IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2008 5266

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: NIKOS VOURDOULIDIS

Delivered On:	27 May 2013
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne Victoria
Hearing Dates:	6 and 7 December 2012
Findings of:	CORONER K. M. W. PARKINSON
Representation:	Ms P Carey for Office of the Public Advocate
Police Coronial Support Unit Assisting the Coroner	Leading Senior Constable Tania Cristiano

I, K. M. W. PARKINSON, Coroner having investigated the death of NIKOS VOURDOULIDIS
AND having held an inquest in relation to this death on 6 and 7 December 2012
AT MELBOURNE
find that the identity of the deceased was NIKOS VOURDOULIDIS
born on 13 March 1962
and that the death occurred on 25 November 2008
at 74A Maribyrnong Road, Moonee Ponds 3039

from:

1 (a) MYOCARDIAL FIBROSIS IN A MAN WITH EPILEPSY

in the following circumstances:

1. An inquest was held into the death of Mr Nikos Vourdoulidis on 6 and 7 December 2012. Oral submissions were made at the conclusion of the inquest and written submissions were filed on behalf of the Office of Public Advocate (the 'OPA') on 2 May 2013. I have been greatly assisted by these submissions.

2. The following witnesses gave evidence at the inquest: Ms Soulla Hatzistamatis, Personal Care Assistant and Mr Ravinder Singh, Facility Manager each of Corandirk House Supported Accommodation Facility; Mr Atilla Yazar, Disability Support Worker of Disability Assist; Dr Jay Hewa, General Medical Practitioner; Mr Patrick McGee, employee of the OPA.

BACKGROUND AND CIRCUMSTANCES

3. Mr Nikos Vourdoulidis had a past medical history of mild intellectual disability, epilepsy and post ictal psychosis and personality disorder. His parents were deceased. He had resided with his mother until 2004 when due to illness she could no longer provide him with the necessary care. He then resided at supported care facilities in Heidelberg, Brunswick and more recently at the time of his death, Corandirk House at Moonee Ponds.

4. Mr Vourdoulidis was subject to a Guardianship order administered by the OPA until 6 weeks prior to his death. His financial affairs were also under administration by the Office of the State Trustee. The Guardianship order had included capacity to make decisions as to residential arrangements and medical treatment.

5. Mr Vourdoulidis resided at Corandirk House, a supported residential service located at Maribyrnong Road, Moonee Ponds. He had transferred to Corandirk House in April 2008, after his previous residential facility in Heidelberg had ceased operating.

6. The facility was managed by Mr Ravinder Singh. The facility is described as providing accommodation and special or personal care including assistance with bathing, dressing, personal hygiene and meals and medication administration. Mr Singh stated that it did not provide the level of supervision of a low care or high care nursing home facility. Mr Vourdoulidis was protective of his privacy and independence and resented intrusion into his personal domain. His accommodation needs were arranged with this in mind.

7. When Mr Vourdoulidis was admitted, a client care plan was completed which Mr Singh stated was related to his medication requirements, room cleaning and management of behavioural issues[1]. Mr Singh stated that it was his understanding that the OPA having been appointed as his guardian was responsible for making decisions in relation to medical, health and accommodation issues.

8. He was assisted by staff at the unit with activities of daily living, including medication management and administration. He received very good support from his care worker, Mr Atilla Yazar, who assisted him to participate in social and church activities and generally helped to support his sense of community engagement and wellbeing. Mr Yazar was engaged to provide up to 10 hours per week of support.

9. Whilst Mr Vourdoulidis resided at Heidelberg, he attended a specialist epilepsy clinic at the Austin Hospital. His last visit to this clinic was in February 2008, shortly before he had moved to Corandirk House. He was taken to that appointment by Mr Yazar. That appointment had been made when he was still a resident at the Heidelberg care facility. After that appointment, no further appointments for clinic attendance were made and it does not appear that his care was transferred to any other specialist epilepsy clinic. After the move from Heidelberg, Mr Vourdoulidis was unable to continue to attend his previous GP, Dr Sam Assad who had treated him since 1999.

[1] Inquest Brief page 29.

10. His general medical care from April 2008 was arranged by the Corandirk House staff. It appears that they had some difficulty locating a GP available to attend Mr Vourdoulidis although they made contact from time to time with previous GP's for repeat prescriptions for both the anti-convulsant and anti-psychotic medication.

11. In April 2008, Mr Vourdoulidis attended an appointment with Dr Mitchell Smith who stated that he had no history of treatment of Mr Vourdoulidis and that he had seen him on that occasion only at which time he issued prescriptions for Tegretol and Valpro 200mg. He did not see Mr Vourdoulidis again although he was requested by a pharmacy and by the facility to provide repeat prescriptions for his medication over the phone. It appears that after the consultation with Dr Smith in April, Mr Vourdoulidis was next seen by a GP in October 2008.

12. Dr Jay Hewa, a general medical practitioner who attended from time to time at Corandirk House, was approached by facility staff in October 2008 and agreed to see Mr Vourdoulidis. He saw him on 7 October, 13 October, 21 October and 18 November 2008.

13. On 24 November 2008, Mr Vourdoulidis was seen at dinner time at approximately 6pm. It was his usual practice to retire to his rooms after dinner. Mr Vourdoulidis usually received his evening medication with the evening meal. The medication records are limited and it is not clear whether he was administered all of his medication that evening and at what time this occurred. There are no notes in the patient care record for this day or the previous day although the medication chart has been signed.

14. It was reported that it was not uncommon for Mr Vourdoulidis to shower at night however; the manager also stated that on occasions he would shower very early in the morning. Another facility resident reported to police that he heard the shower running in his room late in the evening of 24 November, and that he heard a large bang come from Mr Vourdoulidis' room. The resident however was operating under a disability and did not appreciate that there may have been anything untoward and did not inquire further or report the matter to the overnight staff member.

15. Mr Vourdoulidis was not checked by a staff member during the night, it is not possible to say with precision when he entered the shower. However it appears that during the shower he suffered a collapse of some type either an epileptic seizure or cardiac event.

16. At approximately 7am on 25 November 2008, Mr Yazar attended the facility to accompany Mr Vourdoulidis to church. He was unable to raise Mr Vourdoulidis and entered the room. He stated that he observed that the bed was made and that he could hear the shower running. After calling out a number of occasions, he entered the bathroom and located Mr Vourdoulidis unresponsive on the floor of the shower cubicle. He stated that he was cold and that he had no detectable pulse. A staff member, Ms Soulla Hatzistamatis stated that she did not commence CPR, as it appeared that Mr Vourdoulidis had been deceased for some time. Ambulance attended however, Mr Vourdoulidis was deceased and it was apparent he had been deceased for some hours.

17. I am satisfied that Mr Vourdoulidis entered the shower in the evening of 24 November 2008 or the early hours of 25 November 2008 and that shortly thereafter he collapsed. Whilst it is not possible to be more precise about the timing of the collapse or whether death occurred immediately, I am satisfied that he remained in the shower cubicle for a number of hours before being located by Mr Yazar.

FORENSIC PATHOLOGIST EXAMINATION AND EVIDENCE

18. A post mortem examination was undertaken by Dr Ariyarathna, Forensic Pathologist with Victorian Institute of Forensic Medicine who provided a report to the Coroner. There was no specialist neuropathology examination of the brain. Dr Ariyarathna reported that in his opinion the cause of death was myocardial fibrosis in a man with epilepsy.

19. Dr Ariyarathna commented :

> "The myocardial fibrosis that was demonstrated in this case was in keeping with a well known finding in epileptics which is supposed to be the result of episodic hypoxia from apnoea during fits. Individuals with myocardial fibrosis may develop sudden cardiac arrhythmia, which can lead to death (heart attack). Also pulmonary oedema is present which is a common finding in autopsies of people dying from seizures, neurogenic pulmonary oedema has been proposed as a possible mechanism of death in seizure disorders. Whether Mr Nikos Vourdoulidis had an epileptic seizure or whether he collapsed suddenly from his heart disease is difficult to say. The cause of death is therefore expressed in terms to accommodate both possibilities."

20. Mr Vourdoulidis had a history of witnessed and unwitnessed seizures. Mr Yazar stated that he had observed seizure like activity on a number of occasions in the weeks leading up to Mr

Vourdoulidis death. It appears that Mr Vourdoulidis experienced epilepsy related seizure activity on a not infrequent basis and that there is some evidence that in the period between February 2008 and the date of his death, 25 November 2008 that the seizure activity was increasing.

21. One such seizure occurred whilst he was at his appointment at the Austin Hospital epilepsy clinic in February 2008 and was witnessed by Mr Yazar and hospital staff. Mr Yazar also stated that he had observed another seizure, which occurred in his motor vehicle as he was taking Mr Vourdoulidis on an errand. There is no documentation of this event in any of the care facility notes or in the GP notes. He recounted that he had been informed of other seizures by staff at Mr Vourdoulidis' previous care facility, Heidelberg Executive Care in about 2007 at Brunswick Lodge.

22. Mr Singh gave evidence of a seizure occurring at the Corandirk facility in 2008 however, he was unable to be precise about the date or time of that event. Mr Vourdoulidis also suffered another seizure whilst out supermarket shopping on 10 October 2008. During the course of the seizure, he struck and injured his head and was transported to the Royal Melbourne Hospital by ambulance. He was treated at the emergency department and discharged on 11 October 2008[2]. No continued outpatient follow up care was indicated.

23. Mr Yazar's evidence was that after Mr Vourdoulidis moved from the Heidelberg care facility to Corandirk he was not asked to accompany him to any further appointments at the Austin Hospital Epilepsy clinic. The evidence is that he did not attend any other epilepsy clinic or specialist service. His epilepsy management was provided by the general medical practitioner, Dr Hewa.

MEDICAL ATTENDANCES: REVIEWS AND OUTCOMES

24. Dr Hewa's evidence was that he had seen Mr Vourdoulidis on 4 occasions in the period 7 October 2008 to his death on 25 November 2008. Prior to that time Mr Vourdoulidis medication was prescribed by telephone order from doctors who had seen him whilst he was resident at other facilities.

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[2] Royal Melbourne Hospital Medical Records page 58 – 63 Inquest Brief.

25. Dr Hewa saw Mr Vourdoulidis on 7 October 2008, 13 October, 21 October and 18 November 2008. His evidence was that he commenced to see the patient at the request of the care facility and that the only information available to him at the first consultation was that Mr Vourdoulidis had a history of epilepsy since 2008 and schizophrenia also since 2008. He first saw Mr Vourdoulidis at his residential facility. His evidence was that he had limited information available to him as to the patient's prior history.

26. Dr Hewa's evidence was that he was not aware that Mr Vourdoulidis had been suffering recent seizures and that this information was not brought to his attention. His evidence was that whilst he was seeing Mr Vourdoulidis at the facility, he didn't regard himself as his treating GP. It was rather a matter of convenience because he was calling at the facility to see other patients and he was asked to see Mr Vourdoulidis and agreed to do so.

27. When asked what information he had been provided he stated:

> "Madam when you go to these places there's hardly anything left there. They just tell you that we have got a patient like this and you practically find it very difficult to find anything at all. He had no information about the patient, his clinical course or his background medical history or admissions to hospital. Nothing they didn't have anything".
>
> "So did you have any background information available to you about what his previous clinical course had been, either by way of previous admissions to hospital when you first saw him -?---Nothing." [3]

28. The next consultation occurred on 13 October 2008 in a visit scheduled by Dr Hewa to follow up on the pathology results obtained from the 7 October consultation. This consultation occurred after Mr Vourdoulidis had experienced the seizure for which he was taken to the Royal Melbourne Hospital on 10 October 2008. Dr Hewa stated that he understood only that he had a 'fall at a shop' went to hospital and was sutured and discharged.

29. Dr Hewa did not attend the facility in response to any request by the facility to follow up that incident and did not understand that the 'fall' was in the context of a seizure. His evidence is that he had no information as to the hospital admission other than that he had a fall down the

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[3] Transcript dated 6 December 2012 at page 93.

street and that he was taken to hospital. He stated that he was not told that Mr Vourdoulidis had experienced an epileptic seizure. An example of the lack of continuity of medical care is to be seen by this evidence:

> On 13 October when you make the adjustment to the Epilim levels - "Epilim dose increased" - on that day did anyone tell you that - you understood that day he'd been in hospital and that he'd been - did they tell you how long he'd been in hospital for?---No, madam. All what was told, that he had a fall and he's back in the nursing home.
>
> Did you have an opportunity to look at the hospital notes or any information in relation to the fall - - -?---No.
>
> - - - as it's described?---No, nothing was there.
>
> Because did anyone discuss with you the fact that he'd had a grand fall or he'd had a seizure?---There were used no words at all that day. He had a fall down the street and he was taken to the hospital.
>
> So you weren't told on that day that he'd actually been admitted as a result of an epileptic seizure?---No, nobody contacted, not even the hospital or nobody.
>
> What did they say to you about the fall?---He fell down the street or something, fell down at the shop and he was taken to the hospital, so (indistinct) well, that's all that actually they told, that he was down the street, he had a fall and he was taken to the hospital and he's back.
>
> Because usually when they discharge someone from hospital there are discharge notes and information that accompany the patient home or are sent to the GP?---Because I'm not the GP so they probably didn't know who I am and with the - it doesn't happen necessarily sometimes that we have this conversation most of the time from hospital. In fact, always they send - and they send it to the place where they (indistinct) that's the Corandirk House but then they didn't have anything.
>
> When you say your not the GP, you attended this gentleman on - - -?---On the first time I was called on the 7th, "We have a patient, can you come and see."
>
> So it's surprising that you didn't get any information from either Corandirk House or from the Royal Melbourne Hospital about what had occurred?---I think there, madam, most of the time when you go to these places that is normally - is the norm rather than the exception there - nothing - a patient is sent there, no notes whatsoever there. You sometimes tell the - even the management, "Can you find out from the social worker or from somewhere to get these notes?" Hardly nothing, so you go and see the patient and from the medication and various things you try to make sure you write some medications so that he won't miss the medication but more often than not that continually is lost.
>
> THE CORONER: Did you inquire of the patient or of the people with him as to how he actually came to sustain the fall, given that you'd been treating him for epilepsy?---No, I hadn't been treating him - the epilepsy, madam. That's what I was told, that the - only on this particular first day there when I went there I saw him and I read the drug sheets and did what was necessary to look after a patient, like ordering blood tests, as a responsible doctor, and second time when I went there the story was that he has had a fall down the street and he has been taken to the hospital and been discharged.

Because on that occasion - on the first occasion you saw him you prescribed for epilepsy, that is on 7 October?---Yes. They were his regular medication and they were continued.

Where did you get that information about his regular medication from?---Nursing home probably had some sort of a piece of paper to show all this previous medication.

So then on 13 October do I take it that your response to the situation of his medication - his epilepsy medication - was driven by the pathology results?---Yes, madam.

- as opposed to driven by any information that you had about what had occurred three days earlier when he'd had a seizure - - -?---Of course.

- and fallen?---Of course, yes. I went there to see him after ordering all these blood tests as a follow-up visit.

Given his Epilim levels had fallen was it not appropriate at that time to provide for further investigation as to what was happening with him?---Clinically, if there is an obvious one reason there that - the compliance issue there, yes, and a therapeutic level is low, so we would like to make sure that is raised to the therapeutic level. If a person is having the level - a therapeutic level - and is still is fitting then, yes, maybe it - you look either for a reason or at another medication.

Had you known that he'd had the seizure that had resulted in the fall and the stitches and a three-day admission to the hospital and there he's presenting low Epilim levels - - -?---At this point - - -

- - - would that have changed your position in relation whether he's reviewed by a specialist or not?---Absolutely, yes. He's been already seen by the Royal Melbourne Hospital and they would have done some sort of (indistinct) neurological assessment there and if there were some concerns or some brain scans have to be done or a neurology referral has to be made or whatever they would have done and they would have had done some sort of a - if they had a concern, some follow-up might have been done at that particular time. So it is clinical judgment at that particular time there, how far to investigate or not.

So you would have made that decision about further investigation subject to whatever information was contained in the hospital records?---If the Royal Melbourne wanted things being followed up there, there would have been follow-up appointments sent to Corandirk House, simply because they didn't know me, so nothing came to us. So if Corandirk House did not get or whether they go, I'm unable to comment. But if they had some appointments, that means the hospital was concerned. But if there was no concern, then there may not have been any follow-up.

I guess the missing link here for me, doctor, is that on the 13th there are low Epilim levels and you change his medication?---Yes.

He'd only recently been discharged from the hospital and nobody in there bothered to mention that to you. Nobody mentioned to you that he'd been discharged because of an epileptic event?---No, nobody told me, nobody told me.

Even though you were expressing concern about his Epilim levels and the fact that his epilepsy medication dosage didn't seem quite right?---Yeah, but that is the time I

> went to see him, the second visit. The first visit I went I ordered all the tests, so then I went to see him with the results because I noted that there is a low Epilim level so that's the day I raised the concern that the levels are low. That means some sort of a problem with his complaints. [4]

30. Dr Hewa noted that the results of the blood pathology he had ordered identified low epilim levels. Dr Hewa's evidence was that sub-optimal dosage may have predisposed the patient to seizure activity or at least reduced the level of seizure control. Dr Hewa adjusted the medication and noted that further investigation was not warranted at that stage but if necessary, he would review the situation.

31. The evidence is that at this visit (13 October) he did not have knowledge of the recent fall being related to a seizure and did not himself obtain that information from the patient or the staff at the facility or the facility notes. His evidence is also that had he known he would have followed up the issue and that he would have expected the hospital to do so.

32. On 21 October, Dr Hewa attended at Corandirk House to remove the scalp sutures. He recorded that the patient was stable and '*psychiatrically much improved as a result of the medications being crushed and given in a drink without his knowledge*'. His scalp wound was described as healed.

HISTORY AND FREQUENCY OF EPILEPTIC SEIZURES

33. The evidence identifies that Mr Vourdoulidis had suffered witnessed seizure activity in February 2008, at a further unidentified time later in 2008 and on 10 October 2008 resulting in hospitalisation. The facility notes record that Mr McGee was notified by the facility of Mr Vourdoulidis refusal to take his medication and the difficulties being experienced in administering the medication. There does not appear to be any notation as to seizure activity and there is no notation that Mr McGee was informed about the seizure activity.

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[4] Evidence of Dr Hewa - Transcript 6 December 2012 at page 93.

MEDICATION RELUCTANCE

34. Mr Vourdoulidis was not always co-operative in taking his medication and staff struggled to find a way of administering the directed dosage. The evidence of the facility manager was that Mr Vourdoulidis did not like certain colour medication and this became a problem for the staff at the accommodation facility, although it is apparent from the notes that he on occasions refused to take medication irrespective of its colour.

35. Despite attempts to encourage and assist him to take him medication, Mr Vourdoulidis would often refuse. Mr Singh's evidence was also that Mr Vourdoulidis explained his reluctance to take his anti psychotic medication as because he believed it to bring on his seizures. He also explained to Mr Yazar that he did not like taking them as they made him feel sick. Mr Yazar did not recall that there was any mention made by Mr Vourdoulidis that the reason for the refusal was the colour of the tablet.

36. The concerns expressed by Mr Vourdoulidis were not examined by any medical clinician or discussed in any detail with Mr Vourdoulidis by any qualified person. It does not appear that there was any process or procedure for the documenting of his precise concerns and that the only documenting was of the refusal to take the medication, not the reason for the refusal. No trigger existed for follow up with a specialist epilepsy clinician, despite his previous history of attendance at such a program.

37. The facility manager notified the guardian of the persistent refusal. The evidence of the facility manager is that he was advised by Mr McGee that there was nothing, which might be done to force Mr Vourdoulidis to take the medication. Mr McGee arranged for a medical review by the GP in relation to medication. There was no subsequent follow up by the OPA in relation to the outcome of that medical review or the recommendations as to solving the issue of medication refusal. Mr McGee took the view that there was nothing that could be done to 'force' Mr Vourdoulidis to take the medication, as it was not the anti-psychotic medication being refused. He confirmed in evidence that this was his advice and view. In an email on 11 June 2008 to Mr Singh, it appears that he misunderstood that the medication being refused was the epilepsy medication. Whilst it is submitted by counsel for the OPA that the medication being refused was only the anti-psychotic medication, it appears from the

statement of Mr Singh and also the medical records that the refusal may on occasions also have involved the anti convulsive or 'blue' tablet, Epilim.

38. It is unclear from the medication records whether Mr Vourdoulidis was only refusing his anti-psychotic medication or his anti-convulsant medication or both. The medication records at the accommodation were incomplete and inadequate as to timing or identity of person administering and details of what drugs were administered and those not.

39. However, it appears that the medication colour which he was noted as refusing was generally the anti-psychotic medication, respiridol and seroquel, although often it is referred to by its tablet colour rather than its pharmaceutical name. The refusal of this medication was of concern as sub-optimal dosage resulted in difficulty with Mr Vourdoulidis' mood and behaviour. In order to ensure that Mr Vourdoulidis took his medication Dr Hewa directed that it be crushed and mixed into the patient's orange juice at mealtime without the patient's knowledge.

40. There is a regular record of refusal of medication. There is also a record of notification to the guardian, Mr McGee of the refusal. Mr Singh's evidence was that he advised Mr McGee on a number of occasions as to the medication issues. He conceded that he had not advised of the recent seizure activity.

41. Mr McGee gave evidence that he was unaware of the frequency of the refusal to take medication. He also stated that he was not advised that there had been a recent history of seizures. His evidence was that had he known of these matters he would not have made application to revoke the Guardianship order on 14 November 2008, 10 days before Mr Vourdoulidis' death.

MEDICATION REGIME AND TIMING OF ADMINISTRATION

42. Mr Vourdoulidis' medication was administered on occasions by its secretion in his juice. Dr Hewa consulted on 14 October 2008 and advised the facility manager that in view of the medication refusal that the medication be crushed and administered with his orange juice. It appears that this occurred on a number of occasions from that time, although this method of administration is not noted in the progress notes.

43. Medication was administered from a Webster pack preloaded by the pharmacist. However, it is unclear from the medication records and charts what medication had been administered and when it was administered and what medication had been refused. The notes refer to colour of tablets on some occasions and drug type on other occasions.

MANAGEMENT AND OVERSIGHT OF MR VOURDALIDIS' MEDICAL CARE REQUIREMENTS

44. The evidence is that the medical and guardianship oversight of Mr Vourdoulidis' care was largely directed to his behaviour management rather than any focused attempt to provide comprehensive medical care for epilepsy. Notwithstanding that the Guardianship orders when originally granted, (as evidenced in the reports to the Board by Mr McGee) placed great weight upon the issue of epilepsy and the necessity for medical and medication management of his medical supervision and medication for this condition.

45. No comprehensive expert clinical review of his condition, notwithstanding that he had been experiencing seizures not all of which were able to be attributed to medication refusal.

46. There does not appear to have been any effective co-ordinated regime of medical care, supervision or management of either Mr Vourdoulidis' epilepsy or his medication and a lack of clarity as between those caring for Mr Vourdoulidis as to who was responsible for following up on medical issues. Nor was there any effective exchange of information between the guardian and the medical practitioner or the guardian and the facility.

47. After moving facilities, he no longer attended a specialist clinic. The GP attendances were limited, the GP had no access to any documented medical history and his medication was not managed effectively.

48. It was submitted on behalf of the OPA that the Guardianship was limited in its responsibility to intervene in circumstances of medication refusal. However, Mr Vourdoulidis was not apparently refusing care for epilepsy management and the issue, which apparently arose in this case, was the need for expert clinical assessment of his epilepsy status and medication regime. For whatever reason this did not occur. There was no comprehensive plan for the delivery and supervision of medical care for Mr Vourdoulidis.

49. Mr Vourdoulidis had a psychiatric illness, which resulted in his being unable to make decisions for his own medical and personal care. It was for this reason in part that the Guardianship order was first made. It appears that the Guardianship order was revoked in a circumstance where the Guardianship Board did not have knowledge that he was continuing to be non compliant with medication, that the monitoring of his epilepsy was inadequate and that he had been experiencing recent seizures. The order was revoked on 14 November 2008.

FACTORS CAUSING AND CONTRIBUTING TO DEATH

50. It is apparent that the forensic pathologist is uncertain as to the contribution, if any, that a seizure may have had to the death. Death may have been due to a cardiac incident absent any seizure. Equally, a seizure may have been the cause of death or a contributing factor.

51. In the circumstances of his epilepsy and in the absence of precise understanding as to what time the collapse may have occurred, it is not possible to conclude with the requisite level of certainty that earlier intervention or greater supervision may have resulted in the death being prevented.

52. It is also apparent from the pathologist report that the cardiac disease identified at autopsy is not uncommon in patients with epilepsy particularly those who are subject to hypoxic episodes arising from seizure activity.

53. The absence of expert epilepsy clinical management may have resulted in this issue being overlooked in the more general management of Mr Vourdoulidis' health requirements however I am unable to conclude that such management would have resulted in the death being prevented.

54. The lack of adequate specialist monitoring, in circumstances of what appears to have been more recent increase in seizure activity. resulted in an opportunity being lost to review the adequacy and appropriateness of the medication regime for the epilepsy.

55. Mr Vourdoulidis had been experiencing recent and increased seizure activity. Although it is possible that more comprehensive supervision and management of his epilepsy by way of a specialist clinic or clinician may have resulted in a more extensive and comprehensive review

of his general health, including cardiac health, again I am unable to conclude that this matter was contributory, with the requisite level of certainty.

56. I find that Mr Nikos Vourdoulidis died on 25 November 2008 and that the cause of his death was myocardial fibrosis in a man with epilepsy.

COMMENTS

Pursuant to section 67(3) of the *Coroners Act* 2008, I make the following comment(s) connected with the death:

57. Mr Vourdoulidis was under a Guardianship order to the OPA as to medical matters. This was because it had been established to the satisfaction of the tribunal that he was a man requiring of care and supervision in relation to his medical management.

58. It does not appear that the oversight of the medical management throughout the latter period of the guardianship extended to ensuring that comprehensive services were in place to manage and monitor his epilepsy and associated health conditions. Mr Vourdoulidis had significant private financial resources available to provide for comprehensive specialist medical care, however it appears that this resource was not utilised for these purposes.

59. It also appears that there is some uncertainty lack of clarity as to the scope of the obligation of the OPA in undertaking medical administration functions. This matter would be appropriately considered by that Office with a view to ensuring that the scope of responsibilities for intervention and information provision are identified.

60. There are a number of aspects of the medical care and oversight, which appear to be less than optimal. Somehow, the communication between those having varying levels of responsibility for the care of Mr Vourdoulidis failed. Whilst the boundary of responsibility of the guardian is unclear, the order contemplated oversight and management of medical and health care issues having regard to Mr Vourdoulidis' inability to properly manage his own health or medical care.

61. When the application was renewed on 2 October 2007, it was reported that one of the issues of concern continued to be that Mr Vourdoulidis was not taking his epilepsy medication. This had been a frequent concern during the life of the Guardianship orders. On review in November 2008 it was submitted that the Guardianship order ought to be removed. It does not appear that the issues, which were in contemplation when the order was made, had resolved or improved at the time when the application was made to remove the order.

62. In this case, the evidence establishes that there was a reduction in medical care and management of the epilepsy when he transferred from the Heidelberg facility with no apparent recognition of this reduction by any of those responsible for his care at the time. In particular, there does not appear to have been any detailed analysis of the health issues or medication compliance.

63. Mr McGee gave evidence that the Guardianship responsibility does not encompass responsibility for supervision of day to day affairs of the person subject to the order. Whilst that may be so, it would nevertheless seem to be an appropriate exercise of the Guardianship power to follow up to ensure that the health services, which are put in place, are appropriate and delivered. This did not appear to occur in this case.

64. These matters have been recognised by the OPA and in submissions the OPA commented that the Public Advocate has identified the following issues for her office arising from the medical care provided to Mr Vourdoulidis:

- The difficulty in obtaining a medical practitioner for Mr Vourdoulidis upon his living in new accommodation at Corandirk House.
- Obtaining a review of Mr Vourdoulidis' medication in a timely manner.
- Following through on the implementation of the guardian's decisions or directions by service providers.
- The responsibility of a guardian when service providers are unable to provide the health care required of them.
- Guardians identifying the level of knowledge required of them to direct the appropriate care of the represented person.

70. The OPA noted that there is a need to balance ensuring adequate health care with the need to be as least restrictive and intrusive as possible and that other jurisdictions, such as New South Wales, who operate under different legislation, are more prescriptive in their oversight of medication of people under Guardianship orders. It was also noted that the level of intervention or oversight depended somewhat upon the accommodation setting of the individual. In supported settings (e.g. SRSs, group homes, aged care facilities) the accommodation provider has a duty to manage ongoing health care needs and the guardian's role may simply be to ask questions of the provider. In less supported settings, the role may be more extensive.

71. The minutes record that the matters discussed pointed to the following issues for consideration by the Advocate Guardian program:

- In terms of reactivity, what should trigger a more active than normal role for a guardian concerning a person's medical treatment regime?
    - Rejection by the person of proposed medication;
    - Old and unreviewed diagnoses; and
    - Dual diagnoses.
- When it comes to being proactive – the role of the guardian (with power to make health care decisions) will depend on the accommodation setting. The more regulated the setting, the less onerous the duty. But at the very least we should contain on the file information such as:
    - What a represented person's treatment regime is; and
    - When it was last reviewed.

72. The Advocate Guardian program is planning a trial implementation of new procedures in relation to health care guardianship.

73. The Public Advocate considers that a copy of patient medical records held by general practitioners should be provided to any subsequent general practitioner, particularly where the patient may be unable to give a clear and accurate account of his or her own medical history due to intellectual disability or mental illness.

74. It is apparent from this submission that the OPA in its comprehensive review of the circumstances of this case has identified similar issues relating to future prevention as those which have been apparent to and commented upon by the Coroner. In that context the recommendation I intend to make is directed only to encourage the further consideration of these issues in the terms described in paragraphs 70 to 73 herein.

RECOMMENDATIONS

Pursuant to section 72(2) of the *Coroners Act* 2008, I make the following recommendation(s) connected with the death:

1. That the Public Advocate review OPA policy in relation to the scope of exercise of guardianship powers in particular in relation to the level of supervision and follow up of delivery of medical treatment.

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

The Family of Mr Vourdoulidis
The Interested parties
The Investigating member
The Office of the Public Advocate
State Trustees

Signature:

CORONER K. M. W. PARKINSON
Date: 27 May 2013