IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 5204

**FINDING INTO DEATH WITHOUT INQUEST**

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

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| Findings of: | Simon McGregor, Coroner |
| Deceased: | **Chris Perdios** |
| Date of birth: | 25 January 1976 |
| Date of death: | 15 October 2018 |
| Cause of death: | 1(a) Aspiration pneumonia<br>1(b) Impacted large bowel in a man with intellectual disability and chronic constipation |
| Place of death: | Monash Medical Centre, 246 Clayton Road, Clayton Victoria 3168 |

## INTRODUCTION

1. Chris Perdios was a 42-year-old man living in supported accommodation at 3/46 McMahens Road, Bangholme Victoria 3175, at the time of his death.

2. Mr Perdios became acutely unwell and was transported to Monash Medical Centre located at 246 Clayton Road, Clayton Victoria 3168, he subsequently died there on 15 October 2018 from aspiration pneumonia in the setting of an impacted large bowel.

## THE PURPOSE OF A CORONIAL INVESTIGATION

3. Mr Perdios' death was reported to the Coroner as it appeared unexpected and occurred whilst Mr Perdios was in care so fell within the definition of a reportable death in the *Coroners Act 2008.*

4. 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.

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

6. The Coroner's Investigator, Senior Constable Constantinos Anagnostopoulos prepared a coronial brief in this matter. The brief includes statements from witnesses, including family, the forensic pathologist who examined Mr Perdios, treating clinicians and investigating officers.

7. As Mr Perdios was in care immediately before his death, the Disability Services Commissioner (DSC) conducted an investigation into the care and services provided to Mr Perdios. I have used the material produced by the DSC to inform my findings.

8. After considering all the material obtained during the coronial investigation, I determined that I had sufficient information to complete my task as coroner and that further investigation was not required. 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.

9. I have based this finding on the evidence contained in the coronial brief. In the coronial jurisdiction facts must be established on the balance of probabilities.[1]

10. In considering the issues associated with this finding, I have been mindful of Mr Perdios' basic human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

## BACKGROUND

11. Chris Perdios was the second child born to Dimitrios and Eleftheria Perdios. Mr Perdios was diagnosed with autism and intellectual disability when he was about 2 years old. He lived with his parents and older brother until he was about 6, when he was placed in full time care. Mr Perdios lived in a several care facilities before he commenced living in shared supported accommodation managed by Yooralla in Bangholme in 2003.[2]

12. In addition to autism and intellectual disability, Mr Perdios was diagnosed with anxiety, bipolar affective disorder, hypothyroidism, chronic constipation, gastroesophageal reflux, and hepatitis B.[3]

13. Mr Perdios required assistance with all aspects of personal care and displayed some behaviours attributed to his autism including assaulting others and self-injurious behaviour. He did not communicate using speech, however used gestures and actions to indicate his needs.[4]

14. Mr Perdios' family visited him regularly and he particularly enjoyed eating Greek food with his father. Mr Perdios was also known to enjoy walking in quiet areas, using the trampoline at his home, and assisting in the kitchen.[5]

## CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

15. On 12 October 2018, a Yooralla staff member accompanied Mr Perdios on a walk and noticed he was slow and appeared drowsy. On returning home he continued to appear drowsy and his behaviour was unusual. Yooralla staff requested an ambulance and he was

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[1] This is 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.

[2] Statement of Arthur Pedrios dated 26 August 2019, Coronial Brief.

[3] Clayton Road Doctors Medical Records.

[4] Statement of Tinei Marembo dated 7 January 2020, Coronial Brief.

[5] Yooralla Client Support Plan for Chris Pedrios.

transported to Monash Medical Centre. The Service Manager attended the hospital with a copy of Mr Perdios' client support file.[6]

16. At hospital, Mr Perdios was agitated, and he was sedated and intubated to assist treatment.[7] He was diagnosed with acute pancreatitis, small bowel ileus and possible large bowel obstruction in the setting of chronic constipation. Mr Perdios was treated in the Intensive Care Unit (ICU) with a nasogastric tube, intravenous fluids, and nil to be taken by mouth. Mr Perdios also underwent fleet enemas, which appeared to have good effect.[8]

17. Despite sedation Mr Perdios remained agitated and he self-extubated on 14 October 2018. His condition remained stable following extubation and he was planned for transfer to the general ward in the following days.[9]

18. At examination on 15 October 2018, Mr Perdios' abdomen was non-tender and his tolerance of oral fluids and the recent opening of his bowels were noted. Mr Perdios' treatment plan proposed a flexible sigmoidoscopy to investigate a possible rectal mass, and progressive re-introduction of food.[10] That day, he was also visited by his general practitioner and was noted to be showing signs of withdrawal from his usual daily medications (quetiapine and clonazepam). Permission was subsequently given to re-introduce these medications.[11]

19. Several Yooralla support workers from Mr Perdios' home attended the hospital throughout his admission. On 15 October 2018, a staff member left the hospital about 8.00pm, after he had eaten dinner. She thought Mr Perdios appeared relaxed and settled.[12]

20. At about 8.15pm, Mr Perdios went into asystole arrest. Cardiopulmonary resuscitation (CPR) was briefly attempted, before it was confirmed that Mr Perdios had passed away.[13]

**IDENTITY AND CAUSE OF DEATH**

21. On 18 October 2018, Arthur Peridios visually identified the body of his brother, Chris Perdios, born 25 January 1976. Identity is not in dispute and requires no further investigation.

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[6] Ibid.
[7] E-Medical Deposition Form completed by Dr Alice Andrawos dated 15 October 2018.
[8] Statement of Associate Professor Gregory Moore dated 16 October 2019, Coronial Brief.
[9] Ibid.
[10] Ibid.
[11] Clayton Road Doctors Medical Records; Statement of Alice Andrawos dated 16 October 2019, Coronial Brief.
[12] Statement of Tinei Marembo dated 7 January 2020, Coronial Brief.
[13] E-Medical Deposition Form completed by Dr Alice Andrawos dated 15 October 2018.

22. On 22 October 2018, Dr Yeliena Baber, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon Mr Perdios' body and reviewed a post mortem computed tomography (CT scan), medical records from Clayton Road doctors, medical deposition from Monash Health, and the Police Report of Death for the Coroner. Dr Baber provided a written report, dated 12 February 2019, in which she formulated the cause of death as '*I(a)Aspiration pneumonia 1(b) Impacted large bowel in a man with intellectual disability and chronic constipation'*.

23. Toxicological analysis of post mortem samples taken from Mr Perdios identified the presence of several therapeutic medications.

24. Dr Baber commented that based on the material available to her she was of the opinion that Mr Perdios' death was due to acute pneumonia caused by aspiration of gastric contents.

25. At autopsy, both the small and large bowel contained food material to the extent that the large bowel had become impacted. Histology testing revealed established aspiration pneumonia in the left lung, and early changes in the right lung.

26. Dr Baber commented that on the information provided to her in this matter, and as the result of her investigation into the death, she was of the opinion that the death was due to natural causes.

27. I accept Dr Baber's opinion as to cause of death.

**REVIEW OF CARE**

28. In their review of care and services provided to Mr Perdios, the DSC identified some concerns about the adequacy of Yooralla's management of Mr Perdios' medical issues, choking and aspiration risk, hospital admission, and communication plan. The DSC subsequently issued a notice to take action with prescribed steps to address the identified concerns.

29. I am satisfied that the matters identified for improvement by the DSC did not cause Mr Perdios' death. However, I acknowledge that these deficiencies may have effected Mr Perdios' overall comfort, wellbeing, and dignity. Further, the prescribed actions may offer broader safety improvements for other persons who are provided services by Yooralla, and so I will comment on these below.

30. A foundational issue of many of the DSC's concerns was the reliance on staff familiarity to identify problems or risks to Mr Perdios' wellbeing. That is, as Mr Perdios did not use formal speech to communicate, he was heavily reliant on support staff correctly interpreting his behaviour to assess his needs. Whilst it is clear from the material before me that Mr Perdios was supported by many staff who had known him for many years and who were very familiar with him, most shared supported accommodation, including Mr Perdios' home, also utilise casual staff. This also increases the onus on support staff to provide detailed handover and assistance when other services (for example a hospital) become involved in the care of their resident. In these circumstances, appropriately detailed plans and assessment tools are required to ensure the best possible care and support.

31. In light of these circumstances, the DSC identified that it may have been appropriate to use the 'DisDat' tool with Mr Perdios to provide a framework for staff to assess his pain or discomfort.

32. Concerning medical management, the DSC noted that Mr Perdios did not have a specific health management plan. Rather, information regarding the management of Mr Perdios' medical conditions could be found dispersed amongst his various other plans (client support plan, behaviour support plan, lifestyle plan, GP based care plan). This may have reduced the capacity of casual or less familiar staff to understand Mr Perdios' health issues and to provide appropriate healthcare management. Amongst his various plans, the DSC identified that Mr Perdios' plans lacked specific monitoring of his food and fluid intake to assess nutrition and constipation, despite some documented concerns about both of these issues. There were also no specific plans for management of Mr Perdios' documented hyperthyroidism and gastroesophageal reflux.

33. In consideration of Mr Perdios' choking and aspiration risk, the DSC noted that he had undergone review with a speech pathologist in September 2018. The assessment and recommendations were largely consistent with his previous plans that required 1:1 supervision of all oral intake to minimise choking risk, however also noted the need to prompt Mr Perdios to bring his chin down/forward to reduce the risk of laryngeal penetration/aspiration. It was not documented if or how this information was communicated to both Yooralla and hospital staff.

34. In respect of Mr Perdios' hospital admission, the DSC proposed actions designed to improve Yooralla support staff communication with hospitals admitting their residents. Two mechanisms outlined by the DSC are the use of a 'health passport' that accompanies a

resident to hospital, and the allocation of a designated staff member to act as the primary hospital liaison. These are simple systems to ensure that relevant health and care information is communicated in a timely and accessible manner. These systems may have avoided the delay in Mr Perdios being provided his regular daily medications and with tools and supports to manage his agitation, distress, and self-injurious behaviour in hospital.

**YOORALLA'S RESPONSE**

35. Yooralla has since responded to the Notice to Take Action and confirmed that their staff have been educated about the findings and recommendations of the DSC.

36. Yooralla has confirmed that all residents that require communication support now have DisDat assessment tools in place, with relevant training provided to staff.

37. Yooralla has confirmed that all residents at Mr Perdios' former home have a comprehensive health assessment plan, managed by their general practitioner, and a client support plan. The client support plans include information covering:

    i. Medication, medical and paramedical;
    ii. Chronic health support requirements;
    iii. Complex health care requirements;
    iv. Other care issues;
    v. Behaviours and habits;
    vi. Communication support;
    vii. Mealtime assistance and dietary requirements; and
    viii. Personal care.

38. These plans include current swallowing assessments and where required, mealtime support plans. Essential notes from these are included on the weekly menu as an accessible prompt for staff. Yooralla has also provided education to all staff, including casual staff, about charting food and fluid intake and bowel movements to monitor constipation, weight or nutrition issues, as well as mealtime management plans and the importance of monitoring for risk of choking and aspiration.

39. Following the Notice to Take Action, Yooralla has developed health passports for residents at all of their locations, and the client support plan documents the need for a primary point of contact to be determined if and when a resident is admitted to hospital.

40. I am satisfied that Yooralla's changes to policy and practice as recommended by the DSC represent improvements to the care, safety and dignity afforded to all Yooralla residents.

**FINDINGS AND CONCLUSION**

41. I express my sincere condolences to Mr Perdios' family for their loss.

42. 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 Chris Perdios, born 25 January 1976;

    (b) The death occurred on 15 October 2018 at Monash Medical Centre, located at 246 Clayton Road, Clayton Victoria 3168 from aspiration pneumonia in the setting of an impacted large bowel in a man with intellectual disability and chronic constipation; and

    (c) The death occurred in the circumstances described above.

43. Pursuant to section 73(1B) of the Act, I direct that this finding be published on the Internet.

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

    (a) Mr Dimitrios Perdios, senior next of kin;

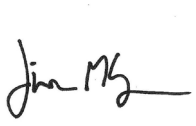
    (b) Monash Health;

    (c) Clayton Road Doctors;

    (d) Yooralla, care of Ms Samantha Downes;

    (e) Senior Constable Con Anagnostopoulos, Coroner's Investigator.

Signature:




**SIMON McGREGOR**

**CORONER**

Date: 25 May 2020