IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 002866

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paul Lawrie
Deceased:	Cheryl Balassopoulos
Date of birth:	27 August 1969
Date of death:	28 May 2023
Cause of death:	1(a) COMPLICATIONS OF MOTOR NEURONE DISEASE
Place of death:	Austin Hospital, 145 Studley Road, Heidelberg, Victoria, 3084
Keywords:	In Care, Specialist Disability Accommodation, Motor Neurone Disease

INTRODUCTION

1. On 28 May 2023, Cheryl Balassopoulos was 53 years old when she died at the Austin Hospital in Heidelberg. She had been diagnosed with Motor Neurone Disease (**MND**) in 2002. Since 2013, Ms Balassopoulos had been living in Specialist Disability Accommodation at Yooralla House, 105 Royal Parade, Reservoir, Victoria (**Yooralla House**).

THE CORONIAL INVESTIGATION

2. Ms Balassopoulos' 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 is a mandatory report to the Coroner, even if the death appears to have been from natural causes. Ms Balassopoulos was a 'person placed in custody or care' within the meaning of section 4 of the Act, as she was 'a prescribed person or a person belonging to a prescribed class of person' due to her status as an 'SDA[1] resident residing in an SDA enrolled dwelling[2]'.

3. 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.

4. 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.

5. Victoria Police assigned First Constable Rebekah Brough to be the Coroner's Investigator for the investigation of Ms Balassopoulos' death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as Ms Balassopoulos' father and her neurologist, the forensic pathologist, and investigating officers – and submitted a coronial brief of evidence.

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[1] Specialist Disability Accommodation
[2] Namely, Yooralla House.

6. This finding draws on the totality of the coronial investigation into the death of Cheryl Balassopoulos 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.[3]

BACKGROUND

7. Ms Balassopoulos worked as a legal secretary from the time she finished school until 2002. She was diagnosed with MND in 2003 when her son, Mark, was just three years old. For the next 10 years she lived with her father, Andrew Mitilineos. Ms Balassopoulos' parents cared for her together until her mother passed away from cancer. It then became too difficult for Mr Mitilineos to care for his daughter on his own and, in March 2013, Ms Balassopoulos moved into Yooralla House where she received full-time care.

8. Ms Balassopoulos' MND progressed more slowly than is typical for the disease but, for the last several years prior to her death, she had been quadriplegic, anarthric[4] and unable to swallow.

9. In 2018 an advanced care plan was made stating that Ms Balassopoulos did not wish to receive life-prolonging treatments, including non-invasive or invasive ventilation, or tracheostomy.

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

Circumstances in which the death occurred

10. At 9.00am on 27 May 2023, at Yooralla House, Ms Balassopoulos asked to start her personal care routine. She then told staff she was feeling faint and was offered her PRN[5] medication for dizziness, but she declined and requested to wait 15 minutes. The dizziness persisted and staff called an ambulance at 9.25am. The ambulance arrived at 10.15am and Ms Balassopoulos was taken to the Austin Hospital. Her father remained with her throughout the time in hospital.

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

[4] Unable to articulate speech

[5] 'As needed'

11. At 10.45pm Ms Balassopoulos was transferred to the Neurology Ward.

12. On the morning of 28 May 2023, Ms Balassopoulos experienced increasing respiratory distress and became hypoxic and unresponsive. In accordance with her advanced care plan the attending medical staff did not intervene with means such as cardiopulmonary resuscitation or intubation. Ms Balassopoulos passed away at 11.20am and was pronounced deceased at that time.

Identity of the deceased

13. On 1 June 2023, Cheryl Balassopoulos, born 27 August 1969, was visually identified by her son, Mark Balas.

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

Medical cause of death

15. Senior Forensic Pathologist, Dr Matthew Lynch from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 31 May 2023 and provided a written report of his findings dated 1 June 2023.

16. The post-mortem examination included a CT scan and revealed findings consistent with the history of Ms Balassopoulos' disease and the acute effects shortly before her death.

17. The need for toxicological analysis was not indicated.

18. Dr Lynch provided an opinion that the medical cause of death was 1 (a) COMPLICATIONS OF MOTOR NEURONE DISEASE.

19. I accept Dr Lynch's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Cheryl Balassopoulos, born 27 August 1969;

    b) the death occurred on 28 May 2023 at Austin Hospital, 145 Studley Road, Heidelberg, Victoria, 3084, from COMPLICATIONS OF MOTOR NEURONE DISEASE; and

    c) the death occurred in the circumstances described above.

21. I am satisfied that the care received by Ms Balassopoulos during the final phases of her illness was appropriate.

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

I thank the Coroner's Investigator for their work in this investigation.

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:

Mark Balas, Senior Next of Kin

First Constable Rebekah Brough, Coroner's Investigator

Signature:

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Coroner Paul Lawrie

Date : 09 January 2024

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.