IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2008 002029

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of STEVEN SIMON KARASTAVROU

Delivered On:	6 August 2014
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street Southbank, Victoria, 3006
Hearing Dates:	15-16 October 2012
Findings of:	CORONER JACQUI HAWKINS
Representation:	Mr J Goetz appeared on behalf of St Vincent's Hospital
Police Coronial Support Unit	Leading Senior Constable R Treverton appeared to assist the Coroner

I, Jacqui Hawkins, Coroner, having reviewed the investigation into the death of

STEVEN SIMON KARASTAVROU

AND the inquest[1] held by Coroner Hendtlass in relation to this death on 15-16 October 2012

at the Coroners Court, Level 11, 222 Exhibition Street, Melbourne, Victoria, 3000

find that the identity of the deceased was STEVEN SIMON KARASTAVROU

born on 15 December 1959

and the death occurred on 14 May 2008

at 44 Fordham Avenue, Camberwell, Victoria, 3124

from:

1 (a) CARDIOMEGALY AND FATTY LIVER IN A MAN WITH ALCOHOL INTOXICATION

in the following circumstances:

1. Mr Karastavrou was a 48 year old unemployed man with paranoid schizophrenia who lived with his elderly mother, Mrs Despina Karastavrou, at 44 Fordham Avenue, Camberwell. Mr Karastavrou had completed a philosophy degree, worked in the public service as a clerical officer prior to 1994 and for a short time worked for his brother's accountancy practice.

2. He separated from his wife of six years in 1991 following which he was cared for by his mother. He was heavily reliant on her for cooking, cleaning and buying his alcohol. Mr Karastavrou was one of four siblings and his sister, Betty Mantalvanos, also assisted with his care and management at home.

3. In 2000, the State Trustees were appointed as Mr Karastavrou's financial administrator, providing him with $75 a week. Mr Karastavrou did not pay board to his mother nor contribute to food or bills. It appears he spent his money on alcohol, drugs, gambling and cigarettes.

4. Mr Karastavrou's medical history included high cholesterol, hypertension and diabetes. He smoked cigarettes and cannabis, had a poor diet and led a sedentary lifestyle. Mrs Karastavrou said that he would drink two bottles of wine or spirits a day.

5. His psychiatric history was particularly long and complex including chronic paranoid schizophrenia which was compounded by poly-substance abuse (alcohol, cannabis and amphetamines). He was first diagnosed with schizophrenia in 1985 and his first contact with the public mental health system was in 1989.

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1 This finding does not purport to refer to all aspects of the evidence obtained in the course of the investigation. The material relied upon included statements and documents tendered in evidence together with the transcript of proceedings and submissions of legal counsel. The absence of reference to any particular aspect of the evidence, either obtained through a witness or tendered in evidence does not infer that it has not been considered.

6. In 2008, Mr Karastavrou was a patient of the Hawthorn Community Mental Health Service (HCMHS); an outpatient component of the Mental Health Service at St Vincent's Hospital.

7. Over the course of his life, Mr Karastavrou had been the subject of a number of Community Treatment Orders (CTO)[2]. His last admission to the inpatient psychiatry unit at St Vincent's Hospital was on 31 December 2007 in the context of a CTO being revoked due to a deterioration of his mental health. He remained at St Vincent's Hospital for one month and was released on another CTO with follow-up from HCMHS.

8. Ms Helen Peddington worked at HCMHS and was Mr Karastavrou's Psychiatric Case Manager from August 2004 until his death. This included home visits to administer medication, monitor adherence to his treatment plan, coordinate medical reviews, assess physical health needs, encourage attendance at his general practitioner, liaise with carers and family members and provide education around substance abuse and alcohol dependence. Ms Peddington also assisted with requests for funding and assistance for transport.

9. Ms Peddington would usually review him on a fortnightly basis. Due to an escalation of Mr Karastavrou's behaviour approximately nine months prior to his death, Ms Peddington was assisted by other clinicians with his case management appointments.

10. Mr Karastavrou consistently displayed little interest in engaging with psychiatric care or case management. Ms Peddington characterised his interactions as "frequently irritable, demanding, condescending and rude, with the developed therapeutic relationship being centred around the schedule of his prescribed intramuscular antipsychotic administration".[3]

11. The evidence of Ms Peddington is that from January 2008 Mr Karastavrou began drinking one or two bottles of spirits per day.[4] This is consistent with the evidence of Mrs Karastavrou who reported that he was frequently intoxicated to the point of stupor and incoherence, such that he was rejecting food and at times was incontinent.

12. On 15 February 2008, Dr Patel and Ms Peddington conducted a home visit as part of a medical review. Dr Patel assessed Mr Karastavrou as over-sedated and reduced the frequency of Zuclopenthixol[5] from 300 milligrams intramuscularly each fortnightly to every three weeks.[6]

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2 A community treatment order pursuant to section 14 the Mental Health Act 1986 (Vic) (applicable at the time of Mr Karastavrou's death) means an order requiring the person to obtain treatment for their mental illness while not detained in an approve mental health service

3 Exhibit 2 – Statement of Helen Peddington dated 29 September 2012, Inquest Brief, p6

4 Exhibit 2 – Statement of Helen Peddington dated 29 September 2012, Inquest Brief, p7

5 Zuclopenthixol (Clopixol) is used to treat acute psychotic episodes or to treat exacerbation of psychoses associated with schizophrenia. It is usually administered by intramuscular injection every 2-4 weeks for maintenance treatment of noncompliant patients.

13. Dr Patel and Ms Peddington also conducted a home visit on 14 March 2008. According to Dr Patel, Mr Karastavrou was adamant he did not wish to change his alcohol and amphetamine use and declined an offer to be admitted to hospital for detoxification. Mr Karastavrou was not concerned about the hazards associated with his health and the risk of sudden death due to his alcohol and amphetamine abuse.[7]

14. At the request of Ms Peddington, a family meeting was held on 23 April 2008 with Mrs Karastavrou, Ms Mantalvanos and Dr Patel. The family reported that he had recently been more cooperative, less demanding and was drinking less alcohol but that he continued to use amphetamines and had difficulty managing his self care. Mrs Karastavrou indicated that she did not wish to initiate any change to Mr Karastavrou's current situation including accommodation prior to her own death.[8]

15. On 1 May 2008 Ms Peddington and a nurse from HCMHS, Jon Bilboa, attended Mr Karastavrou's home to administer the Zuclopenthixol. Ms Peddington noted that Mr Karastavrou's self care had noticeably improved however there was an ongoing risk to his physical health due to his substance abuse, diet, sedentary lifestyle and pre-existing physical conditions.[9]

16. On Wednesday 14 May 2008, Mr Karastavrou was at home with his mother and had consumed alcohol. At 3am, Mrs Karastavrou went into Mr Karastavrou's bedroom and found him collapsed on the floor, not breathing. She called an ambulance and paramedics found Mr Karastavrou deceased on arrival.

JURISDICTION

17. At the time of Mr Karastavrou's death the *Coroners Act 1985* (Vic) applied. From 1 November 2009, the *Coroners Act 2008* (Coroners Act) has applied to the finalisation of investigations into deaths that occurred prior to its introduction.

18. The Coroners Court of Victoria is an inquisitorial jurisdiction.[10] Section 67 of the Coroners Act provides that a coroner must find, if possible, the identity of the deceased, the cause of death and, in some cases, the circumstances in which the death occurred.

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6 Exhibit 2 – Statement of Helen Peddington dated 29 September 2012, Inquest Brief, p9, Exhibit 3 – Statement of Dr Gunvant Patel dated 31 July 2009, Inquest Brief, p12

7 Exhibit 3 – Statement of Dr Gunvant Patel dated 31 July 2009, Inquest Brief, p13

8 Exhibit 2 – Statement of Helen Peddington dated 29 September 2012, Inquest Brief, p10

9 Medical Records of St Vincent's Hospital

10 Section 89(4) of the Coroners Act.

19. The role of a coroner in this State includes the independent investigation of deaths to contribute to a reduction in the number of preventable deaths, the promotion of public health and safety, and the administration of justice.

20. A coroner may comment on any matter connected with the death, may report to the Attorney-General and may make recommendations to any Minister, public statutory authority or entity, on any matter connected with the death, including recommendations relating to public health and safety or the administration of justice.[11]

ASSIGNMENT OF INQUEST FINDINGS

21. Coroner Hendtlass retired on 31 December 2013 without completing the inquest findings in this investigation. The State Coroner of Victoria, His Honour Judge Gray, assigned the completion of this Finding into Death with Inquest (Finding) to me pursuant to section 96 of the Coroners Act.

22. In writing this Finding, I have conducted a thorough forensic examination of the evidence including reading all the witness statements contained within the inquest brief, supplementary statements, exhibits, submissions and transcripts of both the directions hearing and the Inquest.

CORONIAL INVESTIGATION AND INQUEST

23. Coroner Hendtlass conducted an investigation and held an inquest into Mr Karastavrou's death on 15-16 October 2012.

24. At the conclusion of the Inquest Counsel for St Vincent's Hospital provided written submissions which I have considered for the purpose of this finding.

Viva Voce evidence at the Inquest

25. The following witnesses gave *viva voce* evidence at the Inquest:

- Ms Betty Mantalvanos, sister of Mr Karastavrou;
- Helen Peddington, Psychiatric Case Manager, Hawthorn Community Mental Health Service, St Vincent's Hospital;
- Dr Gunvant Patel, Supervising Psychiatrist, St Vincent's Mental Health, St Vincent's Hospital; and
- Dr Peter Bosanec, Director of Clinical Services, St Vincent's Mental Health Service, St Vincent's Hospital.

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11 Sections 72(1) and (2) of the Coroners Act.

Issues investigated

26. Section 67 of the Coroners Act requires me to find:

    a) the identity of the deceased
    b) the cause of death and
    c) the circumstances in which the death occurred.

IDENTITY OF THE DECEASED

27. I find that the identity of Steven Simon Karastavrou was without dispute and required no additional investigation.

CAUSE OF DEATH

28. On 16 May 2008, Dr Michael Burke, Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM), conducted a post mortem examination on Mr Karastavrou. Dr Burke attributed Mr Karastavrou's medical cause of death to 1a) CARDIOMEGALY AND FATTY LIVER IN A MAN WITH ALCOHOL INTOXICATION.

29. The examination revealed a fatty liver which Dr Burke noted can be associated with significant metabolic abnormalities including profound hypoglycaemia.[12] He also noted that Mr Karastavrou's heart was enlarged which may reflect hypertension and/or excessive alcohol consumption and may have caused a sudden cardiac arrhythmia.

Toxicological Analysis

30. Toxicological analysis revealed a blood alcohol concentration of 0.23g/100mL. Dr Burke commented that this level was quite elevated and could be associated with respiratory depression. There was no evidence of renal impairment and no other common drugs or poisons were identified.[13]

31. A supplementary toxicological report was requested which showed a Zuclopenthixol concentration of ~150ng/ml.

Did Zuclopenthixol contribute to Mr Karastavrou's death?

32. Given the elevated level identified through toxicological analysis, the contribution of Zuclopenthixol to the cause of death was considered as part of the Inquest. When injected intramuscularly, Zuclopenthixol is slowly released into the circulation. Symptoms of Zuclopenthixol toxicity include a decreased conscious state.

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12 Autopsy Report, Inquest Brief, p20

13 Autopsy Report, Inquest Brief, p20

33. According to Professor Olaf Drummer, Head of Forensic Scientific Services at VIFM:

> the drug, as with all anti-psychotic drugs has the potential to cause adverse reactions but these are not common. When they occur these are often seen clinically, dystonia, altered mental status or cardiac arrhythmias.[14]

34. Dr Dimitri Gerostamoulos, Chief Toxicologist at VIFM noted that "two fatalities have been reported with blood concentrations of Zuclopenthixol ranging from 395ng/mL to 680ng/mL".[15]

35. According to the Manufacturer's Guidelines, Mr Karastavrou prescribed dosing and frequency of 300mg every three weeks was within the manufacturer's limits.[16]

36. Mr Karastavrou's most recent injection was on 1 May 2008; 13 days prior to his death. Ms Mantalvanos advised that her mother was suspicious about the administration of Zuclopenthixol on this day and thought that he may have received an overdose. Ms Mantalvanos provided evidence that her mother thought he became very sick, was vomiting and incontinent, and had no appetite or no strength to move or otherwise do anything.[17]

37. When questioned at inquest whether she may have accidentally given Mr Karastavrou an overdose, Ms Peddington was adamant that she had not.[18] She testified that she obtained two 200mg ampoules of Zuclopenthixol prior to her attendance at Mr Karastavrou's home. She administered one and a half ampoules to Mr Karastavrou and disposed of the remainder of the second ampoule into the sharps container.[19] According to Ms Peddington, this was consistent with the signed treatment sheet and the ordered dose. The frequency, route and patient were all checked and correct at the time of administration.[20]

38. Dr Burke noted that there was little information in the forensic literature about interpreting Zuclopenthixol levels post-mortem. Similarly, Professor Drummer indicated that the degree of redistribution is largely unknown however, given its high fat solubility, blood concentrations are likely to increase substantially post mortem.[21]

39. Dr Burke concluded that because Zuclopenthixol is subject to post mortem redistribution, the significance of the elevated level is difficult to determine.[22] Dr Gerostamoulos concurred with this view[23] as did Professor Drummer.[24]

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14 Statement of Professor Olaf Drummer dated 21 October 2009, Inquest Brief, p31

15 Supplementary toxicology report, Inquest brief, p31

16 See inquest brief, p46 and p120

17 Exhibit 1 - Statement of Ms Mantalvanos undated.

18 Transcript of evidence, p81

19 Transcript of evidence, p81

20 Exhibit 2 – Statement of Helen Peddington dated 29 September 2012, Inquest Brief, p10

21 Statement of Professor Olaf Drummer dated 21 October 2009, Inquest Brief, p32

22 Autopsy Report, Inquest Brief, p20

40. Associate Professor Doherty[25] similarly believed that although the levels of Zuclopenthixol were abnormally high it was likely related to redistribution after death.[26] He further commented that the sedative effect of alcohol is increased in a person who is on Zuclopenthixol.

41. Although it is possible that Mr Karastavrou was administered a larger than normal dose of Zuclopenthixol, it is also possible that the concentration is consistent with a standard dose coupled with post mortem elevation due to redistribution.

Conclusions as to cause of death

42. I accept the evidence of Ms Peddington that she administered the correct dose of Zuclopenthixol to Mr Karastavrou on 1 May 2008. As such, there is insufficient evidence to support a conclusion that that Mr Karastavrou received an overdose of Zuclopenthixol.

43. I further accept the evidence of Professor Drummer, Associate Professor Doherty, Dr Burke and Dr Gerostamoulos with respect to the post mortem redistribution of Zuclopenthixol. Accordingly, I find that the high level of Zuclopenthixol found post mortem did not cause, nor likely contribute, to Mr Karastavrou's death.

44. Finally, I accept and adopt Dr Burke's conclusion that no one factor lead to Mr Karastavrou's death but rather, the combination of heart and liver disease, in conjunction with his alcohol intoxication, probably led to a sudden cardiac arrest.[27]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

45. I do not propose to recount or summarise all of the evidence but rather refer to the parts that are necessary touching upon the relevant circumstances investigated as part of the inquest.

Issues investigated as part of the Inquest

46. For the purpose of this Finding I have considered the overall case management of Mr Karastavrou's psychiatric condition including:

- Conditions of the Community Treatment Order;
- Knowledge of risks associated with Mr Karastavrou's health;
- Mr Karastavrou's engagement with mental health services
- Mental health service engagement with Mr Karastavrou's family
- St Vincent's Hospital Initiatives

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23 Supplementary Toxicology Report Inquest Brief, p30

24 Statement of Professor Olaf Drummer dated 21 October 2009, Inquest Brief, p32

25 Associate Professor Doherty is Consultant Psychiatrist who reviewed the medical records of St Vincent's Hospital

26 Inquest brief, p97

27 Autopsy Report, Inquest Brief, p21

47. I was assisted by two statements provided by Associate Professor Peter Doherty who reviewed the medical records of St Vincent's Hospital and provided an opinion as to the appropriateness of care and management by staff.[28]

Conditions of the Community Treatment Order

48. Mr Karastavrou had been on various CTOs since 1994. CTO's are generally renewed every year; for renewal to occur, the individual must meet the criteria under the *Mental Health Act* 1986 that they require ongoing involuntary treatment and care.

49. Mr Karastavrou's CTO was last reviewed in December 2007 at which time the Mental Health Review Board was satisfied Mr Karastavrou's continued involuntary treatment was necessary.

50. On 31 December 2007, Mr Karastavrou attended Tullamarine Airport and tried to board a plane without a ticket. Due to this incident Dr Patel formed the view that Mr Karastavrou's condition had deteriorated and he needed urgent hospitalization. Accordingly, his CTO was revoked and he was treated at St Vincent's Hospital between that time and 31 January 2008.

51. After his release from St Vincent's Hospital, Mr Karastavrou was subject to a new CTO which was valid for one year.[29] The terms of the CTO were that he:

- Be available for 2 weekly visits by his case manager, to administer the medication, or attend the clinic fortnightly for depot administration;
- Be available for regular medical review as required;
- Participate in regular case management review as required;
- Contact with case manager, duty or triage workers in times of stress, distress, symptom exaggeration and risk; and
- Liaise with administrator, family, GP and other health professionals.

Knowledge of risks associated with Mr Karastavrou's health

52. Mr Karastavrou's medical records note numerous occasions were he was informed about the risks associated with his poor health, lifestyle and substance abuse. Ms Mantalvanos and Mrs Karastavrou were also aware that due to his lifestyle, death was a current and immediate risk.

53. On 29 February 2008, Ms Peddington telephoned Ms Mantalvanos and informed her that there was a risk that Mr Karastavrou might die if he continued his pattern of substance abuse. She noted that apart from the damages caused to his body when under the influence of substances, he was at risk of immediate harm or death, for example from an obstructed airway.[30]

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28 I have accorded this opinion appropriate weight in light of it having been provided to the Court by counsel for St Vincent's Hospital.

29 Medical Records of St Vincent's Hospital

30 St Vincent's Hospital Medical Records

54. Ms Peddington noted that whilst Mr Karastavrou appeared to accept that there were deleterious physical consequences inherent to his lifestyle and substance use profile, "he continued to reject most health education or suggestions regarding interventions aimed at improving his physical health, apart from consistently taking multivitamins to reduce the risk of alcohol-related brain damage".[31]

Alcohol and Substance Abuse

55. Despite the knowledge of the risks associated with his lifestyle, in the last months of Mr Karastavrou's life he was drinking excessively and using amphetamines regularly when he could access them.

56. At the time of his death, severe substance abuse was not a legislated ground for compulsory detention.[32] This is no longer the case, following the introduction of the *Severe Substance Dependence Treatment Act* 2010 which became effective in 2011. The objective of the Act is to provide for the detention and treatment of persons with severe substance dependence where it is necessary as a matter of urgency to save the persons life or to prevent serious damage to a person's health.

57. Associate Professor Doherty believed Mr Karastavrou would have met that criteria of this Act, had it been in place in 2008. It would have allowed the compulsory detention of Mr Karastavrou (not exceeding 14 days), to assist with detoxification and assistance with his substance abuse.[33]

58. Dr Patel believed that a drug and alcohol specialist would have been of assistance to Mr Karastavrou but considered he would have required long-term assistance and that Mr Karastavrou would have required much more than 14 days of compulsory detention. He stated:

> I think that for someone like Steven, to put him in a facility on an involuntary basis for 14 days to manage his substance abuse, and then to expect that after that time he'll be ready to be then managed in the community with his ... substance abuse, is I think grossly unrealistic.[34]

59. Dr Patel noted that an Outreach drug and alcohol worker would have been beneficial for Mr Karastavrou. However, they would probably have needed to interact very frequently over a long period of time to even consider being able to make changes.[35]

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31 Exhibit 2 – Statement of Helen Peddington dated 29 September 2012, Inquest Brief, p8

32 Statement of Associate Professor Peter Doherty, Inquest Brief, p43

33 Statement of Associate Professor Peter Doherty, Inquest Brief, p43

34 Transcript of evidence, p110

35 Transcript of evidence, p127

Mr Karastavrou's engagement with mental health services

60. It was common knowledge among the mental health clinicians that Mr Karastavrou was not happy being on a CTO and was therefore difficult to engage. Ms Peddington thought Mr Karastavrou did not believe he had a mental illness and resented that he had to accept medication and treatment.[36]

61. In fact Ms Peddington noted that "multiple and ongoing attempts to engage Mr Karastavrou including focusing on goals or interests were unsuccessful".[37] Consequently, Ms Peddington believed she did not have any therapeutic relationship with Mr Karastavrou other than to administer his medication.[38]

62. Dr Patel agreed that Ms Peddington was not alone with experiencing difficulty engaging with Mr Karastavrou. In fact Dr Patel said any case manager would have experienced the same antagonism from him.[39]

Mental health service engagement with Mr Karastavrou's family

63. Due to Mr Karastavrou's virtual non-engagement with services, engagement with his family by the mental health clinicians was an essential, if not delicate, issue.

64. The medical notes record many interactions by telephone and in person with Mr Karastavrou's mother or sister. In the last few months of his life there was a consistent theme in these discussions about the risk of sudden death to Mr Karastavrou.

65. Problematically, Mr Karastavrou did not like health clinicians communicating with his family and withheld permission for them to do so. According to Ms Peddington, when clients withhold permission it becomes a balancing exercise between the client's rights and the rights of the carers.[40]

66. Ms Peddington believed she did need to meet with the family to discuss Mr Karastavrou's health, particularly in the month preceding his death. She further believed that "it had reached the point where really the issue of his safety had overridden to some degree his right to withdraw [consent]...the carer's rights were paramount".[41] Accordingly, conversations generally occurred when Mr Karastavrou was not around, either outside the house on the way to the car, or through phone conversations.

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36 Transcript of evidence, p77

37 Transcript of evidence, p57

38 Transcript of evidence, p77

39 Transcript of evidence, p87

40 Transcript of evidence, p61

41 Transcript of evidence, p61 and as described in section120A of the *Mental Health Act* 1986

67. It appears that during the first few months of 2008, Mr Karastavrou's condition was deteriorating. The meeting held on 23 April was important because there was a "situation of a long term chronic pattern of significant health risk because of the lifestyle and the poly substance abuse".[42]

68. Despite the family's impression that he seemed to be improving, clinical notes indicate that Mr Karastavrou showed marked avolition and disorganisation and could not manage self care. Mrs Karastavrou and Ms Mantalvanos were aware that if changes were not implemented that his risk of death was very high.

69. Mrs Karastavrou commented that she was focused on caring for Mr Karastavrou and meeting his expectations/demands even at a great financial cost to herself, however she had no wish for change. The plan for the family was to continue with his management and to attempt to work on Mr Karastavrou's expectations and appropriate limit setting.[43]

70. Although preferences for Mr Karastavrou's care and accommodation were considered at the meeting, the focus was on the need for change and to increase Mrs Karastavrou's awareness that "she was enabling his behaviour through love".[44] An example of this is that she would purchase and store alcohol for Mr Karastavrou in the garage and provide money for drugs. This situation was convenient for Mr Karastavrou and provided little incentive for him to change.[45]

71. Overall, Associate Professor Doherty was impressed by the clinician's engagement with the family and considered staff had given clear consideration of the family's views and needs.[46]

Accommodation considerations

72. Mr Karastavrou's accommodation was also canvassed at the family meeting. Specifically, an alternative accommodation environment with a greater level of staff support was considered. This would have assisted clinician's to work more actively and assertively with him particularly with respect to his lifestyle and substance abuse.[47]

73. To this end, the prospect of a secure unit was discussed with the family. However, Dr Patel believed this would not have been suitable and that it was more appropriate for him to have been placed in a less restrictive facility to receive ongoing 24 hour support.[48]

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42 Transcript of evidence, p98
43 Medical Records Community Mental Health Notes
44 Transcript of evidence, p62
45 Transcript of evidence, p72
46 Statement of Associate Professor Peter Doherty, Inquest brief, p44
47 Transcript of evidence, p106
48 Transcript of evidence, p106

74. Conversely, Associate Professor Doherty said that a community care unit was not appropriate because: his level of substance abuse; poor compliance; independence and unwillingness to follow clinical directions; and his disinterest in rehabilitation, all suggest that it would have been a failed exercise.[49] Associate Professor Doherty therefore considered a secure unit the best option.[50] His rationale for this was that it provides long term care to persons who are mentally ill and so vulnerable or so disturbed that they cannot live in the community. He believed that the risks need to be significantly high for the person to be contained and treated in a secure unit.

St Vincent's Hospital Initiatives

75. Dr Bosanec gave evidence of a number of new initiatives introduced by St Vincent's Hospital to improve mental health service delivery, including:

- High Risk Review Panel – meets monthly and provides proactive reviews on patients with complex backgrounds and circumstances. It is focused on patients who pose a risk to themselves or others or have ongoing risks to their general health. Mental health clinicians at St Vincent's now have the ability to refer a patient for consideration.
- Metabolic monitoring – This now ensures that a mental health patient's continuing metabolic results, including pathology tests are recorded on a single sheet, which can be easily accessed by clinicians.
- Appointment of a Carer Consultant – this position provides peer support for carers who may be family members. The benefits to mental health patients and their carers include the following augmentation of education and the patient's condition and treatment options together with psychological and social support, minimization of carer burden and distress and augmentation of engagement of patients and their carers with the Mental Health Service and treatment.
- Wellness Recovery Action Plan – incorporates the wishes of the patient in relation to their mental health care and recovery and allows for advance consideration regarding changes in their well-being. The patients detail how they wish to be treated should their condition deteriorate and they have to be readmitted into St Vincent's Hospital in a more restrictive care setting.
- Family Recovery Action Plan – provides for a process of engaging the family/carer in terms of discussing how to support the patient in the process of recovery.

FINDINGS

76. I accept and adopt the medical cause of death provided by Dr Michael Burke and find that Mr Steven Karastavrou died on 14 May 2008 from 1a) CARDIOMEGALY AND FATTY LIVER IN A MAN WITH ALCOHOL INTOXICATION.

77. I accept that no one factor lead to Mr Karastavrou's death, rather the combination of heart and liver disease together with alcohol intoxication, resulted in a sudden cardiac arrest.

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49 Statement of Associate Professor Peter Doherty, Inquest brief, p42

50 Inquest brief, p42

78. I find that Mr Karastavrou was at a high risk of death because of his significant co-morbidities including paranoid schizophrenia and alcohol and poly substance abuse.

79. I find that Zuclopenthixol was an appropriate medication to treat Mr Karastavrou's schizophrenia and I further find that the post-mortem levels, whilst unusually high, did not contribute to his death.

80. I find that the care and management provided by St Vincent's Hospital was appropriate and reasonable in the circumstances particularly given that Mr Karastavrou was not motivated to engage or to change his behaviour in relation to his alcohol and poly substance abuse.

81. I find that the complexities of Mr Karastavrou's case were recognized, considered and managed accordingly. In particular, I acknowledge the dedication of Ms Peddington and Dr Patel who worked hard to assist and support Mr Karastavrou with his mental illness and the risks associated with his health and lifestyle.

82. Finally, I acknowledge the impact Mr Karastavrou's death has had on those who loved him and I express my sympathy to his family and friends. In particular, I would like to acknowledge the tireless work of Mrs Karastavrou and Ms Mantalvanos who appeared to have showed Mr Karastavrou unconditional love and support for his ongoing mental illness.

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

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

- Mrs Despina Karastavrou
- Ms Betty Mantalvanos
- St Vincent's Hospital

Signature:

Jacqui Hawkins

CORONER JACQUI HAWKINS
Date: 6 August 2014

Coroners Court of Victoria