IN THE CORONERS COURT OF VICTORIA AT MELBOURNE	Court Reference: COR 2021 4638

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the ***Coroners Act 2008***

Findings of:	Coroner Paresa Antoniadis Spanos
Deceased:	Dimitrios Alexandrou
Date of birth:	15 May 1969
Date of death:	2 September 2021
Cause of death:	1(a) Gastric adenocarcinoma
Place of death:	Wantirna Health Palliative Care Unit, 251 Mountain Highway, Wantirna, Victoria

INTRODUCTION

1. On 9 September 2021, Dimitrios Alexandrou was 52 years old when he died in hospital, following palliative care treatment. At the time, Mr Alexandrou lived in a Life Without Barriers (**LWB**) disability accommodation at 2 Hennessy Street, Chadstone.

2. Mr Alexandrou was diagnosed with epilepsy from four months of age and was later diagnosed with severe cerebral palsy. His medical history also included severe intellectual disability, extremely limited communication, autism, drug-resistant epilepsy, osteoporosis, adenocarcinoma of stomach and he was wheelchair bound. At the time of his passing, his regular medications included Benefiber powder (wheat dextrin), Epilim EC (sodium valproate), Keppra (levetiracetam), Tegretol (carbamazepine), Topamax (topiramate), Vimpat (lacosamide), midazolam, and clonazepam.

3. Mr Alexandrou's brother, Efstratios, noted that after their parents passed away, he became his brother's guardian. Financial matters were managed by the State Trustees and Mr Alexandrou was the recipient of support services through the National Disability Insurance Scheme.

THE CORONIAL INVESTIGATION

4. Mr Alexandrou's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Generally, reportable deaths include deaths that appear to be unexpected, unnatural or violent, or to have resulted wither directly or indirectly, from accident or injury. However, if a person satisfies the definition of a person placed in care immediately before death, the death is reportable even if it appears to have been from natural causes.[1]

5. While Mr Alexandrou's death was reported to the Coroner, I note with concern that, as funding for disability services has shifted from the Department of Families, Fairness and Housing (**DFFH**) to the National Disability Insurance Scheme (**NDIS**), the definition of a person placed in custody or care in section 3(1) of the Act to include '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' no longer adequately captures the group of vulnerable people in receipt of disability services that the legislature had intended. Where the deaths of those people are from natural causes and not otherwise reportable, then, though this cohort is as vulnerable as

[1] See the definition of "reportable death" in section 4 of the *Coroners Act 2008* (**the Act**), especially section 4(2)(c) and the definition of "person placed in custody or care" in section 3 of the Act.

ever, their deaths and the circumstances in which they died – including the quality of their care – would not be subjected to coronial scrutiny.

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

8. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Alexandrou's 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. This finding draws on the totality of the coronial investigation into Mr Alexandrou's death, 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

10. On 6 September 2021, Dimitrios Alexandrou, born 15 May 1969, was visually identified by his brother, Efstratios Alexandrou, who signed a formal Statement of Identification to this effect.

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

[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.

Medical cause of death

12. Forensic Pathologist, Dr Melanie Archer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination of Mr Alexandrou's body in the mortuary on 3 September 2021 and provided a written report of her findings dated 14 September 2021.

13. The post-mortem CT scan revealed a distended stomach and duodenal stent. There was the impression of stomach wall thickening around the gastric bubble region and increased lung markings. Dr Archer stated there was no evidence of any injury that could have caused or contributed to the death.

14. Dr Archer provided an opinion that the Mr Alexandrou died from natural causes, namely *1(a) Gastric adenocarcinoma"*.

15. I accept Dr Archer's opinion.

Circumstances in which the death occurred

16. On 14 July 2021, LWB staff took Mr Alexandrou to his general practitioner, Dr Darshika Herath, due to a loss of appetite and reduced food intake. Dr Herath ordered routine tests and reviewed Mr Alexandrou again on 17, 23, and 26 July 2021.

17. On 26 July 2021, Dr Herath decided to refer Mr Alexandrou to the emergency department at Box Hill Hospital (**ED**). This was in the context of decreased appetite and rapid weight loss that had not improved.

18. Investigations in the ED by way of CT scan and gastroscopy were showed a mass in Mr Alexandrou's gastric antrum. Histology confirmed this as an adenocarcinoma of the stomach which was preventing ingestion of food and liquid. In late July 2021, a duodenal stent was placed in Mr Alexandrou's stomach to allow for ingestion of food and liquid.

19. Mr Alexandrou's brother subsequently decided that surgery, chemotherapy, or radiotherapy would not be pursued and instead treatment would focus on symptom management and comfort measures. The oncology team at Box Hill Hospital estimated his life expectancy in the order of months.

20. Following the placement of the stent, Mr Alexandrou was transferred to the Wantirna Health Palliative Care Unit on 6 August 2021. Wantirna Health planned to stabilise Mr Alexandrou so that he could return to familiar surroundings in his disability group home.

21. By late August 2021, Mr Alexandrou's condition had stabilised. He was able to tolerate food and liquid, and his seizures were being well managed with medication. The staff at Wantirna Health planned to discharge him back to the disability group home the following week, once the LWB staff had time to learn about his new medication requirements.

22. In the afternoon and evening of 30 August 2021, Mr Alexandrou stopped accepting food and started vomiting again. Maxolon (metoclopramide) was provided with limited benefit. His brother and LWB were contacted on 1 September 2021 to advise that due to this change in presentation, Mr Alexandrou's transfer back to the group home would be delayed.

23. Mr Alexandrou's brother was contacted in the early afternoon of 2 September 2021 and informed that his brother's condition was rapidly deteriorating. Mr Efstratios Alexandrou and his wife attended Wantirna Health that afternoon to say goodbye and Mr Alexandrou passed away peacefully at 6.25pm.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was Dimitrios Alexandrou, born 15 May 1969;

    (b) the death occurred on 2 September 2021 at Wantirna Health Palliative Care Unit, 251 Mountain Highway, Wantirna, Victoria;

    (c) the cause of Mr Alexandrou's death was gastric adenocarcinoma; and

    (d) the death occurred in the circumstances described above.

25. I am satisfied that his death was due to natural causes. There is no evidence of a want of clinical management or care on the part of the staff of Box Hill Hospital or Wantirna Palliative Care unit that caused or contributed to Mr Alexandrou's death.

I convey my sincere condolences to Mr Alexandrou's 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:

Efstratios Alexandrou, Senior Next of Kin

State Trustees

National Disability Insurance Scheme

First Constable Matthew Graham, Victoria Police, Coroner's Investigator

Signature:

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Coroner Paresa Antoniadis Spanos

Date : 10 August 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.