IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 000693

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	Jacqui Hawkins, Deputy State Coroner
Deceased:	Vasiliki Simopoulos
Date of birth:	26 May 1971
Date of death:	7 February 2019
Cause of death:	1(a) Probable sudden unexpected death in epilepsy (SUDEP)
Place of death:	5 Anama Street, Greensborough, Victoria, 3088
Keywords:	EPILEPSY; SUDEP; DEATH IN CARE; DISABILITY SERVICES COMMISSIONER; DISABILITY ACT 2006 (VIC)

INTRODUCTION

1. Vasiliki Simopoulos was 47 years old when she was found deceased on 7 February 2019. At the time of her death, Ms Simopoulos lived in a residential care home at 5 Anama Street, Greensborough.

2. Ms Simopoulos had a severe form of epilepsy known as Lennox-Gastaut Syndrome. She had a history of tonic seizures that were considered to be triggered by stress. She took anticonvulsant medication and had an epilepsy management plan in place.

3. Ms Simopoulos was described as having an outgoing personality and a good sense of humour. She enjoyed spending time with her family and experiencing her Greek culture.

THE CORONIAL INVESTIGATION

4. Ms Simopoulos's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

5. Ms Simopoulos was *"a person who immediately before death"* was in care.[1] Section 52 (3A) of the *Coroners Act 2008* recognises the vulnerability of people who are in the care of the State by requiring that their deaths are reported to the coroner irrespective of the cause of death. A further safeguard is the mandatory requirement for an inquest as part of the coronial investigation. However, if the investigating coroner is satisfied that the death is due to natural causes, they may choose to finalise the investigation without an inquest. In such a case, the coroner must publish their finding.

6. 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.

7. 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

[1] Under section 3(1) of the *Coroners Act 2008,* a person placed in care includes a person under the control, care or custody of the Secretary to the Department of Human Services or the Secretary to the Department of Health. Pursuant to section 4(2)(c) of the Act, the death of such a person is reportable irrespective of the cause of death.

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

8. Victoria Police assigned Constable Emily Stevens to be the Coroner's Investigator for the investigation of Ms Simopoulos' death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

9. The care provided to Ms Simopoulos by the Department of Health and Human Services (**DHHS**), now Department of Families, Fairness and Housing (**DFFH**) was also investigated by the Disability Services Commissioner (**DSC**), pursuant to section 128I of the *Disability Act 2006* (Vic). Details of their investigation and outcomes were submitted to the Court and I have considered these in my investigation into the circumstances surrounding Ms Simopoulos's death.

10. This finding draws on the totality of the coronial investigation into the death of Ms Simopoulos including evidence contained in the coronial brief. 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. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

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

Identity of the deceased

11. On 7 February 2019, Vasiliki Simopoulos, born 26 May 1971, was visually identified by her mother, Elizabeth Simopoulos, who signed a formal statement of identification to that effect.

12. Identity is not in dispute and requires no further investigation.

Medical cause of death

13. On 11 February 2019, Dr Michael Burke, Senior Forensic Pathologist from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy and provided a written report

[2] 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.

of his finding. Dr Burke also reviewed the Victorian Police Report of Death Form 83, post-mortem computed tomography (**CT**) scan, a letter of concern from Ms Simopoulos' sister, medical records from Brunswick Betta Health and St Vincent's Hospital and the Ambulance Victoria report.

14. The post-mortem examination showed no evidence of any heart disease which would have led to sudden death.

15. There was no evidence of any respiratory disease which would have led to sudden death. In particular, there was no evidence of pulmonary thromboembolism.

16. The post-mortem showed no morphological changes within the small or large bowel which would have led to sudden death. In particular, there was no evidence of gastrointestinal haemorrhage. A small stromal nodule (benign) was noted within the oesophagus.

17. The bowel contents contained semi-fluid faecal material, however microbiological examination showed no evidence of pathogens or parasites.

18. The toxicological analysis showed mild impairment of renal function with a vitreous urea concentration of 11 mmol/L.

19. The full toxicological analysis showed no alcohol. The drugs primidone, phenobarbitone, lamotrigine and phenytoin (all anticonvulsants) were present in the blood.

20. Ms Simopoulos had a history of severe allergic reactions. A serum tryptase is a marker of allergic reactions. The post-mortem level was 5 mmol/L, suggesting anaphylaxis was not involved in her death.

21. The Victoria Police Report of Death Form 83 raised an issue of a *"red mark around the neck".* Dr Burke concluded that these appear to be from post-mortem hypostatic lividity. There were no bruises to the neck and a formal neck dissection showed no evidence of any injury to the neck. Dr Burke was of the opinion that neck compression was not involved in Ms Simopoulos' death and her death was due to natural causes.

22. Dr Burke provided an opinion that the medical cause of death was 1 (a) probable sudden unexpected death in epilepsy (SUDEP). I accept Dr Burke's opinion.

Circumstances in which the death occurred

23. On 6 February 2019, Ms Simopoulos attended a group-based program and was observed to be her usual self. She came home early from the program as she had been vomiting and had diarrhoea. The house supervisor noted that Ms Simopoulos did not appear unwell when she returned home.

24. Ms Simopoulos went to bed at about 8:00pm that evening and apparently appeared happy.

25. At about 1:20am on 7 February 2019, a night staff member was cleaning the residence. They entered the women's bathroom and found Ms Simopoulos unresponsive and not breathing on the bathroom floor.

26. The staff member commenced CPR and contacted emergency services. Paramedics arrived at about 1:30am, however Ms Simopoulos was unable to be revived and was declared deceased.

FAMILY CONCERNS

27. The Victorian Police Report of Death Form 83 notes that Ms Simopoulos had a red mark around her neck. Ms Simopoulos' family wrote to the court and raised concerns as to the cause of this injury. The family requested that the cause of this mark be determined.

28. I note that this concern has been addressed by Dr Burke in his report. He stated that the reported red mark is likely due to post-mortem hypostatic lividity,[3] and that there were no bruises to the neck. Dr Burke has concluded that Ms Simopoulos' death was as a result of natural causes.

29. Ms Simopoulos' brother, Alex Simopoulos, also flagged some concerns with the state of Ms Simopoulos' bedroom, and the way in which she was found in the bathroom. He thought it was unusual that there was a winter blanket folded neatly on her bed, when it was apparently a hot night. He also noted that Ms Simopoulos would usually wear a nightie and this was not seen in the photos, and that she would never usually take her underwear completely off to use the bathroom, and yet her underwear was found behind the toilet. Mr Simopoulos also noted that she would usually have a small laceration or bruising to her head if she experienced a grand mal seizure.

[3] Post-mortem hypostatic lividity is the intravascular pooling of blood in gravitationally dependent parts of the body after death.

30. I have reviewed Mr Simopoulos' statement and acknowledge his concerns as to the circumstances in which Ms Simopoulos died. However I do not consider these to be sufficiently related to the cause of Ms Simopoulos' death.

DISABILITY SERVICES COMMISSIONER INVESTIGATION

31. The care provided to Ms Simopoulos by the residential group home was investigated by the DSC, pursuant to section 128I of the *Disability Act 2006* (Vic) and provided to the Court in accordance with standing administrative arrangements between the DSC and the Court.

32. It was noted by the DSC that Ms Simopoulos did not have specific health management plans in place for all of her medical conditions. This issue has since been addressed by the service provider.

33. The DHHS initiated their own review of the services provided at the group home and identified an issue relating to the management of deteriorating health in residents. Practices in accordance with departmental guidelines were not followed. Particular reference was made to the requirement to seek medical advice when needed and documentation requirements as per departmental guidelines.

34. As part of the service review, DHHS provided DSC with a plan of action to address the issues. Specifically, management of deteriorating health was to be an agenda item at a team meeting where staff obligations were to be discussed, and specific health management plans for residents with chronic health conditions were to be developed.

35. On 11 November 2021, DFFH provided evidence and confirmation of the completion of these actions. Based on these improvements, DSC concluded that no further action was required.

FINDINGS AND CONCLUSION

36. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Vasiliki Simopoulos, born 26 May 1971;

    b) the death occurred on 7 February 2019 at 5 Anama Street, Greensborough, Victoria, 3088, from probable sudden unexpected death in epilepsy (SUDEP); and

    c) the death occurred in the circumstances described above.

37. I acknowledge the improvements made by DFFH following the DSC investigation. Whilst these changes will hopefully assist current and future residents of the residential home, I do not consider them to be causally related to Ms Simopoulos' death.

38. The weight of available evidence does not support a finding that there was any want of care on the part of the staff of the residential home or any suspicious circumstances that caused, or contributed, to Ms Simopoulos' death.

39. Nor does the weight of available evidence support a finding that Ms Simopoulos' death was preventable.

40. I convey my sincere condolences to Vasiliki's family for their loss.

41. Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

    Elizabeth Simopoulos, Senior Next of Kin

    Pauline Chapman, Austin Health

    Marianna Codognotto, Death Review Unit, Disability Services Commissioner

    Constable Emily Stevens, Coroner's Investigator

Signature:

Jacqui Hawkins, Deputy State Coroner

Date : 25 July 2022