IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 004554

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

*Amended pursuant to section 76 of the **Coroners Act 2008** on 19/12/2022*[1]

Findings of:	Jacqui Hawkins, Deputy State Coroner
Deceased:	Arthur Peter Andrianakis
Date of birth:	25 July 1970
Date of death:	28 August 2021
Cause of death:	1(a) Hyperthermia of unknown cause in a man with cardiac hypertrophy 2 Chronic Obstructive Airways Disease
Place of death:	Alfred Hospital, 55 Commercial Road, Melbourne, Victoria, 3004

[1] This document is an amended version of the Finding into the death of Arthur Peter Andrianakis dated 16 December 2022. Corrections have been made to paragraphs 1 and 3 to Arthur Peter Andrianakis's pronouns.

INTRODUCTION

1. Arthur Andrianakis was 51 years old when he passed away on 28 August 2021. Just prior to his death he had been living with his mother Mrs Irene Andrianakis in Albert Park.

2. Mr Andrianakis had a complex medical history including asthma, chronic obstructive airways disease, congestive cardiac failure, obstructive sleep apnoea, schizoaffective disorder, polysubstance abuse (methylamphetamine, cannabis and alcohol), type 2 diabetes, pulmonary thromboembolism (provoked by surgery), acquired brain injury due to two prior vehicle incidents and hypercholesterolaemia.

3. At the time of his passing, Mr Andrianakis was on an Inpatient Treatment Order under the *Mental Health Act 2014* (Vic).

THE CORONIAL INVESTIGATION

4. Mr Andrianakis' 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.

5. Mr Andrianakis was *"a person who immediately before death"* was considered in care as he was on an Inpatient Treatment Order.[2] Section 52 of the *Coroners Act 2008* recognises the vulnerability of people who are in the care of the State by requiring that their deaths are reported to the coroner irrespective of the cause of death. A further safeguard is the mandatory requirement for an Inquest as part of the coronial investigation. However, if the investigating coroner is satisfied that the death is due to natural causes, they may choose to finalise the investigation without an inquest.[3] In such a case, the coroner must publish their finding.

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.

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[2] Under section 3(1) of the *Coroners Act 2008,* a person placed in care includes a patient detained in a designated mental health service within the meaning of the *Mental Health Act 2014* (Vic). Pursuant to section 4(2)(c) of the Act, the death of such a person is reportable irrespective of the cause of death.

[3] Section 52 (3A) *Coroner Act 2008* (Vic).

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. Victoria Police assigned Detective Leading Senior Constable Andrew White to be the Coroner's Investigator for the investigation of Mr Andrianakis' 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 the passing of Mr Andrianakis 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.[4]

IDENTITY OF THE DECEASED

10. On 28 August 2021, Arthur Peter Andrianakis, born 25 July 1970, was visually identified by his sister Adriana Didaskalou, who signed a formal statement of identification to this effect.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

Mental health history

11. Mr Andrianakis had a history of multiple inpatient admissions to both the Alfred Health medical units and the Inpatient Psychiatry Unit. He was diagnosed with schizoaffective disorder in 1991 for which he received regular medication. At the time of his death his treatment by Alfred Health had been his depot medication which was supplemented by oral mood-stabilising medication.

12. According to Dr Neerah Sareen, Head of Community Psychiatry at Alfred Health, Mr Andrianakis received community treatment from the Alfred Mental and Addiction Health (**AMAH**). He was managed as a voluntary mental health patient from 2011 until August 2014

[4] 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.

when his treatment was successfully transferred to his GP and he was eventually discharged from compulsory community treatment. His mental health admissions were usually in the context of deterioration in his mental state, which was characterised by increased irritability, aggression and reported assaults against his mother, in the setting of cannabis use and non-adherence to medication.

13. In 2018 Mr Andrianakis had three inpatient psychiatry admissions and was discharged to the care of the Alfred Health's Mobile Support and Treatment Team (**MSTT**) who provided intensive mental health assessment, treatment, rehabilitation, and support.

14. In January 2019, Mr Andrianakis was admitted to the Alfred Hospital Psychiatric ward on a varied Treatment Order. Between 25 January and 10 February 2020, he was again admitted to the Alfred Hospital Psychiatric ward.

15. On 6 July 2021, Mr Andrianakis was taken to the Alfred Hospital Emergency Department by ambulance, suffering breathing difficulties. He was medically reviewed but later discharged himself against medical advice.

16. Prior to his final presentation to Alfred Health in August 2021, Mr Andrianakis was being assertively managed by the MSTT and had been compliant with his prescribed medications. The MSTT had mostly daily contact for medication supervision.

17. Mr Andrianakis had a telehealth appointment with a Consultant Psychiatrist on 20 July 2021 to review his case. Mr Andrianakis expressed concerns about his depot medication and ongoing issues with his olanzapine prescription. He reported difficulty with walking, feeling breathless, blurred vision, constipation and asthma. He considered these were side effects of the medication. He was advised to cease olanzapine and increase his dose of flupenthixol.

18. Mr Andrianakis remained on a Community Treatment Order and was provided medication supervision and support by MSTT

History of family violence

19. Mr Andrianakis had a longstanding forensic history predominantly as a perpetrator of family violence against his elderly mother and occasionally his sister. The incidents would escalate when Mr Andrianakis ceased taking his medication and or used methylamphetamine.

20. At the time of his death, he was the respondent in a Family Violence Intervention Order (**FVIO**) which prohibited him from committing family violence offences against his mother.

Circumstances proximate to his death

21. On 22 August 2021 at 1.50am police received a call via the Police Communications Centre to attend the Andrianakis family home in Albert Park in relation to a domestic dispute. Constable Chris Barter and First Constable Perri Chequer attended the home at 2.51am. Mr Andrianakis was verbally aggressive to police. He was arrested for assaulting his mother and breaching an existing FVIO. Another police unit was called to assist due to Mr Andrianakis' history with violence and his physical size.

22. Ambulance Victoria paramedics were called to the scene to conduct an assessment of Mrs Andrianakis.

23. Whilst the police members were walking Mr Andrianakis to their vehicle, he complained he was suffering from an asthma attack and was struggling to breathe. Ambulance paramedics assessed Mr Andrianakis and treated him with a dose of Ventolin. They assessed that he appeared fine but needed to warm up.

24. At 3.27am Mr Andrianakis was transported to the Prahran Police Station where he again complained of breathing difficulties. Police helped him to sit up and he reported that he was able to breathe better. Mr Andrianakis then walked from the sally port to the charge counter inside the police station.

25. At 3.33am Acting Sergeant (**A/Sgt**) Tarryn McDonald spoke to Mr Andrianakis who complained again that he was having difficulty breathing. He was observed by A/Sgt McDonald to be 'mucusy' and had extremely dry lips which he explained was due to an asthma attack and low oxygen. He was placed in an interview room. A/Sgt McDonald spoke to arresting members who reported that he had been given Ventolin by paramedics at the scene.

26. At 4.03am First Constable Matthew Kirby spoke to Mr Andrianakis and gave him some Ventolin to self-administer and a bottle of water. He showed him the location of the duress button inside the interview room and told him to press it if he needed medical attention.

27. Four minutes later, Mr Andrianakis pressed the duress button and was visibly struggling to breathe. He appeared to be suffering from an asthma attack. An ambulance was called and arrived shortly after. Mr Andrianakis reported a two week history of productive cough and said he had been using Ventolin more frequently than normal.

28. At 4.47am Mr Andriankis was transported by ambulance to the emergency department at the Alfred Hospital suffering respiratory distress. He was found to be in respiratory failure, and he appeared agitated.

29. Mr Andrianakis was admitted to the Intensive Care Unit (**ICU**) given his condition and the level of care needed. He was diagnosed with an infective exacerbation of Chronic Obstructive Pulmonary Disease (**COPD**) and treated with antibiotics and oxygen therapy. He received clearance for COVID-19 infection after six negative tests. He also received treatment from psychiatry for his agitation and was placed on an Inpatient Treatment Order under the *Mental Health Act 2014* (Vic).

30. On 23 August 2021, a Code Grey was called in ICU due to aggressive behaviour, non-compliance with treatment and refusal of care. Clinicians performed an emergency intubation to facilitate his care. Mr Andrianakis was given a depot flupenthixol and administered lithium, olanzapine and valproate. An echocardiogram showed some right heart dysfunction, and a CT pulmonary angiogram (**CTPA**) revealed right sided pulmonary embolism. He was commenced on a heparin infusion to treat this. He became feverish on 26 August 2021 and was noted to have some right sided chest x-ray changes. A bronchoscopy was performed, and his antibiotics therapy was adjusted.

31. Mr Andrianakis appeared stable on 28 August 2021 but was persistently febrile. His oxygenation improved and he was spontaneously breathing on a ventilator. However, his temperature climbed to over 41 degrees, and he became more hypotensive. His support requirements rapidly escalated and his temperature continued to rise to 43 degrees. Active cooling was initiated, and dantrolene was given (with no immediate benefit). Despite aggressive treatment, Mr Andrianakis continued to deteriorate and went into cardiac arrest. An attempt to put him on ECMO failed. Mr Andrianakis' care was redirected to palliation after the ECMO failure, and he was pronounced dead at 2.40pm on 28 August 2021.

32. Police were notified and commenced a coronial investigation.

MEDICAL CAUSE OF DEATH

33. On 31 August 2021, Dr Melanie Archer, Forensic Pathologist from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on Mr Andrianakis. Dr Archer also considered the post-mortem computed tomography (**CT**) scan, Victoria Police Report of

Death Form 83, the e-medical deposition, Ambulance Victoria records and the medical records of Alfred Health and Craigirossie Medical Centre.

34. Dr Archer noted the cause of death is hyperthermia (extreme elevation in body temperature) in a man with cardiac hypertrophy (enlargement of the heart). Chronic obstructive airways disease was also considered a contributing factor. The cause of the hyperthermia was not clear. Although, Dr Archer considers that Mr Andrianakis' initial presentation to hospital may have been a combination of lung infection and heart failure. Information received indicated that Mr Andrianakis had a productive cough in the weeks prior to his presentation to hospital and was feverish. He also had symptoms suggestive of an exacerbation of heart failure (pulmonary oedema and chronic orthopnoea). However, he was treated for this, and autopsy showed no evidence of ongoing infection in the lungs. Nevertheless, he continued to deteriorate, and developed unexplained elevation in his body temperature. The cause of the Mr Andrianakis' rise in temperature prior to death remains unclear.

35. He was also shown clinically to have a right sided pulmonary thromboembolism, and a peripheral thromboembolus was found at autopsy. There is evidence he had been partially treated with heparin infusion, which would likely have reduced its size.

36. The post-mortem examination showed Mr Andrianakis had an enlarged heart, the cause of which is unclear. However, the most common cause of cardiac hypertrophy in the community is hypertension. It may also be associated with ischaemic heart disease, valvular pathology or various forms of cardiomyopathy. Cardiac hypertrophy is associated with increased myocardial oxygen demand, arrythmias and sudden death. This is especially true in the setting of physiological stress, such as hyperthermia.

37. There was no evidence of any trauma found on examination.

38. Antemortem toxicological testing on admission to hospital was not available for testing. However, antemortem tests from two days after his admission identified the presence of a number of drugs including analgesic morphine, atracurium, antipsychotic drugs olanzapine, flupenthixol, haloperidol, the mood stabiliser valproic acid, the antiseizure drug acetazolamide, and the analgesic paracetamol. There was a detection of the cannabis metabolite delta-9-tetrahydrocannabinol.

39. Dr Archer was of the view Mr Andrianakis passed due to natural causes. Dr Archer provided an opinion that the medical cause of death was 1 (a) hyperthermia of unknown cause in a man

with cardiac hypertrophy, with contributing factor of chronic obstructive airways disease. I accept Dr Archer's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Arthur Peter Andrianakis, born 25 July 1970;

    b) the death occurred on 28 August 2021 at the Alfred Hospital, 55 Commercial Road, Victoria, 3004 from 1a) Hyperthermia of unknown causes in a man with cardiac hypertrophy, 2) Chronic Obstructive Airways Disease; and

    c) the death occurred in the circumstances described above.

41. Having considered all of the circumstances, I am satisfied that the care provided to Mr Andrianakis whilst at the Alfred Hospital was reasonable and appropriate. The evidence indicates Mr Andrianakis passed away due to natural causes.

42. Pursuant to section 73(1B) of the Coroners Act 2008, I order that the finding be published on the internet.

I convey my sincere condolences to the Andrianakis' family for their loss.

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

Mrs Irene Andrianakis, Senior Next of Kin
Mrs Adriana Didaskalou
Ms Karen Day, Director, Clinical and Enterprise Risk Management, Alfred Health
Mrs Jane Dove, Alfred Mental and Addiction Health
Detective Leading Senior Constable Andrew White, Coroner's Investigator

Signature:

JACQUI HAWKINS
DEPUTY STATE CORONER
Date: 16 December 2022