IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 001682

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Findings of:	Coroner David Ryan
Delivered on:	22 May 2026
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street, Southbank, Victoria
Inquest hearing dates:	12 May 2026
Counsel Assisting the Coroner:	Dan McCredden of counsel Instructed by Dominique Cuschieri Coroners Court of Victoria
Eastern Health:	Sebastian Reid of counsel Instructed by Lander & Rogers
Keywords:	In care - compulsory treatment – medication and behaviour management – natural causes

INTRODUCTION

1. On 28 March 2025, Stratos Ioannidis passed away at Maroondah Hospital in Victoria. He was 45 years old and resided in Wantirna with family, including his son, Sebastian, and Sebastian's partner. He is also survived by his parents, Chris and Kathy Ioannidis, and his siblings, Christina, John and Steven Ioannidis.

BACKGROUND

2. Stratos was born and grew up in Mildura. He was a very intelligent man who had flourished at secondary school and later obtained tertiary degrees in law and commerce. In a moving Family Impact Statement delivered to the Court, Stratos is warmly remembered as a loving, charismatic, caring and loyal person who is deeply missed. His family emphasised that his behaviour when he had periods of being mentally unwell were not reflective of the person he was or their experience and memory of him.

3. Stratos's medical history included bipolar affective disorder, anxiety, obstructive sleep apnoea, gastro-oesophageal reflux disorder and gout. He had been prescribed medication by his General Practitioner (**GP**) including esomeprazole, lithium and colchicine. His last appointment with his GP was on 13 March 2025 when he was treated for gout.

4. Stratos had experienced psychosis in the past, in the context of medication changes and compliance issues, which had resulted in hospital admissions. His treatment had included electroconvulsive therapy (**ECT**). His last hospital admission for his mental health had been in 2015.

CORONIAL INVESTIGATION

5. Stratos's death constitutes a "*reportable death*" under sections 4(1)(b) and 4(2)(c) of the *Coroners Act 2008* (**the Act**), as his death occurred in Victoria and immediately before his death, he was a person placed in custody or care.[1]

[1] Stratos was considered to be *"in care"* under the Act as he was a patient detained in a designated health service within the meaning of the *Mental Health and Wellbeing Act 2022*.

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

9. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Stratos's death. The Coronial Investigator conducted inquiries on my behalf, including obtaining relevant CCTV footage and taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence. Evidence was also obtained directly by the Court from Eastern Health, including medical records, and expert reports were obtained by Consultant Psychiatrist Associate Professor Vinay Lakra and Cardiologist and Electrophysiologist Dr Mark Perrin.

10. A directions hearing was held in the Coroners Court on 1 May 2025 to discuss the progress of the investigation and introduce the family to the process.

11. As Stratos's death appeared to be due to natural causes, an inquest was not required to be held into his death pursuant to section 52(3A) of the Act. However, in the circumstances, I considered it appropriate that an inquest be held, which occurred on 12 May 2026.

12. This finding draws on the totality of the coronial investigation into Stratos's death including evidence contained in the coronial brief, the submissions made by Counsel Assisting and Eastern Health and the correspondence received from Stratos's family. 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.[2]

CIRCUMSTANCES IN WHICH DEATH OCCURRED

13. In the evening on 26 March 2025, Stratos's family contacted emergency services after observing a deterioration in his mental state with some aggressive behaviour. Victoria Police and Ambulance Victoria arrived at their home at around 7.30pm. Stratos's family advised that he had been experiencing worsening delusions over the last three days, had minimal sleep, and had been non-compliant with his prescribed medications. His behaviour had reportedly grown increasingly erratic and unpredictable, which included threats towards his son.

14. Stratos was verbally aggressive towards paramedics and police and refused to engage in meaningful conversation, claiming that he was a *"sovereign citizen"*. On assessment, he was reported to be nonsensical with erratic and disorganised thoughts. He had also expressed thoughts of suicide. Responding paramedics and police were unable to de-escalate Stratos and he refused oral olanzapine (an antipsychotic medication), prompting paramedics to restrain him on a stretcher to administer 10mg of droperidol via intramuscular **(IM)** injection, an antipsychotic also used as a sedative.

15. Given Stratos's presentation, advice was sought from the Police, Ambulance and Clinical Early Response unit (**PACER**), who ultimately formed the view that he should be transported to hospital for psychiatric assessment. At 8.01pm, an Inpatient Assessment Order was made pursuant to the *Mental Health and Wellbeing Act* 2022 (**the MHWB Act**) and Stratos was transported to Maroondah Hospital, arriving at around 8.30pm.

[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.

16. While awaiting a bed in the inpatient psychiatric unit, Stratos remained in the Emergency Department (**ED**) overnight. His regular lithium and colchicine were withheld due to concerns regarding his elevated lithium levels and reduced kidney filtration rate.

17. Stratos was observed to be sleeping overnight, with intermittent snoring and periods of apnoea. His oxygen saturations were recorded as 85% intermittently. His levels improved to above 95% after receiving three litres of supplemental oxygen. At 10.23pm, Stratos underwent an electrocardiogram (**ECG**). It was reviewed by a consultant in the Intensive Care Unit and it was recorded that his QT interval (the time for the heart muscle to contract and recover)[3] was 410 milliseconds.

18. At around 11.20pm, Stratos became erratic and wanted his continuous monitoring to be removed. He was administered 10mg diazepam, a benzodiazepine, and 10mg olanzapine.

19. On 27 March 2025 at around 2.35am, Stratos began to display further erratic behaviour, prompting a Code Grey[4] to be called. A decision was made to apply wrist and ankle restraints to facilitate the administration of a further 10mg IM droperidol.

20. A further Code Grey was called shortly after 4.30am when the restraints were removed and Stratos began pacing around the cubicle. He refused medications and his behaviour continued to escalate. He was again placed in restraints and 10mg IM midazolam, a benzodiazepine, was administered at 4.47am.

21. Stratos's oxygen levels were observed to drop following the administration of midazolam and he experienced episodes of apnoea. His restraints were removed and he was placed on his side with supplemental oxygen, however his oxygen levels continued to drop intermittently. Stratos was unable to tolerate nasal prongs or an oropharyngeal airway. An oxygen mask remained in place and his oxygen levels gradually improved throughout the morning.

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[3] The time from the start of the Q wave to then end of the T wave on an ECG.

[4] A Code Grey is activated when an immediate emergency response is required for actual or potential violent, aggressive, abusive or threatening behaviour, exhibited by patients or visitors, towards themselves or others, which creates a risk to health and safety.

22. At 9.40am on 27 March 2025, Stratos underwent a psychiatric assessment. The assessing clinician noted his history and current presentation of manic relapse, and considered that he was at an increased risk of misadventure, absconding, aggression and non-compliance with treatment. The assessing clinician considered that Stratos was unable to be treated in the community and required an inpatient admission to address his risks.

23. At 9.45am, Stratos accepted 10mg olanzapine and 10mg diazepam.

24. At 10.22am, a Temporary Treatment Order was made by a psychiatrist pursuant to the MHWB Act. Stratos was subsequently admitted as an involuntary patient to the acute psychiatric high dependency inpatient unit at 12.35pm.

25. At 10.25pm, Stratos was administered 50mg chlorpromazine, an antipsychotic.[5]

26. Throughout the early hours of 28 March 2025, Stratos displayed increasingly intrusive and aggressive behaviour and required redirection on several occasions.

27. At 12.35am on 28 March 2025, Stratos was administered 50mg promethazine, a sedative. At 3.10am, he received a further 10mg diazepam and 100mg chlorpromazine with minimal effect. At 6.15am, he was administered 10mg diazepam, with some effect.

28. At around 10.00am, Stratos assaulted a staff member. He was administered 10mg IM droperidol shortly afterwards and was then commenced on 500mg sodium valproate.[6]

29. At 11.10am, Stratos underwent a further ECG. It was reviewed by a Consultant Psychiatrist and it was recorded that there was a prolonged QT interval of 519 milliseconds. As a result of the prolonged QT interval, a decision was made to conduct daily ECGs and not commence Stratos on Accuphase antipsychotics.[7] Further, the administration of chlorpromazine was ceased. It was recorded that staff would *"continue to consider risk/benefit"*.[8]

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[5] A drug known to have the potential to prolong QT intervals to a greater extent than other antipsychotic medication.
[6] An anticonvulsant and mood stabiliser used to treat epilepsy and bipolar disorder.
[7] A long-acting antipsychotic medication (zuclopenthixol) used in the initial treatment of acute psychosis. It may prolong QT intervals.
[8] Medical records, p42.

30. At 12.24pm, a further Code Grey was called after Stratos struck a staff member. He was escorted to seclusion and despite agitation, he was cooperative and administered 2mg IM lorazepam, a benzodiazepine. He did not undergo a physical review at this stage due to his impulsive and unpredictable behaviour.

31. During a review about an hour later, Stratos appeared less agitated but remained highly driven despite sedation. Following a review at around 3.05pm, Stratos returned to the ward. He was noted to be cooperative, took diazepam and olanzapine without issue, and appeared less sedated than at the earlier review. He was scheduled to be observed by staff at 15-minute intervals. At around 4.45pm, Stratos was administered 200mg quetiapine.[9] At around 5.15pm, Stratos was again placed in seclusion after he verbally threatened another patient. He was administered lorazepam. The quetiapine administration was noted and he was described as "*sedated but still driven*". Due to his sedation, the 2mg clonazepam[10] charted for 4.55pm had not been administered at that time.

32. At 6.15pm, a seclusion review was conducted and Stratos accepted 2mg clonazepam. Despite sedation, his behaviour was considered unpredictable and disinhibited and physical observations were not conducted; however, his breathing was recorded as *"ok"* and his respiratory rate did not appear decreased.

33. During a further review at 8.55pm, Stratos accepted further 2mg clonazepam. His seclusion was terminated and he was encouraged to return to his room. He was not observed to be combative, however he appeared increasingly agitated and his speech was slurred as a result of his sedation. Due to his unpredictable behaviour on return to the ward, a physical review was not conducted but he was observed to be responsive and breathing spontaneously with no decreased respiratory rate. A physical examination and an ECG were planned for when Stratos was more settled. His medications that evening included 10mg diazepam, 10mg olanzapine, and 500mg sodium valproate.

[9] An antipsychotic drug which may prolong QT intervals.
[10] A benzodiazepine.

34. At around 9.50pm, Stratos was observed to be sleeping on the floor in his room. He was observed to be breathing and snoring. His bathroom and floor lights were left on to enable clear visual observations.

35. During a round of visual observations at 10.45pm, Stratos was observed through the door window to be lying on his side, facing the bed base, before rolling onto his back. Staff observed his chest rising and falling.

36. At 10.58pm, staff entered Stratos's room to conduct an observation and noted that he remained on the floor but was unresponsive to voice and touch and not breathing. Stratos was in a difficult position between the bed and other furniture and a transfer board was required to move him into a suitable position on his back so that cardiopulmonary resuscitation (**CPR)** could be commenced.

37. A Code Blue[11] was called and the Hospital-wide Coordinator arrived at 11.01pm. Despite resuscitation efforts, Stratos was unable to be revived and was pronounced deceased at 11.26pm.

38. There is a discrepancy between the CCTV and the medical records in relation to the timing of the commencement of CPR and the calling of the Code Blue. I am satisfied that the timing of events occurred as they are depicted in the CCTV and accept that information contained in medical records completed after the event contain some inaccuracies.[12] In the circumstances, I am satisfied that there was no unreasonable delay in the commencement of CPR.

EASTERN HEALTH INTERNAL REVIEW

39. Stratos's death was reported to the Office the Chief Psychiatrist and Eastern Health conducted an In-depth Case Review with the involvement of his family. The review panel made the following relevant findings:

[11] It is recorded in the medical records that the Code Blue was called at 11.06pm and CPR commenced at 11.10pm. I am satisfied from the CCTV that these events occurred at around 11.01pm.

(a) Seclusion processes were followed by staff consistent with the requirements of the MHWB Act and Stratos was observed and medically reviewed at the required intervals;

(b) It is possible that Stratos had undiagnosed obstructive sleep apnoea as he was observed to be intermittently snoring in the ED. He had been placing himself on the floor to sleep, despite staff encouraging him to sleep on the bed, which might have further compromised his airway when he turned onto his back around 15 minutes before he was found unresponsive;

(c) The ECG taken on 28 March 2025 disclosed an increased QT interval from the ECG taken on 26 March 2025.[13] Some psychotropic medication can elongate the QT interval which can increase the chance of sudden cardiac arrhythmia. The Consultant Psychiatrist was aware of the change in QT interval and decided to withhold Accuphase to prevent further deterioration.[14]

(d) Stratos required numerous doses of intramuscular and oral sedatives to manage his symptoms and the safety of staff and other patients. The prescribing was reviewed by a senior pharmacist who concluded that the pharmacological management was appropriate;

(e) Some of Stratos's observations were conducted by staff through the window in his door without entering his room. Although this was not consistent with best practice, there was sufficient light in the room and Stratos was in a position from where his breathing could be observed without compromising his sleep.

40. The panel recommended that ECG changes/thresholds that require escalation to Cardiology are clearly defined and incorporated into the relevant guideline. In response to the recommendation, Eastern Health undertook to develop a clear protocol to identify ECG changes/thresholds that require escalation to Cardiology for review in the context of a person admitted as an involuntary mental health patient. The protocol is currently

[13] The panel also noted that the ECG results taken on 26 March 2025 were unchanged from an ECG taken in 2015.
[14] It was also decided to cease chlorpromazine and conduct daily ECGs.

under development and is scheduled to be incorporated into the Physical Health Assessment of Consumers in the Eastern Health Mental Health Program Practice Guideline by August 2026.

EXPERT REPORTS

Dr Lakra

41. The Court obtained an expert opinion dated 31 December 2025 from Consultant Psychiatrist Associate Professor Vinay Lakra. He is currently employed as the Divisional Director, Mental Health of Northern Health.

42. In his report, Dr Lakra expressed the following opinion in relation to the care and treatment of Stratos by staff during his admission at Maroondah Hospital:

    (a) Stratos was presenting with a relapse of bipolar disorder with manic presentation and psychotic symptoms. Bipolar disorder is associated with premature mortality and sudden death is also known in psychiatric patients;

    (b) It seems that staff used appropriate strategies to engage him in managing his challenging behaviour. They offered to work with him, utilised distraction and other sensory techniques, offered him oral medications and where possible attempted psychiatric as well as physical health review. These strategies indicate that their approach in managing his behaviour was reasonable;

    (c) It was appropriate for Stratos to be prescribed both benzodiazepines and antipsychotic medications to treat both his behavioural disturbance and his underlying illness;

    (d) Some patients with manic psychosis, especially those with severe agitation, are at a higher risk of sudden death during an early period of relapse and that risk increases if they are restrained despite receiving therapeutic doses of antipsychotic medications. Whether the antipsychotic medications contributed to the cause of death is difficult to say. Such events can occur despite adequate levels of clinical monitoring;

(e) QT prolongation is a well-known but less common side effect of several medications, including antipsychotic medications. The most common advice in hospital guidelines is to cease the medication which is causing the QT prolongation. In situations where more than one medication is used, one has to review the medications and identify which ones are contributing to QT prolongation and cease them and use those medications which have less impact; and

(f) The use of restrictive practices on Stratos appears to be consistent with the MHWB Act and the Chief Psychiatrist's guidance on restrictive intervention. The application, notification, use of bodily restraint and seclusion and subsequent monitoring were also consistent with those requirements.

Dr Perrin

43. The Court also obtained an expert opinion dated 4 May 2026 from Cardiologist and Electrophysiologist Dr Mark Perrin. He is currently employed as a cardiologist at University Hospital in Geelong and at the Royal Melbourne Hospital.

44. Dr Perrin calculated the QT intervals[15] in relation to the ECGs conducted on Stratos as follows:

(a) 13 March 2021 436 milliseconds;

(b) 26 March 2025 455 milliseconds (borderline prolonged); and

(c) 28 March 2025 476 milliseconds (prolonged).

[15] The calculations represent corrected QT intervals (QTc) which take into account the patient's heart rate and provide a more effective measure to assess the risk of heart arrythmia.

45. Dr Perrin expressed the following opinion in relation to the impact of Stratos's medication regime at Maroondah Hospital on his heart:

(a) The combination of medications had the *potential* to cause respiratory depression with hypoxia, and cause clinically relevant QT prolongation, thereby increasing the risk of ventricular arrhythmia;

(b) Stratos had structural heart disease which may lead to sudden cardiac death due to ventricular arrhythmia;

(c) Drug induced QT prolongation is a recognised mechanism for arrhythmia, particularly in the presence of other risk factors. Relative bradycardia during sleep, hypoxia, and underlying structural heart disease, all increase the risk of QT-related ventricular arrhythmia;

(d) The toxicology report does not show a single medication at a clearly fatal level concentration;

(e) The combined effect of sedation, sleep related reduction in respiratory drive, and cumulative exposure to QT prolonging medications, provide a plausible explanation for cardiac arrest on the evening of 28 March 2025; and

(f) It is not possible to determine if medication alone was sufficient to cause death. Multiple factors may have acted together. The relative contribution of medication and underlying cardiac disease cannot be determined with certainty.

SCOPE OF INQUEST

46. The focus of the inquest was on whether the administration of antipsychotic and sedative medications to Stratos during his admission to Maroondah Hospital was reasonable and appropriate to treat his illness and manage his behaviour.[16] Dr Lakra and Dr Michael

[16] Although the scope of the inquest was limited, the coronial investigation considered broader issues, including the timing of the emergency response.

Burke, Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine were called to give evidence.

IDENTITY OF THE DECEASED

47. On 1 April 2025, Stratos Ioannidis was visually identified by his son, Sebastian Ioannidis.

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

MEDICAL CAUSE OF DEATH

49. On 3 April 2025, Dr Burke, performed an autopsy and prepared a report of his findings dated 29 April 2025. He also reviewed a post-mortem computed tomography (**CT**) scan.

50. Dr Burke noted significant heart disease with an enlarged heart and coronary artery atherosclerosis. He stated that the degree of heart disease would be consistent with causing sudden death as a result of cardiac arrhythmia.

51. Toxicological analysis of post-mortem samples detected the presence of diazepam (and its metabolite), clonazepam (and its metabolite), quetiapine, olanzapine, chlorpromazine and promethazine.[17] The level of olanzapine was elevated but the other drugs were detected at therapeutic or sub-therapeutic levels.

52. Dr Burke noted that drugs such as quetiapine and chlorpromazine may elongate the QT intervals on an ECG and increase the chance of sudden cardiac arrhythmia.

53. Dr Burke formulated the cause of death as "*1(a) Focal coronary artery disease and cardiomegaly*". He expressed the opinion that the death was due to natural causes.

54. In evidence at the inquest, Dr Burke confirmed that the findings on autopsy provided clear evidence of a reasonable cause of death, being focal coronary artery disease and cardiomegaly. He agreed with the opinion of Dr Perrin that the medication administered to Stratos during his admission at Maroondah Hospital *could* have contributed to his death, leading to him experiencing cardiac arrythmia. However, he stated that the

[17] Promethazine is an anti-histamine.

evidence did not enable him to determine whether the medication did in fact contribute to death, or express an opinion as to the likelihood that it may have done so. On balance, he remained satisfied that the death was likely due to natural causes. I accept the evidence of Dr Burke.

55. I am satisfied that Stratos's death was the result of him experiencing a cardiac arrest that was primarily caused by his significant heart disease. It is possible that other factors contributed to the cardiac arrest, including cumulative exposure to QT prolonging medications, and sedation and sleep related reduction in respiratory drive.[18] However, the evidence does not enable me to be comfortably satisfied on the balance of probabilities that there were other contributing factors.

MANAGEMENT AT MAROONDAH HOSPITAL

56. In evidence at the inquest, Dr Lakra stated that Stratos had suffered an acute relapse of his mental illness with severe behavioural disturbance. He considered that the combination and dosage of sedative and antipsychotic medications administered to Stratos during his admission at Maroondah Hospital were reasonable and appropriate to treat his mental illness and manage his behaviour and the associated risk to himself, staff and other patients.

57. Dr Lakra stated that it is well-known, but uncommon, that some sedative and antipsychotic medications can have the effect of prolonging the QT intervals in some patients, increasing the risk of cardiac arrhythmia. He said that chlorpromazine was the most likely medication to have that effect. He noted that Accuphase could also prolong QT intervals, to a lesser degree, but that it was a long-acting medication the effects of which were hard to reverse. Further, he considered that the administration of quetiapine in the afternoon on 28 March 2025 was reasonable, notwithstanding its potential to prolong QT intervals, because of the relatively low dose and the ongoing need to treat Stratos's illness.

[18] If a finding were to be made that medication contributed to Stratos's death, then it could not be found that it was solely due to natural causes.

58. With one exception, Dr Lakra considered the plan formulated by clinicians after receiving the results of Stratos's ECG conducted on 28 March 2025 was reasonable and appropriate. He stated that it was appropriate to cease chlorpromazine given that, of the medications being administered to Stratos, it was more likely to prolong QT intervals. Further, he considered that it was appropriate to not commence Accuphase given its lesser relative potential to affect QT intervals combined with its long-acting effects. He considered that clinicians could have ordered another ECG later in the day given the high QT interval which had been recorded at 519 milliseconds. On balance, however, he concluded that the plan for daily ECGs was reasonable, noting the practical difficulties of actually persuading Stratos to cooperate in the process given his level of agitation and aggression displayed in the afternoon on 28 March 2025.

59. The exception identified by Dr Lakra in evidence was that, given the recorded prolonged QT interval calculated from the ECG taken on 28 March 2025, it was unreasonable for the mental health clinicians not to have escalated the results to Cardiology or a Medical Team for advice which could have informed the plan for Stratos. He acknowledged that the advice may not have altered the plan that had been made, although it is possible it may have resulted in an earlier ECG being sought or Stratos's transfer to another part of the hospital where continuous monitoring could have been performed.

60. Dr Lakra considered that the level and quality of observation being conducted by staff on Stratos in the evening on 28 March 2025 was reasonable and appropriate in the circumstances. He acknowledged that ideally Stratos would not have been sleeping on the floor and that staff would have entered his room when conducting the observations. However, during the evening, and particularly in Stratos's case given his reported insomnia in the days leading to his admission, it was reasonable for staff to prioritise his undisturbed sleep with effective observations being able to be conducted through the window in his door.

61. In terms of the guidelines available to clinicians treating mental health patients when it comes to assessing ECGs and QT prolongation, Dr Lakra identified the well-known and often-used resource, *The Maudsley Prescribing Guidelines in Psychiatry*.[19]

CONCLUSION

62. Stratos suffered an acute relapse in his mental illness with severe behavioural disturbance which required his admission to Maroondah Hospital for compulsory treatment under the MHWB Act. His relapse was very distressing for his family and his presentation created a difficult and complex challenge for clinicians.

63. I am satisfied that the medication prescribed to Stratos while he was at Maroondah Hospital was reasonable and appropriate in the circumstances, and was administered to treat his illness, manage his symptoms and ensure the safety of himself, staff and other patients. It was known by clinicians that some of the sedative and antipsychotic medications prescribed could increase his QT intervals, leading to an increased risk of cardiac arrhythmia. Accordingly, some antipsychotic medication was avoided or ceased. However, Stratos presented challenges to clinicians in terms of his level of insight, engagement and his behaviour management, noting that he had assaulted both staff and other patients. Clinicians had to delicately balance the need to effectively and safely treat Stratos while also managing the risk presented to staff and other patients.

64. I am satisfied that the management and treatment of Stratos by clinicians at Maroondah Hospital was generally reasonable and appropriate, although consistent with the evidence of Dr Lakra, I consider that the results of his ECG taken on 28 March 2025 should have been escalated to Cardiology for advice to inform the plan for his ongoing management given the prolonged QT interval which had been recorded.

65. It is possible that some of the antipsychotic medication prescribed to Stratos (eg quetiapine and chlorpromazine) contributed to his death from focal coronary artery

[19] The 15th Edition was published in early 2025.

disease and cardiomegaly, by precipitating a cardiac arrest. However, I am unable to be comfortably satisfied that the medication did in fact contribute to his death.

FINDINGS

66. Having held an inquest into Stratos's death, I make the following findings, pursuant to section 67(1) of the Act:

    (a) the identity of the deceased was Stratos Ioannidis, born on 25 September 1979;

    (b) the death occurred on 28 March 2025, at Maroondah Hospital, 1/15 Davey Drive, Ringwood East, Victoria;

    (c) from focal coronary artery disease and cardiomegaly; and

    (d) that the death occurred in the circumstances set out above.

RECOMMENDATIONS

67. Pursuant to section 72(2) of the Act, I make the following recommendations:

    (a) Eastern Health continue to develop and finalise a protocol to identify ECG changes/thresholds that require escalation to Cardiology for review in the context of a person admitted as an involuntary mental health patient; and

    (b) Eastern Health review the Physical Health Assessment of Consumers in the Eastern Health Mental Health Program Practice Guideline to ensure that it is consistent and appropriately informed by the *Maudsley Prescribing Guidelines in Psychiatry* in respect of ECG changes and QT prolongation.

I convey my sincerest sympathy to Stratos's family for their loss.

Pursuant to section 73(1) 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:

Sebastian Ioannidis, Senior Next of Kin

Christina Ioannidis

Eastern Health

Office of the Chief Psychiatrist

Senior Constable Terence Hawking, Coronial Investigator

Signature:

Coroner David Ryan

Date: 22 May 2026

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 inquest. 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.