IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2013 / 02202

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of: ANASTASIOS KOSMAS

Delivered On:	4 December 2014
Delivered At:	Coroners Court of Victoria Kavanagh Street, Melbourne
Hearing Dates:	4 December 2014
Findings of:	PHILLIP BYRNE
Representation:	
Counsel Assisting the Coroner	Mr Marc Fisken, Coroner's Solicitor

I, PHILLIP BYRNE, Coroner, having investigated the death of ANASTASIOS KOSMAS

AND having held an inquest in relation to this death on 4 December 2014
at MELBOURNE
find that the identity of the deceased was ANASTASIOS KOSMAS
born on 18 January 1953
and the death occurred on 24 May 2013
at the Austin Hospital, Studley Road, Heidelberg
from:

1 (a) ISCHAEMIC CEREBROVASCULAR ACCIDENT

in the following circumstances:

1. Mr Anastasios Kosmas, 60 years of age at the time of his death, resided at Parkland Close Supportive care home, located at 10 Childers Street, Kew.
2. Mr Kosmas had a history of depression and had previously been diagnosed with manic schizophrenia. He had previously spent time as an inpatient in psychiatric wards and hospitals. Mr Kosmas also had a medial history that included type II diabetes mellitus, hypertension and hyperlipidaemia.
3. On 12 December 2011 Mr Kosmas was admitted to St Vincent's Hospital for treatment. Mr Kosmas was placed in a high dependence area, the extra care unit and treated with olanzapine and diazepam as well as thiamine.
4. On 16 November 2012 Mr Kosmas was transferred to the Austin Secure Extended Care psychiatric unit for on-going management as an involuntary patient.
5. At approximately 8am on 19 May 2013 Mr Kosmas was found collapsed on the bathroom floor at the secure extended care unit. He was reported to be difficult to rouse. Mr Kosmas was transferred by ambulance to the ICU. A CT scan revealed that he had suffered an acute left middle cerebral artery cortical infarct involving two thirds of the left cerebral hemisphere.
6. On 21 May 2013 Mr Kosmas was reviewed by a neurologist and a stroke team doctor. They reached the conclusion that Mr Kosmas was not suitable for surgical intervention and should be managed conservatively.

7. A meeting was then held with Mr Kosmas' family and medical staff from the ICU, the stroke team, psychiatry and the social work team. Mr Kosmas' poor prognosis was discussed and it was agreed that invasive respiratory support would be withdrawn and comfort care only would be provided.

8. On 23 May 2013 Mr Kosmas was extubated and at approximately 9am on 24 May 2013 Mr Kosmas passed away.

9. The death was referred to the Coroner and an external only post mortem examination was carried out at the Victorian Institute of Forensic Medicine by Senior Forensic Pathologist Dr Matthew Lynch. A post mortem CT scan revealed a hyper dense area in the left hemisphere consistent with an ischaemic infarct. Dr Lynch found the cause of death to be ischaemic cerebrovascular accident.

10. In the circumstances, I have concluded that as Mr Kosmas death was due to natural causes no further investigation is necessary and propose to finalise the matter by way of this short finding.

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

Mr Thomas Kosmas

Dr Mark Oakley Browne

First Constable Mark Milone, Heidelberg Police Station

Signature:

PHILLIP BYRNE
CORONER
Date: **4 December 2014**