IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2020 3121

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of ARSINOI KAROMOSKOS

Delivered On:	30 MARCH 2022
Delivered At:	THE CORONERS COURT OF VICTORIA 65 KAVANAGH STREET, SOUTHBANK
Hearing Dates:	9 MARCH 2022
Findings of:	CORONER PHILLIP BYRNE
Counsel Assisting the Coroner:	MS RACHEL QUINN
Representation:	MS HUMAIRA DAD, REPRESENTING WESTERN HEALTH

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I, PHILLIP BYRNE, Coroner having investigated the death of ARSINOI KARAMOSKOS
AND having held an inquest in relation to this death on
find that the identity of the deceased was ARSINOI KARAMOSKOS
born on 12 July 1931
and the death occurred on 12 June 2020
at Royal Freemasons Springtime Aged Care Facility

from:

I (a) COMPLICATIONS OF A FEMORAL NECK FRACTURE (OPERATED) IN AN ELDERLY WOMAN WITH MULTIPLE COMORBIDITIES

Pursuant to section 67(1) of the **Coroners Act 2008** I make findings with respect to **the following circumstances**:

BACKGROUND

1. Arsinoi KARAMOSKOS, 89 years of age at the time of her death, was a patient in the Secure Geriatric Evaluation Management (**GEM**) Unit at the Sunshine Hospital. Unfortunately, Mrs Karamoskos suffered from mixed Alzheimer and Vascular dementia. A fellow patient at the facility Mrs Lyla Travis unfortunately also suffered from Alzheimer's dementia.

BROAD CIRCUMSTANCES SURROUNDING DEATH

2. On 23 May 2020 both ladies were in a corridor within the secure GEM ward. Mrs Travis was proceeding down the corridor with the aid of her four-wheel walking frame. She stopped at the drinking fountain. As this occurred Mrs Karamoskos approached from behind and began to play with the left-hand lever of the walking frame. Noticing this Mrs Travis

turned and pushed Mrs Karamoskos who fell to the floor. There is no controversy surrounding this event as the entire event was captured on CCTV. Unfortunately, due to the fall Mrs Karamoskos suffered a fractured neck of femur. Mrs Karamoskos was transferred to Footscray Hospital where the fracture was surgically repaired. Post-surgery Mrs Karamoskos did not do well and on 2 June 2020 she was transferred to the Royal Freemasons Springtime aged care facility for palliative care. Mrs Karamoskos passed away on the morning of 12 June 2020.

REPORT TO THE CORONER

3. Mrs Karamoskos's death was appropriately report to the coroner. Having considered the circumstances, having conferred with a forensic pathologist I directed an autopsy and ancillary tests. The directed autopsy was conducted at Victorian Institute of Forensic Medicine (**VIFM**), by Forensic Pathologist Dr Joanne Glengarry. A separate neuropathological investigation was undertaken at VIFM by Neuropathological Forensic Pathologist Dr Linda Iles.

4. Dr Glengarry advised Mrs Karamoskos untimely death was due to:

   I(a) COMPLICATIONS OF A FEMORAL NECK FRACTURE (OPERATED) IN AN ELDERLY WOMAN WITH MULTIPLE COMORBIDITIES

   Autopsy also demonstrated cardiac amyloidosis and diabetic kidney disease.

FURTHER INVESTIGATION

5. As it was clear the femoral fracture was the major contributing factor in Mrs Karamoskos death the matter was reported to Victoria Police and an investigation was undertaken by Detective Sergeant Tim Bell of the Homicide Squad. Not surprisingly the investigation was finalised without criminal charges being laid. I say not surprisingly because it became clear that in light of Mrs Travis advanced dementia, she did not have the mental capacity to form criminal intent, *mens rea;* it was clear Mrs Travis did not intend to harm Mrs Karamoskos.

6. However, the circumstances mandated under the Coroners Act 2008 that the matter be finalised by way of inquest. I concluded the matter could be finalised by way of a summary inquest where evidence would not be heard and I would rely on the coronial brief of evidence submitted by Detective Sergeant Bell which included statements by a number of clinicians, doctors and nurses, involved in the assessment and treatment of both ladies.

7. The matter proceeded as summary inquest, in effect a formality, on 9 March 2022. In attendance by way of video link were Mr Peter Karamoskos, Mrs Karamoskos' son, Ms Kerryn Underwood, Mrs Travis' daughter and Ms Humaira Dad, solicitor for Western Health, my coroner's solicitor Ms Rachel Quinn assisting, and Detective Sergeant Bell. I explained to those present the nature of the hearing and invited input.

8. It must be said that to their great credit Mr Karamoskos and Ms Underwood were entirely magnanimous, both understanding the unfortunate circumstances leading to Mrs Karamoskos death.

9. At the completion of the hearing, I engaged in dialogue with both family members, and indicated I had no issues with Western Health, noting that the care/management of patients in secure units like GEM pose a real challenge, with tragic events generally impossible to predict.

FINDING

10. I formally find that Arsinoi Karamoskos died at Royal Freemasons Springtime Aged Care Facility on 12 June 2020 due to complications of a fractured neck of femur suffered on 23 May 2020 when as a patient at the Secure Geriatric Evaluation Management Unit (GEM) at the Sunshine Hospital she was pushed over by another dementia patient.

11. Pursuant to section 73(1) of the Act, I order this this finding be published on the Coroner Court of Victoria website in accordance with the rules.

12. I direct that a copy of this finding be provided to the following:

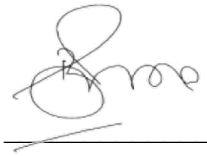
    Mr Peter Karamoskos, Senior Next of Kin;

    Ms Kerryn Underwood;

    Western Health; and

    Detective Sergeant Tim Bell, Coroner's Investigator, Victoria Police.

Signature:



PHILLIP BYRNE
CORONER
Date: 4 April 2022