IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 001822

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	Con Kostantinou
Date of birth:	6 February 1961
Date of death:	30 March 2024
Cause of death:	1(a) Unascertained
Place of death:	Northern Hospital 185 Cooper Street Epping Victoria
Keywords:	In care – mental health – natural causes

INTRODUCTION

1. On 30 March 2024, Con Kostantinou was 63 years old when he passed away at the Northern Hospital. At the time of his death, Mr Kostantinou lived alone in Oak Park. He is survived by his brother, John Tremoulas.

2. Mr Kostantinou's medical history included bipolar affective disorder, obstructive sleep apnoea prostatic hyperplasia with hydronephrosis and lung emphysema (he had been a heavy smoker). There had been a number of past hospital admissions requiring involuntary treatment in relation to his mental health and he had been prescribed sodium valproate and olanzapine.

THE CORONIAL INVESTIGATION

3. Mr Kostantinou's death constitutes a *"reportable death"* under sections 4(1)(b) and 4(2)(c) of the *Coroners Act 2008* (**the Act**), as his death occurred in Victoria and immediately before his death, he was a person placed in custody or care, being a patient detained in a designated mental health service within the meaning of the *Mental Health and Wellbeing Act 2022* (**MHWB Act**).

4. 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.

5. 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.

6. This finding draws on the totality of the coronial investigation into Mr Kostantinou's death. 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.[1]

[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.

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

Circumstances in which the death occurred

7. On 24 March 2024, Mr Kostantinou was transported by ambulance to the Northern Hospital. He had been exhibiting signs of delirium and mania and his family became concerned. Further, he had reportedly been non-compliant with his medication. An examination was conducted by mental health clinicians and he was assessed as being at a high risk of misadventure. He was refusing medication and it was considered that his judgment and insight were impaired. Accordingly, he was involuntarily admitted under an Assessment Order under the MHWB Act.

8. A review of the medical records from Northern Health document that Mr Kostantinou was subject to regular observation and received a reasonable level of care and treatment during his admission.

9. On 25 March 2024, Mr Kostantinou's mental state had not improved so he was placed on a Temporary Treatment Order under the MHWB Act. He continued to be manic and at times aggressive but was able to be re-directed by staff. He was prescribed diazepam and olanzapine with a plan to also increase his dose of sodium valproate.

10. On 26 March 2024, Mr Kostantinou was reviewed by a psychiatrist on the mental health inpatient unit. He denied thoughts of self-harm but his insight and judgment were assessed to be poor. The psychiatrist discussed with Mr Kostantinou the reason for his admission and his required treatment.

11. On 28 March 2024, Mr Kostantinou was again reviewed by a psychiatrist and he was observed to be incoherent with disorganised thoughts. It was assessed that he required ongoing treatment.

12. On 29 March 2024, medical staff suspected that Mr Kostantinou may have been experiencing concurrent delirium despite exhibiting signs of what appeared to be a purely mental illness. However, a computed tomography (**CT**) scan of his brain was conducted together with a septic screen which were unremarkable.

13. Later on 29 March 2024 at around 8.45pm, medical staff located Mr Kostantinou unresponsive in his room and he was found to have experienced a cardiac arrest. He had last been seen well by staff about 30 minutes earlier. Cardiopulmonary resuscitation (**CPR**) was commenced and spontaneous return of circulation was achieved after around 50 minutes.

14. A CT scan of Mr Kostantinou's brain and pulmonary arteries and an electrocardiogram (**ECT**) were unremarkable. He was admitted to the Intensive Care Unit where he developed liver failure, kidney failure and coagulopathy. He was also displaying signs of having suffered a severe brain injury. Mr Kostantinou was transferred to comfort care in consultation with family and he passed away on 30 March 2024.

Identity of the deceased

15. On 30 March 2024, Con Kostantinou, born 6 February 1961, was visually identified by his cousin, Helen Syrrakos.

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

Medical cause of death

17. Forensic Pathologist Dr Hans de Boer from the Victorian Institute of Forensic Medicine performed an autopsy on 5 April 2024 and provided a written report of his findings dated 26 June 2024.

18. The autopsy revealed evidence of hypoxic ischaemic encephalopathy (damage to the brain due to lack of oxygen). Dr de Boer considered that the brain damage and liver and kidney failure were secondary to the cardiac arrest. However, despite thorough investigations, the cause of the cardiac arrest could not be unequivocally ascertained.

19. Dr de Boer observed some evidence of natural disease including stenosis of the coronary arteries, fenestrations in the pulmonary and aortic heart valve and bronchopneumonia. However, it could not be equivocally stated that these conditions were the cause of death.

20. Toxicological analysis of ante-mortem samples identified the presence of low levels of diazepam (and its metabolite),[2] olanzapine,[3] haloperidol,[4] valproic acid[5] and promethazine.[6] Dr de Boer stated that a toxicological cause of death was not demonstrated.

21. Dr de Boer noted that there are several causes of sudden unexpected death for which there may be no anatomical finding at autopsy, including cardiac arrhythmia and seizure disorders and metabolic and biochemical derangement.

22. Dr de Boer provided an opinion that the medical cause of death was *1(a) Unascertained*. Although he was unable to identify a specific cause of death, Dr de Boer was of the opinion that Mr Kostantinou's death was due to natural causes.

23. I accept Dr de Boer's opinion.

FINDINGS AND CONCLUSION

24. Having considered all of the available evidence, I am satisfied that the care Mr Kostantinou received at the Northern Hospital was reasonable and appropriate.

25. The investigation has not identified any opportunities for prevention arising from Mr Konstaninou's death, and I therefore consider that no further investigation is required.

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

    a) the identity of the deceased was Con Kostantinou, born 6 February 1961;

    b) the death occurred on 30 March 2024 at the Northern Hospital, Epping, Victoria from unascertained causes; and

    c) the death occurred in the circumstances described above.

27. As noted above, Mr Kostantinou's 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 the coroner considers that the death was due to natural causes.

[2] Diazepam is indicated for anxiety, muscle relaxation and seizures.
[3] Olanzapine is an antipsychotic drug.
[4] Haloperidol is a butyrophenone derivative used therapeutically as an anti-psychotic agent.
[5] Valproic acid is indicated for epilepsy, and as an adjunct in mania and schizophrenia where other therapy is inadequate.
[6] Promethazine is an anti-histamine.

28. In the circumstances, I am satisfied that Mr Kostantinou 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 her death.

I convey my sincere condolences to Mr Kostantinou'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:

John Tremoulas, Senior Next of Kin

Constable Charlie Gill, Coroner's Investigator

Signature:

Coroner David Ryan

Date : 09 August 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.