IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 006312

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

(Amended pursuant to section 76A of the Coroners Act 2008)[1]

Findings of:	Coroner David Ryan
Deceased:	Peter Fiorakis
Date of birth:	5 July 1950
Date of death:	2 November 2022
Cause of death:	1(a) Complications of small bowel obstruction in a man with multiple medical co-morbidities
Place of death:	Austin Hospital, 145 Studley Road, Heidelberg, Victoria
Keywords:	In care; disability services; natural causes

[1] This document is an amended version of the Finding into the death of Peter Fiorakis dated 9 December 2022. The Finding has been amended pursuant to section 76A of the *Coroners Act 2008* to insert paragraphs 1 to 19 to include circumstances of Mr Fiorakis' death.

INTRODUCTION

1. On 2 November 2022, Peter Fiorakis was 72 years old when he passed away at the Austin Hospital. At the time of his death, Mr Fiorakis resided in a supported residential care facility at 1 Henderson Court, Bundoora, which was managed by Plenty Residential Services.

2. Mr Fiorakis' medical history included intellectual disability, schizophrenia, recurrent deep vein thrombosis, cardiomegaly, chronic obstructive pulmonary disease (**COPD**), ischaemic heart disease and hiatus hernia.

THE CORONIAL INVESTIGATION

3. Mr Fiorakis' 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.

4. On 9 December 2022, having commenced an investigation into Mr Fiorakis' death, I determined to discontinue my investigation under section 17 of the Act.

5. Since concluding the investigation, it has come to my attention that Mr Fiorakis' death satisfied the definition of a reportable death in section 4(2)(c) of the Act as Mr Fiorakis was, immediately before his death, a person placed in care or custody by virtue of his status as a Specialist Disability Accommodation (**SDA**) resident residing within an SDA enrolled dwelling. In those circumstances, I am required by the Act to make findings with respect to the circumstances of Mr Fiorakis' death and have done so accordingly within this amended 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.

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. This finding draws on the totality of the coronial investigation into the death of Mr Fiorakis. While 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.[2]

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

Circumstances in which the death occurred

9. On 2 November 2022, Mr Fiorakis presented to the Austin Hospital with nausea, vomiting and decreased appetite. A computed tomography (**CT**) scan revealed a high-grade small bowel obstruction, a large paraoesophageal hiatus hernia and marked rectal faecal loading.

10. Mr Fiorakis' treating clinicians formed the view that he was suffering multiorgan failure with acute kidney injury, aspiration pneumonia, and rising lactate on a background of multiple chronic comorbidities. Clinicians tried unsuccessfully to insert a nasogastric tube and he was not considered suitable for surgical intervention.

11. Discussions took place between his treating clinicians and family, after which a decision was made to commence Mr Fiorakis on a palliative pathway. Mr Fiorakis was subsequently pronounced deceased at 10.40pm.

Identity of the deceased

12. On 3 November 2022, Peter Fiorakis, born 5 July 1950, was visually identified by his sister, Nectaria Spiteri.

13. Identity is not in dispute and requires no further investigation.

Medical cause of death

14. Forensic Pathologist Dr Judith Fronczek from the Victorian Institute of Forensic Medicine conducted an examination on 7 November 2022 and provided a written report of her findings dated 9 November 2022.

[2] 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.

15. Dr Fronczek reviewed a post-mortem CT scan, which revealed coronary artery and generalised calcifications, bilateral lung markings with pulmonary emphysema and pleural calcifications, hiatus hernia, and dilated bowels with fluid levels and faecal loading.

16. Dr Fronczek provided an opinion that the medical cause of death was 1(a) Complications of small bowel obstruction in a man with multiple medical co-morbidities. Dr Fronczek considered that Mr Fiorakis' death was due to natural causes.

17. I accept Dr Fronczek's opinion.

FINDINGS

18. Pursuant to section 67(1) of the Act, I make the following findings:

    a) the identity of the deceased was Peter Fiorakis, born 5 July 1950;

    b) the death occurred on 2 November 2022 at the Austin Hospital, 145 Studley Road, Heidelberg, Victoria, from complications of small bowel obstruction in a man with multiple medical co-morbidities; and

    c) the death occurred in the circumstances described above.

19. As noted above, Mr Fiorakis' death was reportable by virtue of section 4(2)(c) of the Act because, immediately before his death, he was a person placed in care as defined in section 3 of the Act. Section 52 of the Act requires an inquest to be held, except in circumstances where someone is deemed to have died from natural causes. In the circumstances, I am satisfied that Mr Fiorakis died from natural causes and that no further investigation is required. Accordingly, I exercise my discretion under section 52(3A) of the Act not to hold an Inquest into his death.

I convey my sincere condolences to Mr Fiorakis' 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:

Nectaria Spiteri, Senior Next of Kin

Cedrick Rwabutozi, Austin Health

Senior Constable Andrea Bearsley, Coroner's Investigator

Signature:

Coroner David Ryan

Date : 10 May 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.