IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 001832

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Voula Hristeas
Date of birth:	3 May 1957
Date of death:	31 March 2024
Cause of death:	1a: Pneumonia 2: Trisomy 21, dementia
Place of death:	43 Denman Street, East Geelong, Victoria 3219

INTRODUCTION

1. On 31 March 2024, Voula Hristeas was 66 years old when she died at her home. At the time of her death, Voula lived in Supported Disability Accommodation in East Geelong.

2. Voula had Down syndrome and an intellectual disability. She was placed into care in 1971 after her mother passed away and her father remarried.

3. Voula lived in several homes operated by the then Department of Health and Human Services, before moving to her residence in East Geelong, where she lived for around 15 years.

4. Voula's medical history also included dementia, arthritis, depression and anxiety. She spent most of her time at home due to the deterioration in her health and mobility but went out on weekends with a support worker.

5. Voula enjoyed going for a drive, sitting by the water and eating her favourite takeaway in the car. She also enjoyed sitting in the lounge to watch television and listen to music.

THE CORONIAL INVESTIGATION

6. Voula's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Specifically, Voula was immediately before her death 'a person placed in custody or care', as she was an SDA resident residing in an SDA enrolled dwelling.[1] The death of a person in care or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes.

7. Section 52(2) of the Act prescribes when a coroner must hold an Inquest into a death. This includes where the deceased was, immediately before death, a person placed in custody or care. However, as Voula's death was due to natural causes, I am not required to hold an Inquest.[2]

8. 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.

[1] Regulation 7(d) of the *Coroners Regulations 2019.*
[2] Section 52(3A) of the *Coroners Act 2008.*

9. 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.

10. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Voula's death. The Coronial 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.

11. This finding draws on the totality of the coronial investigation into the death of Voula Hristeas 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.[3]

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

Circumstances in which the death occurred

12. On 21 February 2024, Voula was admitted to University Hospital Geelong with Covid-19 and pneumonia. She remained in hospital for five days.

13. Voula's health deteriorated over the following weeks, with poor oral intake. She was referred to the community palliative care team and supported by her general practitioner.

14. Voula died at 12:20pm on 31 March 2024, in the presence of her support workers.

Identity of the deceased

15. On 31 March 2024, Voula Hristeas, born 3 May 1957, was visually identified by her support worker, Julie Mippy, who completed a Statement of Identification.

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

[3] 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.

Medical cause of death

17. Forensic Pathologist Dr Hans de Boer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination of the body of Voula Hristeas on 2 April 2024. Dr de Boer considered the Victoria Police Report of Death (Form 83), post mortem computed tomography (**CT**) scan, VIFM contact log, scene photographs and medical records and provided a written report of his findings dated 9 May 2024.

18. The findings of the post mortem CT scan included atrophic brain, consolidation of the upper and lower lobes of the right lung and patchy bilateral lung consolidation (suspicious for pneumonia), left renal pelvic calculus and lumbar scoliosis.

19. The findings at external examination were consistent with the reported circumstances.

20. Toxicological analysis of post mortem blood samples identified the presence of acetone, diazepam, clonazepam and sertraline.

21. Dr de Boer provided an opinion that the medical cause of death was 1(a) PNEUMONIA, 2 TRISOMY 21, DEMENTIA.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Voula Hristeas, born 03 May 1957;

    b) the death occurred on 31 March 2024 at 43 Denman Street, East Geelong, Victoria 3219;

    c) I accept and adopt the medical cause of death ascribed by Dr Hans de Boer and I find that Voula Hristeas, a woman with Trisomy 21 and dementia, died from pneumonia.

2. AND, I have determined that the application of section 52(3A) of the Act is appropriate in the circumstances as I accept that Voula Hristeas' death was due to natural causes and I find there is no relationship or causal connection between her death and her status as a person placed in custody or care immediately before his death.

I convey my sincere condolences to Voula'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.

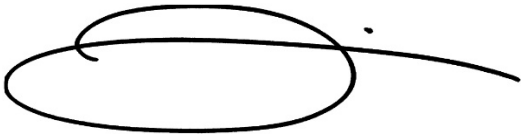
I direct that a copy of this finding be provided to the following:

Peter Hristeas, Senior Next of Kin

Barwon Health

Senior Constable Christopher Tinney, Coronial Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 23 June 2025

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.