IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 000699

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Dimitra Dubrow
Deceased:	Con Koumis
Date of birth:	20 March 1978
Date of death:	5 February 2022
Cause of death:	1(a) complications of decompensated liver failure due to occult sepsis and retroperitoneal haemorrhage 1(b) cirrhosis secondary to blood transfusion 1(c) beta-thalassaemia major
Place of death:	St Vincent's Public Hospital, 41 Victoria Parade, Fitzroy, Victoria, 3065
Keywords:	In custody – natural causes

INTRODUCTION

1. On 5 February 2022, Con Koumis was 43 years old when he died in hospital while remanded in custody. Con had an extensive forensic history and had served ten terms of imprisonment since 2000.

2. Con had an extensive medical history mostly associated with beta-thalassaemia, a life-limiting genetic blood disorder which causes anaemia requiring 2 units of packed red blood cells every month.

3. Con had multiple medical complications associated with chronic transfusion requirements and other effects of thalassaemia including liver cirrhosis, osteoarthritis, osteoporosis, and type 2 diabetes mellitus. Con also had chronic left hip pain from avascular necrosis affecting his mobility and asplenia.

4. Con is survived by his mother, previous partner and daughter who was born in 2004.

THE CORONIAL INVESTIGATION

5. Con'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.

6. 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. A coroner need not hold an inquest if a person's death in care or custody was from natural causes.

7. 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.

8. 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.

9. Judicial Registrar Katherine Lorenz, then coroner, initially held carriage of this investigation. I took carriage of this matter upon my appointment in September 2024 and following Judicial Registrar Lorenz's departure.

10. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Con's death. The Coronial Investigator conducted initial inquiries on the Court's behalf, including taking statements from witnesses. The Court was also assisted by the provision of the Department of Justice and Community Safety's report of their review into the death.

11. This finding draws on the totality of the coronial investigation into the death of Con Koumis. 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.[1]

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

Circumstances in which the death occurred

12. On 7 December 2021, Con was remanded into custody at Melbourne Assessment Prison (**MAP**) on multiple charges including drug trafficking and possession.

13. On 14 December 2021, Con was transferred to Port Phillip Prison (**PPP**) owing to his various medical conditions. While at PPP, he was exclusively accommodated within the St John's sub-acute inpatient unit.

14. The treatment plan for Con was to be transferred to St Vincent's Hospital Melbourne (**SVHM**) for regular blood transfusions when his haemoglobin dropped beyond a certain threshold.

15. This occurred less frequently as recommended as Con refused transfer on four occasions because he would have to complete a period of quarantine upon his return to PPP as required by COVID-19 pandemic protocols at the time.

16. Con was assessed to have understood the risks associated with refusing to be transferred and he signed a refusal of treatment form. Staff continued to monitor Con during this time and his vital signs remained stable.

[1] 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.

17. From about 25 January 2022, Con had increasing hip pain and was administered additional pain medications following advice from the pain clinic at SVHM.

18. On 1 February 2022, Con reported to a medical officer that he was feeling unwell, dizzy, short of breath, and had chest pain. He had an elevated heart rate and was transferred via ambulance to SVHM the same day where he was admitted.

19. On 2 February 2022, at about 1:20pm, a medical emergency team (**MET**) call was made as Con had deteriorated further.

20. Con was assessed as having decompensated liver cirrhosis. It was decided that Con was not a candidate for the Intensive Care Unit (**ICU**) because of his life-limiting conditions and was for ward-based management only. This was consistent with Con's patient goals of care which were not for CPR or intubation.

21. Despite treatment, Con continued to deteriorate, and he passed away on 5 February 2022 at about 2pm.

Identity of the deceased

22. On 5 February 2022, Con Koumis, born 20 March 1978, was visually identified by a staff member at Port Phillip Prison, who completed a statement of identification.

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

Medical cause of death

24. On 8 February 2022, Forensic Pathologist Dr Yeliena Baber from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination and provided a written report of the findings.

25. The findings were consistent with the clinical history.

26. A postmortem CT scan showed a right retroperitoneal haemorrhage of uncertain origin. Dr Baber commented that it is not uncommon for spontaneous bleeding like this to occur in the setting of deranged coagulation.

27. Toxicological analysis of antemortem samples taken 2 February 2022 at the hospital identified the presence of Con's regular medications and medications administered in hospital. There was no alcohol detected.

28. Dr Baber provided an opinion that the death was from natural causes and formulated the medical cause of death as:

    1(a) complications of decompensated liver failure due to occult sepsis and retroperitoneal haemorrhage
    1(b) cirrhosis secondary to blood transfusion
    1(c) beta-thalassaemia major

29. I accept Dr Baber's opinion.

FURTHER INVESTIGATIONS

30. When a person dies in prison, the Department of Justice and Community Safety (**DJCS**) conducts a review of the circumstances and management of the death.

31. The review found that health staff appropriately responded to Con's health needs and escalated his care in accordance with the relevant framework. While Con refused treatment on multiple occasions to avoid quarantine upon his return, health staff reviewed Con regularly to reduce the impacts of COVID-19 restrictions and provided additional support in isolation.

32. The review noted that while the custodial management met the required standards, there was missed opportunity to link Con with disability support services while in custody. The referral pathway at the time relied on people to self-declare disability at intake; the existing system flag recorded in 2018 did not result in a new referral at intake.

33. The policy has since been updated to support staff making referrals regardless of whether the diagnosis is confirmed. This assists staff to facilitate appropriate assessment and support.

34. I do not consider that this missed opportunity contributed to the death.

35. I also do not consider that the outcome would have been different had Con not refused the earlier transfusions.

36. I accept and adopt the findings of the review.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Con Koumis, born 20 March 1978;

b) the death occurred on 5 February 2022 at St Vincent's Public Hospital, 41 Victoria Parade, Fitzroy, Victoria, 3065, from:

1(a) complications of decompensated liver failure due to occult sepsis and retroperitoneal haemorrhage
1(b) cirrhosis secondary to blood transfusion
1(c) beta-thalassaemia major; and,

c) the death occurred in the circumstances described above.

38. As noted above, Con's death was reportable because, immediately before his death, he was person placed in custody. Section 52 of the Act requires an inquest to be held in these cases, except in circumstances where the person is deemed to have died from natural causes.[2] This determination can be based on an opinion from the forensic pathologist that the death was from natural causes.[3]

39. I am satisfied that Con died from natural causes and that his custodial health management was appropriate and did not cause or contribute to the death.

40. I consider that no further investigation is necessary which would otherwise require an inquest and, accordingly, I have exercised my discretion under section 52(3A) of the Act to not hold an inquest.

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

Pursuant to section 73(1B) of the Act, this finding must 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:

Dannielle Whybro
St Vincent's Hospital
Department of Justice and Community Safety

[2] Section 52(3A) of the Act.
[3] Section 52(3B) of the Act.

Signature:

Coroner Dimitra Dubrow

Date: 19 August 2025

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.