IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 003736

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	Periklis Papadopoulos
Date of birth:	1 January 1946
Date of death:	15 July 2021
Cause of death:	1(a) Complications of multiple cardiac and respiratory comorbidities
Place of death:	Port Phillip Prison, St John's Medical Unit, 451 Dohertys Road, Truganina, Victoria, 3029
Keywords:	Death in Custody; Port Phillip Prison; Natural Causes

INTRODUCTION

1. On 15 July 2021, Periklis Papadopoulos was 75 years old when he died at the Port Phillip Prison (**PPP**). He is survived by his two children.

BACKGROUND

2. Mr Papadopoulos was born in Greece and moved to Australia in 1969. After first moving to Australia, Mr Papadopoulos lived between Greece and Australia. His ability to speak English was limited. Prior to his incarceration, Mr Papadopoulos had worked as a painter.

3. Mr Papadopoulos was remanded in custody in October 2011 and was subsequently sentenced to 11 years and six months imprisonment on the charge of manslaughter. He was due to be released on parole on 22 September 2021. During his incarceration, Mr Papadopoulos was accommodated at a number of maximum or medium security prisons in Victoria.

4. Mr Papadopoulos had a number of comorbidities including a history of pulmonary arterial hypertension, right ventricular failure, chronic lung disease, type 2 diabetes, rheumatoid arthritis and Raynaud's phenomenon. On 6 July 2020, Mr Papadopoulos entered an Advanced Care Plan which included his intention for no attempts for resuscitation to be made.

5. On 7 April 2021, while at PPP, Mr Papadopoulos was reviewed by a speech pathologist who placed him on a pureed diet following reported difficulty swallowing. On 20 April 2021, Mr Papadopoulos became acutely short of breath with low oxygen levels and abnormal sounds in his left lung. He was transferred to St Vincent's Hospital in Melbourne where he was diagnosed with multifactorial dyspnoea and aspiration pneumonia. On 3 May 2021, Mr Papadopoulos was discharged and returned to the St John's sub-acute inpatient unit at PPP for palliative care. PPP is managed by G4S Custodial Services Pty Ltd but the medical services provided at the St John's Unit are delivered by the St Vincent's Correctional Health Service (**SVCH**).

6. Mr Papadopoulos's condition continued to deteriorate and he increasingly experienced fatigue and shortness of breath despite receiving oxygen treatment. On 9 July 2021, Mr Papadopoulos was prescribed regular anti-emetics, morphine solution and long-acting morphine tablets for comfort, and haloperidol as required for nausea if first-line anti-emetics were not effective.[1]

[1] Justice Health, *Death in Custody Summary Report- Pericles Papadopoulos,* dated 23 February 2022.

THE CORONIAL INVESTIGATION

7. Mr Papadopoulos' death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Mr Papadopoulos death was reportable as he was in custody immediately before the time of his death.[2] Deaths of persons in custody are reportable to ensure independent scrutiny of the circumstances surrounding their deaths. If such deaths occur as a result of natural causes, a coronial investigation must take place, but the holding of an inquest is not mandatory.

8. 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.

9. 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.

10. Section 7 of the Act requires the coroner to liaise with other investigative authorities and to not unnecessarily duplicate inquiries and investigations

11. Victoria Police assigned Senior Constable Melanie McNamara to be the Coroner's Investigator for the investigation of Mr Papadopoulos' 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.

12. This finding draws on the totality of the coronial investigation into the death of Mr Papadopoulos including evidence contained in the coronial brief. While 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.[3]

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[2] Section 4(2)(c).

[3] 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

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

Circumstances in which the death occurred

13. At around 11.48pm on 14 July 2021, Mr Papadopoulos complained of nausea and shortness of breath to Registered Nurse and rostered nurse-in-charge, Olivia George. Ms George observed that Mr Papadopoulos' lips were cyanosed[4] and that his oxygen saturation level was 85%. At the time, he was not using his oxygen bag as he was nauseous and was instead using an emesis bag. Ms George reported that Mr Papadopoulos was "*dry retching and slightly distressed*." Mr Papadopoulos was administered Maxalon but according to Ms George, the medication had little effect. Mr Papadopoulos was further treated with Haloperidol and Ordine which Ms George stated had good effect.[5]

14. At around 1.30am on 15 July 2021, Mr Papadopoulos was being monitored through his cell door window by Enrolled Nurse Erin Wardley. Ms Wardley observed Mr Papadopoulos self-ambulate to the toilet and then return to bed. Ms Wardley stated that Mr Papadopoulos declined assistance.[6]

15. At around 3.05am on 15 July 2021, Registered Nurse Jeannie Cansancio performed a check on Mr Papadopoulos through his cell door and observed that he did not appear to be breathing.[7] The nurse in charge was informed and corrections staff opened Mr Papadopoulos' cell door. Mr Papadopoulos was unresponsive and Ambulance Victoria were called. In accordance with Mr Papadopoulos' Advanced Care Plan, no resuscitation efforts were made.

16. Ambulance Victoria Paramedics arrived a short time later and did not observe any signs of life. Mr Papadopoulos was formally pronounced deceased at 3.55am on 15 July 2021.

Identity of the deceased

17. On 26 July 2021, Periklis Papadopoulos, born 1 January 1946, was identified by his fingerprints pursuant to a determination by Coroner Olle.

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

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evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[4] Bluish or greyish colour of the skin.

[5] Statement of Olivia George dated 17 November 2021.

[6] Statement of Ein Wardley dated 13 November 2021.

[7] Statement of Jeannie Cansancio dated 13 October 2021.

Medical cause of death

19. Forensic Pathologist Dr Chong Zhou from the Victorian Institute of Forensic Medicine conducted an examination upon the body of Mr Papadopoulos on 16 July 2021 and provided a written report of her findings dated 29 July 2021.

20. Dr Zhou did not observe any evidence of injuries of a type likely to have caused or contributed to Mr Papadopoulos' death.

21. A post-mortem computed tomography (**CT**) scan showed pulmonary emphysema. Calcifications were present along aorta and coronary arteries, and there was probable cardiomegaly.

22. Dr Zhou provided an opinion that the medical cause of death was 1(a) Complications of multiple cardiac and respiratory comorbidities. Dr Zhou considered that Mr Papadopoulos' death was due to natural causes.

23. I accept Dr Zhou's opinion.

REVIEW OF CARE AND CUSTODIAL MANAGEMENT

24. Following Mr Papadopoulos' death, independent reviews were conducted in relation to his medical management by Justice Health[8] and custodial management by the Justice Assurance and Review Office (**JARO**).[9]

25. JARO found that Mr Papadopoulos' custodial management by Corrections Victoria and PPP met the required standards and that the response to his death was consistent with established procedures.

26. Justice Health identified an inconsistency in the diet provided to Mr Papadopoulos at PPP in the weeks prior to his hospitalisation in April 2021, with Mr Papadopoulos being provided a regular diet despite recently being prescribed a pureed diet and thickened fluids. In response to this issue, Justice Health made a recommendation that PPP, in consultation with SVCH,

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[8] Justice Health is a part of the Department of Justice and Community Safety and has responsibility for the delivery of health services to Victoria's prisoners.

[9] JARO is a part of the Department of Justice and Community Safety and reports to the Secretary of the Department, who is responsible for the monitoring of all correctional services to achieve the safe custody and welfare of prisoners pursuant to the *Corrections Act 1986*.

review its policies and procedures for the management of medically prescribed diets to ensure consistent provision of the diet.

27. Apart from the issue with Mr Papadopoulos' diet, Justice Health found that the healthcare provide to Mr Papadopoulos was generally in accordance with the Justice Health Quality Framework. On the evidence before me, I am satisfied the inconsistency with Mr Papadopoulos' diet in April 2021 did not contribute to his death and accordingly I do not propose to investigate this issue further.

28. Having reviewed the available evidence, I am satisfied that the emergency response by medical and corrections staff was appropriate. Further, I am satisfied that Mr Papadopoulos' general medical management by SVCH in the period proximate to his death was reasonable and appropriate.

FINDINGS AND CONCLUSION

29. Pursuant to section 67(1) of the Act, I make the following findings:

    a) the identity of the deceased was Periklis Papadopoulos, born 1 January 1946;

    b) the death occurred on 15 July 2021 at Port Phillip Prison, St John's Medical Unit, 451 Dohertys Road, Truganina, Victoria, 3029, from complications of multiple cardiac and respiratory comorbidities; and

    c) the death occurred in the circumstances described above.

30. As noted above, Mr Papadopoulos' death was reportable by virtue of section 4(2)(c) of the Act because, immediately before his death, he was a person placed in custody. Section 52 of the Act requires an inquest to be held, except in circumstances where the death was due to natural causes. I am satisfied that Mr Papadopoulos died from natural causes and that no further investigation is required. Accordingly, I exercise my discretion under section 52(3A) of the Act not to hold an inquest into his death.

I convey my sincere condolences to Mr Papadopoulos' family for their loss.

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 the following:

Evangelia Papadopoulos, Senior Next of Kin

Alison Will, Justice Assurance and Review Office

Scott Swanwick, Justice Health

Senior Constable Melanie McNamara, Coroner's Investigator

Signature:

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Coroner David Ryan

Date : 16 January 2023

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.