IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 003550

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Darren J. Bracken
Deceased:	Vasiliki Roussis
Date of birth:	13 March 1961
Date of death:	03 July 2020
Cause of death:	1(a) UNASCERTAINED (NATURAL)
Place of death:	Western Health, Sunshine Hospital, 176 Furlong Road, St Albans, Victoria, 3021
Keywords:	Natural Causes, "In Care"

INTRODUCTION

1. On 3 July 2020, Vasiliki Roussis was 59 years old when she was died in the Sunshine Hospital whilst receiving palliative care. Ms Roussis had a profound intellectual disability and cerebral palsy and had been a ward of the state since she was an infant. Ms Roussis had lived in a 'Group Home' for some 20 years and immediately before her death she lived with four others in a home in Pasley Street, Sunbury ("the Home") operated by disability service provider, "Possibility". Ms Roussis had two brothers who visited her.

THE CORONIAL INVESTIGATION

2. Vasiliki'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. The death of a person in care or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes.

3. The role of a coroner is to independently investigate reportable deaths to establish, if possible, the identity of the deceased, the cause of death, and the 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.

4. Under the Act, coroners also have the important functions of helping to prevent deaths, promoting public health and safety and the facilitating the administration of justice through the making comments or recommendations in appropriate cases about any matter connected to the death under investigation.

5. The Disability Services Commissioner investigated the disability services provided to Ms Roussis and made no adverse findings. 'Possibility' also reviewed the services that they provided to Ms Roussis and informed the Disability Services Commissioner of improvements that were made to their operations.

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

Circumstances in which the death occurred

6. Ms Roussis had complex communication needs, she was unable to speak or sign and required support in all areas of personal care. Ms Roussis had to use a wheelchair to move around and needed two staff and a hoist to be moved from her bed to the wheelchair and back again.

7. On 2 July 2020 staff at Possibility noticed that Ms Roussis was lethargic, pale, had experienced diarrhoea and was 'dry retching'. Staff sought medical advice and were instructed to monitor Ms Roussis closely, avoid spicy food and keep her hydrated. They were instructed that if Ms Roussis's condition did not improve in 1 -3 days to seek further medical advice. The 'Possibility' on call manager arranged for a general practitioner to see Ms Roussis the following day. At 9.12pam Ms Roussis's condition deteriorated after a further episode of diarrhea. Staff called an ambulance and Ms Roussis was taken to the Sunshine Hospital and admitted.

8. On 3 July after hospital staff discussed Ms Roussis's condition and prognosis with her brother she was transferred to the Palliative Care Ward. Both of Ms Roussis's brothers were able to spend time with her in the Palliative Care Ward as was the Group Home manager before she died there at 12.03pm 3 July 2020.

9. Ms Roussis's family expressed their preference that an autopsy not be conducted.

Identity of the deceased

10. On 3 July 2020 Mr J Roussis identified the deceased as his sister, Vasiliki Roussis, born 13 March 1961.

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

Medical cause of death

12. On 6 July 2020 Dr M P Burke, a specialist forensic pathologist practising at the Victorian Institute of Forensic Medicine performed an external examination of Ms Roussis's body and in his resultant report dated 7 July 2020 opined that the cause of Ms Roussis's death was "*Unascertained (natural)"*.

13. I accept Dr Burke's opinion that Ms Roussis died of natural causes.

FINDINGS AND CONCLUSION

14. Pursuant to section 67(1) of the *Coroners Act 2008* I find that:

    a) The identity of the deceased was Vasiliki Roussis, born 13 March 1961.

b) Ms Roussis died on 3 July 2020 at Western Health, Sunshine Hospital, 176 Furlong Road, St Albans, Victoria, from unascertained natural causes and

c) the death occurred in the circumstances described above.

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.

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

Mr J Roussis, Senior Next of Kin.

Dr N Watson Director Quality, Safety and Patient Experience, Western Health

Signature:

Coroner Darren J. Bracken

Date : 13 September 2022.

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.