IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 006149

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Leveasque Peterson
Deceased:	Amelia Antonopoulos
Date of birth:	29 May 1962
Date of death:	25 October 2022
Cause of death:	1(a) ASPIRATION PNEUMONIA IN A WOMAN WITH DOWN'S SYNDROME WITH DEMENTIA AND EPILEPSY.
Place of death:	Northern Hospital Epping, 185 Cooper Street, Epping, Victoria, 3076
Keywords:	In Care; Natural Causes

INTRODUCTION

1. On 25 October 2022, Amelia Antonopoulos was 60 years old when she died at Northern Hospital Epping.

2. Amelia loved music and "all things Greek" including music, food and celebrations. She had two younger sisters and three nephews.

3. Amelia had a past medical history of Trisomy 21 (Downs Syndrome), dementia, epilepsy, visual impairment, and chronic constipation. She received support under a National Disability Insurance Scheme (**NDIS**) Participant Plan

4. She resided in disability support accommodation at Aruma in Thomastown, Victoria and required assistance with all activities of daily living. She was non-verbal.

5. Her sisters were her medical treatment decision makers under the *Medical Treatment Planning and Decisions Act 2016* (Vic).

THE CORONIAL INVESTIGATION

6. Amelia's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act).

7. This is because, immediately before death, Amelia was a person "in care", meaning that she was an SDA resident residing in an SDA enrolled dwelling. The death of a person "in care" is a mandatory report to the Coroner even if the death appears to have been from natural causes.

8. Generally, the Coroner must hold an inquest into the death of a person "in care". However, under section 51(3A) and (3B) of the Act, the Coroner is not required to hold an inquest if the Coroner considers that the death was due to natural causes, on the basis of a report from a medical investigator which includes an opinion as such.

9. In this instance, I am satisfied on the basis of a report from Forensic Pathologist Dr Sarah Parsons of the Victorian Institute of Forensic Medicine (**VIFM**) dated 21 November 2022 that Amelia's death was due to natural causes and therefore that an inquest is not required. The report of Dr Parsons is discussed further below in relation to the medical cause of death.

10. 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.

11. 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.

12. Victoria Police assigned Senior Constable Joseph Tsagaratos to be the Coroner's Investigator for the investigation of Amelia's 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.

13. This finding draws on the totality of the coronial investigation into the death of Amelia Antonopoulos 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.[1]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

14. On 1 October 2022, Amelia presented to the Northern Hospital Emergency Department via ambulance. Her carers noted that her overall health had been gradually decreasing over the past 5 months as evidenced by increased lethargy, vomiting and decreased mobility, and that she had an episode that day after vomiting where she became unresponsive.

15. Amelia was diagnosed with right basal pneumonia and received treatment. During admission, she also received input from the palliative care team, noting that she had already been

[1] 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.

receiving palliative care in the community for decreased function and poor oral intake in the previous few weeks.

16. On 10 October 2022, it was determined that Amelia had significantly improved.

17. On 13 October 2022, a meeting was held with Northern Health staff, Aruma staff, and Amelia's sisters to plan for her care post discharge. Northern Health medical staff confirmed that Amelia had a high risk of further aspiration and recurrent aspiration pneumonia. Amelia's sisters agreed to palliation if there were further recurrent episodes of aspiration pneumonia.

18. Amelia's aspiration pneumonia resolved and she was discharged on 21 October 2022.

19. On 23 October 2022, she represented to the Emergency Department after Aruma care staff observed decreased oral intake and vomiting, respiratory distress and saturated oxygen levels. During examination in ED, she was noted to be tachycardic. Investigations showed worsening renal function, decreased albumin levels, and high C-reactive protein levels.

20. Despite treatment, Amelia demonstrated minimal improvement in blood pressure, was unresponsive to intravenous fluids and becoming peripherally shut down. In consultation with Amelia's sisters, it was determined to transition to palliative care.

21. Amelia subsequently died on 25 October 2022.

Identity of the deceased

22. On 27 October 2022, Amelia Antonopoulos, born 29 May 1962, was visually identified by her sister, Georgia Akbari. Identity is not in dispute and requires no further investigation.

Medical cause of death

23. On 28 October 2022, Forensic Pathologist Dr Sarah Parsons from the Victorian Institute of Forensic Medicine (VIFM) conducted an external examination and reviewed relevant materials, including a post mortem CT scan, the police report of death (Form 83), the hospital Medical Deposition, medical records, and progress notes from Aruma. Dr Parsons provided a written report of her findings dated 10 November 2022.

24. The post mortem CT scan showed cerebral atrophy, basal ganglia calcification, increased lung markings and emphysema.

25. Taking into account all available information, Dr Parsons provided an opinion that a reasonable formulation for the medical cause of death was:

    1 (a) ASPIRATION PNEUMONIA IN A WOMAN WITH DOWN'S SYNDROME WITH DEMENTIA AND EPILEPSY.

26. I accept and adopt Dr Parson’s opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Amelia Antonopoulos, born 29 May 1962;

    b) the death occurred on 25 October 2022 at Northern Hospital Epping, 185 Cooper Street, Epping, Victoria, 3076, from aspiration pneumonia in a woman with Down's Syndrome with dementia and epilepsy; and

    c) the death occurred in the circumstances described above.

28. Having considered all of the circumstances, I am satisfied that Amelia died of natural causes and have not identified any concerns in relation to the quality of care provided in the period proximate to her death.

I convey my sincere condolences to Amelia’s family for their loss.

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

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

Georgia Akbari, Senior Next of Kin

Senior Constable Joseph Tsagaratos, Coroner's Investigator

Signature:

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Coroner Leveasque Peterson

Date : 18 January 2024

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.