death occurred pursuant to section 67(1)(c) of the *Coroners Act 2008*

28. At approximately 6.30am on 17 August 2015, Mr Eldridge noticed Ms Lourandos had a cut on her lip. Mr Eldridge stated:

> *I immediately when (sic) to grab the phone but Jo said she had just bitten her lip and she cleaned her face with a wet face washer and did not look anywhere as bad, it was just a tiny cut on her lip.*[32]

29. Mr Eldridge changed Ms Lourandos and saw her PEG site was inflamed. He informed Ms D'Urso and they determined to call Mrs Lourandos.[33] The incident report states Mr Eldridge contacted his Co-ordinator, Judy Keegan, who advised to call her family.[34]

30. At approximately 7.00am on 17 August 2015, Mr Eldridge telephoned Mrs Lourandos.[35] Mrs Lourandos questioned Mr Eldridge about Ms Lourandos' condition and he transferred the call to Jo-Anne D'Urso, who had cared for Ms Lourandos that morning. Ms D'Urso reportedly

[32] Statement of Colin Eldridge, Coronial Brief, p.31.
[33] Statement of Colin Eldridge, Coronial Brief, p.31.
[34] Scope Incident Data Collection Form, Coronial brief, p. 211, 215.
[35] Statement of Pauline Lourandos, Coronial Brief, p.42.

told Mrs Lourandos that Ms Lourandos appeared pale and unwell and had suffered an injury to her lip overnight. Mrs Lourandos reported thinking that Ms Lourandos may have suffered a seizure overnight. Mrs Lourandos told Ms D'Urso to send Ms Lourandos home.[36] Mr Eldridge also thought Ms Lourandos should go home instead of to her day placement at Able Australia.[37]

31. Mrs Lourandos had previously arranged for a taxi to transport Ms Lourandos from the Scope Facility to her day placement on 17 August 2015.[38] At approximately 8.00am, the pre-arranged taxi arrived the Scope Facility.[39] A staff member wheeled Ms Lourandos to the taxi and the driver, Ali Al Lakkiss, wheeled Ms Lourandos into the taxi. Mr Al Lakkiss reported that a staff member told him that Ms Lourandos was unwell and was to be transported home.[40] Mr Al Lakkiss stated that:

    (a) Ms Lourandos was awake and turned her head to look around when he wheeled her into the taxi;

    (b) he looked at Ms Lourandos in the rear-view mirror several times throughout the approximately 30-40 minute journey;

    (c) he saw her turning her head and looking around; and

    (d) Ms Lourandos did not make any noise during the drive.[41]

32. Shortly after 8.30am, Mr Al Lakkiss arrived at Mrs Lourandos' address.[42] He parked on the street out the front of the house and went and knocked on the front door. Mrs Lourandos came out and both she and Mr Al Lakkiss went to the taxi. Mr Al Lakkiss took Ms Lourandos out and wheeled her onto the footpath.

33. Mrs Lourandos then took over and wheeled Ms Lourandos inside the house.[43] Mr Al Lakkiss left the address and continued his shift.

34. Mrs Lourandos moved Ms Lourandos into the loungeroom to watch television.

35. At some point—the material on the Coronial Brief contains inconsistent information regarding precisely when this occurred (see below at paragraph 39)—Mrs Lourandos noticed Ms

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[36] Statement of Jo-Anne D'Urso, Coronial Brief, p.37; Statement of Pauline Lourandos, Coronial Brief, p.42.
[37] Statement of Colin Eldridge, Coronial Brief, p.31.
[38] Statement of Pauline Lourandos, Coronial Brief, p.43.
[39] Statement of Ali Al Lakkiss, Coronial Brief, p.62.
[40] Statement of Ali Al Lakkiss, Coronial Brief, p.62.
[41] Statement of Ali Al Lakkiss, Coronial Brief, p.62.
[42] Receipt of Taxi Fare, Coronial Brief, p.314.
[43] Statement of Ali Al Lakkiss, Coronial Brief, p.62.

Lourandos was unresponsive. She ran to ask her next-door neighbour, Robyn Martin, for assistance.[44]

36. On attending Mrs Lourandos' house, Ms Martin checked Ms Lourandos and could not feel a pulse or see movement in her chest.[45] Ms Martin suggested Mrs Lourandos call an ambulance. Ms Martin telephoned for an ambulance and put the phone on loud speaker.

37. Mrs Lourandos and Ms Martin were instructed to conduct cardiopulmonary resuscitation (**CPR**) on Ms Lourandos, which they did for approximately 10 minutes until Ms Martin asked her partner, John Galletti, to assist them.[46] On arrival at the address at approximately 8.50am, the Metropolitan Fire Brigade officers took over CPR. The ambulance arrived a short time later and the paramedics took over Ms Lourandos' care.[47] They attempted to resuscitate Ms Lourandos for approximately 45 minutes before ceasing compressions, consistent with the family's wishes.[48]

38. Ms Lourandos was declared deceased at 9.27am.[49] Police were contacted and attended the Lourandos home.[50]

39. The Coronial Brief contains inconsistent reports regarding Ms Lourandos' condition when she arrived home. These included the following accounts:

    (a) Mrs Lourandos:

    i. In her written statement dated 13 July 2016, Mrs Lourandos stated:

    > *Antonia came home about 8.15am. When I saw her in the taxi, I saw the lining of her lips were blue. She was cold when I kissed her. She looked grey all over in general. She didn't look herself ... I brought her inside and parked her in front of the television. When I took her jacket off, I realised her hands were blue.*[51]

    ii. In a brief outline of events Mrs Lourandos gave to Leading Senior Constable Paul McMillan on the morning of 17 August 2015, she advised that Ms Lourandos arrived

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[44] Statement of Pauline Lourandos, Coronial Brief, p.43.
[45] Unsigned statement of Robyn Martin, Coronial brief, p.50.
[46] Statement of Pauline Lourandos, Coronial Brief, p.44.
[47] Ambulance Victoria Patient Care Report, Coronial Brief, p.158.
[48] Statement of Pauline Lourandos, Coronial Brief, p.44.
[49] Ambulance Victoria Patient Care Report, Coronial Brief, p.162.
[50] Statement of Paul McMillan, Coronial Brief, p.136.
[51] Statement of Pauline Lourandos, Coronial Brief, p.43.

home at about 8.20am and shortly after she wheeled Ms Lourandos into the house, she realised Ms Lourandos was unresponsive, had cold skin and could not close her eyes.[52]

iii. Sergeant Ian Vistarini's recount of Mrs Lourandos' version of events on the morning of 17 August 2015 was that Ms Lourandos arrived home at 8.00am and observed her as being unwell. She moved Ms Lourandos into the loungeroom to watch television. Mrs Lourandos went to the kitchen for a period of time and, upon her return, noticed that Ms Lourandos had become unresponsive;[53]

(b) Mr Al Lakkiss:

i. Mr Al Lakkiss stated that Ms Lourandos was looking around throughout the drive home from the Scope Facility. He stated her eyes were open and she was awake when he removed her from the taxi and handed her into her mother's care on the footpath outside the Lourandos' residence;[54] and

(c) Ms Martin:

i. When interviewed by police on 17 August 2015, Ms Martin stated that Ms Lourandos was warm to the touch and her lips were red when she first saw Ms Lourandos inside the Lourandos home at approximately 8.00am.[55]

The rumour of being 'sent home dead'

40. In her statement, Mrs Lourandos claimed there was a rumour that Ms Lourandos was '*sent home dead*' and that a causal worker at the Scope Facility by the name of '*Jacinta*', requested an ambulance be called for Ms Lourandos but this was rejected by another worker at the Scope Facility (**the rumours**).[56] Further, Mr Eldridge stated that at 9.00pm on 17 August 2015, he received a call from an unknown person reporting that Ms Lourandos had passed away in the taxi on the way back to her house.[57]

41. I asked the Coroner's Prevention Unit (**CPU**) to examine the veracity of the rumours. The CPU requested the Coroner's Investigator (**CI**) obtain a statement from the person Mrs Lourandos claims to have said Ms Lourandos was '*sent home dead*'.

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[52] Statement of Paul McMillan, Coronial Brief, p.138.
[53] Statement of Ian Vistarini, Coronial Brief, p.151.
[54] Statement of Ali Al Lakkiss, Coronial Brief, p.63.
[55] Unsigned statement of Robyn Martin, Coronial Brief, p.50.
[56] Statement of Pauline Lourandos, Coronial Brief, p.45.
[57] Statement of Colin Eldridge, Coronial Brief, p.32.

42. The CI obtained statements from:

    (a) Liz Davis, mother of a daughter who attended Plenty Valley Disability Services;

    (b) Mary Hullin, mother of a son who attended Plenty Valley Disability Services; and

    (c) Jacinta Hehir, the disability support worker from whom the rumours are believed to have come.

43. Liz Davis stated she was told by a staff member at Plenty Valley Disability Services that another staff member who worked casually at both the Scope Facility and Plenty Valley Disability Services had told her:

    [h]ow grossly unwell Antonia was while she was in the Scope Facility. She saw that Antonia's peg feed wouldn't go in, and that Antonia's' stomach was distended. The casual staff member told another Scope worker to stop pushing the peg feed in and that she thought that they needed to call an ambulance for Antonia. The casual staff member said that the ambulance was never called. She (the casual staff member) felt terrible afterwards, knowing what happened after asking Antonia to go to hospital. She was horrified she was ignored, and Toni passed.[58]

44. Mary Hullin stated that a staff member told her that they knew someone who was working at the Scope Facility who had said they:

    [w]anted to put Toni in an ambulance, as she was unwell, but she was put in a cab. The staff member had rung somebody above her (a manager) whoever that person was, I can only assume the house co-ordinator at Vincent Drive, South Morang, who had said "no, just put her in the cab".[59]

45. Jacinta Hehir stated she worked the afternoon shift on Sunday 16 August 2015. While feeding Ms Lourandos during the shift she noticed the food was not going into her stomach and she thought the PEG might be blocked. Ms Lourandos was moaning, groaning and moving around. Ms Hehir called the supervisor, Judy Keegan, who stated '*Antonia presents like that. That's just the way she is*'.[60]

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[58] Statement of Liz Davies, pp. 1-2.
[59] Statement of May Hullin, p.1
[60] Statement of Jacinta Hehir, p.2.

46. Unsure of what to do, Ms Hehir tried to call the nurse employed by On-Call, an ostensibly 24-hour service, but the phone was not answered.[61] She left about 10 messages for the nurse to call her back, but she never received a call back. She consulted the other staff member on duty who told her that it was her call.

47. When Ms Hehir handed over to the night shift staff, she advised them of what had happened. Both the staff members told Ms Hehir that '*Antonia's mother does not want an ambulance called, she doesn't believe in doctors and they've both seen her pull Antonia out of an ambulance they had called for Antonia themselves in the past*'.[62] This may be a reference to an incident in April 2015 **(the April incident)** when Ms Lourandos appeared unwell and Scope staff members contacted an ambulance. Mrs Lourandos did not agree with the decision.[63] After the April incident, Ms Lourandos' Gastrostomy Support Profile was amended to include contacting Mrs Lourandos (rather than an ambulance) if there is any issue with Ms Lourandos' PEG tube.[64]

48. Ms Hehir stated that as she was leaving for the night, the On-Call nurse called back. The nurse spoke to Mr Eldridge and Ms Hehir heard him say '*does Jacinta need to speak to me?*' to which Mr Eldridge replied that she did not. Ms Hehir asked Mr Eldridge why he hadn't passed the phone to her and he replied, '*Antonia's fine and it's the end of your shift*'.[65]

49. Ms Hehir was not at the Scope Facility on the morning of Monday 17 August 2015 when Ms Lourandos was sent home in a taxi. Ms Hehir states in her statement that she does not remember talking to any mothers of clients about the incident while at Plenty Valley Disability Services, but she may have spoken to other staff members about it, who may in turn have told the mothers.

50. Ms Hehir also states that she may have said to colleagues '*I wish I had called an ambulance*' with the benefit of hindsight, but that she never said to anyone '*I was going to call an ambulance*'.[66]

51. As noted previously, Mr Al Lakkiss saw Ms Lourandos awake and turn her head to look around just before he wheeled her into his taxi. He continued checking on Ms Lourandos in his rear-view mirror and noticed she was turning her head and looking around.[67]

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[61] Statement of Jacinta Hehir, p.3.
[62] Statement of Jacinta Hehir, p.4.
[63] Statement of Maggy Samaan, Legal Counsel, Scope, Coronial Brief, p.72.
[64] Annexure B, Gastronomy Support Profile, Coronial Brief, p.107.
[65] Statement of Jacinta Hehir, p.4.
[66] Statement of Jacinta Hehir, p.5.

52. The CI attempted to obtain a copy of the closed-circuit television (**CCTV**) in the taxi, but it had already been taped over.[68] The CPU believes the statement from Mr Al Lakkiss is a reliable independent source when assessing whether Ms Lourandos was alive when she was put into the taxi.

53. The CPU concluded from the available material that it is likely Ms Lourandos was alive when she left the Scope Facility. They nominated the following points in support:

    (a) Ms Hehir, who has been said to be the person who started the rumours, was not there on the morning Ms Lourandos was sent home and therefore could not have known if Ms Lourandos was '*sent home dead*';

    (b) Staff at the Scope Facility spoke to Mrs Lourandos on the morning of Monday 17 August 2015 when deciding where Ms Lourandos should go. Mrs Lourandos informed the staff that Ms Lourandos should return home. There was no discussion about calling an ambulance or sending Ms Lourandos to hospital;

    (c) The taxi driver who drove Ms Lourandos home on the morning of Monday 17 August 2015 saw Ms Lourandos awake, turn her head and look around during the taxi ride;[69]

    (d) Mrs Lourandos assisted taking Ms Lourandos from the footpath outside her home into their home. She left Ms Lourandos in the loungeroom to watch television; and

    (e) When interviewed by police on 17 August 2015, Ms Martin stated that Ms Lourandos was warm to the touch and her lips were red when she first saw Ms Lourandos inside the Lourandos home at approximately 8.00am.[70]

54. Based on the evidence available, I am satisfied that Ms Lourandos was alive when she arrived at home and that she died from natural causes some short time later. Mrs Lourandos knew her daughter, her conditions and her presentation well and it is inevitable that Mrs Lourandos would have noticed if her daughter were dead when she first saw her, that is very shortly after Mr Al Lakkiss took Ms Lourandos out of the taxi.

55. Ms Lourandos died of natural causes. It is not possible to say whether different conduct by anyone involved in Ms Lourandos' transport home would have prevented her death. It is possible that if she had been taken home in an ambulance and monitored closely throughout the

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[67] Statement of Ali Al Lakkiss, Coronial Brief, p.62.
[68] Statement of Paul McMillan, Coronial Brief, p.141.
[69] Statement of Ali Al Lakkiss, Coronial Brief, p.62.
[70] Unsigned statement of Robyn Martin, Coronial Brief, p.50.

trip and had her death in the ambulance been immediately noticed and CPR immediately commenced Ms Lourandos may have survived. It is possible too that such monitoring may have noticed a change in Ms Lourandos' condition preceding her death and immediate treatment may have allowed Ms Lourandos to survive. These possibilities are naked speculation and not supported by any evidence. Ms Lourandos suffered from a number of serious conditions and illnesses and her death was tragic albeit that I am unable to say what could have been done by whom to have prevented it.

Care and management provided by Scope

Scope Investigation

56. Scope engaged Heather Michaels and Associates (**HMA**) to investigate into the circumstances of Ms Lourandos' stay at the Scope Facility on the weekend of 14 to 17 August 2015. A copy of the Executive Summary of the report produced by HMA dated 1 October 2015 was obtained by the court.

57. Ms Lourandos had regularly attended the Scope Facility and on a number of occasions became unwell, often with a bloated stomach and vomiting. As part of her Gastrostomy Support Profile, if any issues arose with Ms Lourandos' PEG, staff were required to contact Mrs Lourandos immediately.

58. In relation to the events of the weekend of 14 to 17 August 2015, HMA noted Ms Lourandos became unwell on 15 August 2015 but recovered and had an uneventful evening and night. On 16 August 2015 in the early afternoon, she was again reported to be unwell with periods of paleness and quietness and a distended stomach. Staff closely monitored her, and the On-Call Service Coordinator, the House Coordinator and Mrs Lourandos were contacted for advice throughout the day.

59. HMA concluded that Scope had in place an appropriate range of policies and procedures providing instruction and guidance to residential staff who may have concerns about a resident's health.

60. At the time of the incident, Scope had in place a clear procedure for managing unwell people in their care. Scope's '*When a person is unwell*' procedure advised that a locum doctor be called when staff are faced with a non-emergency health concern. Despite seeking advice from the On-Call, no staff member called a locum doctor nor were they expressly instructed to do so by

On-Call. In line with directions in the Gastronomy Support Plan, Mrs Lourandos was contacted for advice and staff followed her instructions.

61. HMA did not identify any evidence of an emergency medical situation but it was clear that Ms Lourandos was unwell. However, the fluctuating nature of her presentation and a lack of clarity about what was usual or unusual in her presentation may have influenced staff in continuing to seek advice by phone rather than call a locum doctor. In addition, staff may have been influenced by the April incident in which Mrs Lourandos had not wanted an ambulance called.

62. HMA made the following findings:

    (a) Conflicting views about Ms Lourandos' presentation over the weekend and a lack of clarity about what was usual about her appearance, in particular her bloated stomach, appears to be a factor in not seeking medical advice;

    (b) A number of calls were made by staff in relation to Ms Lourandos' health over the weekend. The unintentional outcome from these calls may have been that no one person contacted for advice was necessarily aware of the number and type of calls made and the extended period over which they were made; and

    (c) In the absence of medical advice about Ms Lourandos' health and based on their observations and previous experience supporting her, staff and Mrs Lourandos decided to transport her home in a taxi. Her subsequent death could not have been foreseen by either staff or her mother when the decision to transport her was made.

63. HMA made the following recommendations:

    (a) Scope should ensure that the *When a person is unwell* procedure, particularly the requirement to contact a locum doctor, is reinforced to staff of the Scope Facility and On-Call staff; and

    (b) Scope's *When a person is unwell* procedure makes no specific reference to transport of clients in a non-emergency situation and this should be addressed with a view to strengthening the procedure.

Scope's Response

64. By letter dated 14 August 2017, Scope's Legal Counsel Maggy Samaan outlined eight action items implemented by Scope in response to the HMA investigation. These included:

    (a) The provision of training and support to staff to improve responses to client health issues, including when to call a Locum;

    (b) The provision of training and support to staff to improve the consistency and accuracy of recording presentation including illness and improve understanding of the On-Call process and appropriate use of the service;

    (c) The provision of counselling to the On-Call coordinator and development of a Performance Improvement Plan in relation to the provision of On-Call support;

    (d) The On-Call Manual was updated to ensure that On-Call coordinators respond to calls within 15 minutes, and reporting requirements updated to ensure that relevant information is shared with the On-Call coordinator and staff;

    (e) Scope's *When a Person is Unwell* procedure was updated to include that all clients who are unwell are accompanied by a Scope staff member when leaving a Scope service;

    (f) Evaluation of Scope's duty of care '*client v family*' obligations to clarify expectations with staff to ensure that priority rests with Scope's client. Other issues in relation to guardianship were considered; and

    (g) The introduction of Communication Plans across all respite services for regular clients with complex disabilities.[71]

COMMENTS PURSUANT TO SECTION 67(3) OF THE *CORONERS ACT 2008*

65. The first *Annual review of disability service provision to people who have died 2017-18 (***the 2018 Review***)*[72] presented by the Disability Services Commissioner (**DSC**) in June 2018 highlighted the vulnerability of people with disability and complex communication needs.[73] It was noted that:

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[71] Statement of Maggy Samaan, Coronial Brief, pp.69 – 70.
[72] Disability Services Commissioner, *A review of disability service provision to people who have died 2017 – 18.*
[73] From 2017-2018 to 2018-2019, the number of deaths reported to the Disability Services Commissioner where the person had no formal means of communication more than doubled, increasing from 6 per cent to 16 per cent.

Communication difficulties are one of the most significant barriers to the provision of effective healthcare to people with intellectual disability. Research suggests that where a person has difficulties with communication, or cannot communicate verbally, support staff must be alert to the signs of illness or pain, indications of which may include behavioural changes, such as refusing to eat or displaying behaviours of distress.[74]

66. The significance of communication difficulties as a barrier to the provision of effective healthcare provision is reflected in the finding of the HMA report that '*conflicting views about Ms Lourandos' presentation over the weekend and lack of clarity about what was usual about her appearance... appears to have been a factor in not seeking medical advice*'.

67. While staff were alert to Ms Lourandos' behavioural changes over the weekend of 14 to 17 August 2015, they did not follow prescribed protocol to call a locum doctor when it became apparent that Ms Lourandos was unwell on 15 August 2015 and again on 16 August 2015. Likewise, upon observing that Ms Lourandos was unwell on 17 August 2015, staff instead followed the procedure stipulated on Ms Lourandos' Gastrostomy Support Profile and called Mrs Lourandos. I am simply unable to say whether the outcome would have been different if medical advice had been sought from a locum doctor.

68. I note that, following Ms Lourandos death, Scope appropriately reviewed its policies and procedures and implemented various actions to address the findings arising made by the HMA review. In view of the comments made in the 2018 Review, Scope's indication that it will introduce communication plans across all respite facilities for regular clients with complex disabilities[75] is encouraging.

69. I am satisfied, having considered all of the available evidence, that no further investigation into Ms Lourandos' death is required.

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[74] Disability Services Commissioner, *A review of disability service provision to people who have died 2017 – 18*, pp.14.
[75] See paragraph 63(g) above.

FINDINGS AND CONCLUSION

70. Having investigated the death without holding an Inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) the identity of the deceased was Antonia Victoria Lourandos, born 11 January 1993;

    (b) Ms Lourandos' death occurred;

        a. on 17 August 2015, at 737 Gilbert Road, Reservoir, Victoria,

        b. from complications of megacolon due to chronic constipation in a woman with cerebral palsy; and

        c. in the circumstances described in paragraphs 28 - 64 above.

71. Pursuant to section 73(1) of the *Coroners Act 2008,* I order that this Finding be published on the internet.

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

    (a) Pauline and Andrew Lourandos, senior next of kin;

    (b) Sen. Const. Paul McMillan, Coroner's Investigator, Victoria Police;

    (c) St. Vincent's Hospital; and

    (d) Scope.

Signature:

DARREN J BRACKEN

CORONER

Date: 30 APRIL 2020