IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 006491

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	George Platakis
Date of birth:	17 January 1969
Date of death:	22 November 2023
Cause of death:	1a: Klebsiella pneumoniae pneumonia in a man with Huntington's Disease 2: Chronic obstructive pulmonary disease
Place of death:	18 Avaward Street Wyndham Vale Victoria 3024
Keywords:	In care, Huntington's Disease, falls

INTRODUCTION

1. On 22 November 2023, George Platakis was 54 years old when died at his residence after experiencing respiratory distress.

2. At the time of his death, George lived in Specialist Disability Accommodation (**SDA**) at 18 Avaward Street, Wyndham Vale, Victoria, operated by Activate Community Care. George was a National Disability Insurance Scheme (**NDIS**) participant and received funding to reside in an SDA enrolled dwelling.[1] George was receiving these supports due to the progressive effects of Huntington's Disease and injuries sustained in a fall.[2]

3. George was born at Footscray Hospital, one of three children to parents Marualla, who is of Cypriot heritage, and Dinostheusis, who was of Greek heritage. George is survived by his mother, but his father sadly passed away in 1990 as the result of a house fire. George attended school in Footscray until the age of 13, when we went to work in his parents' fruit shop on Barkly Street, West Footscray. In 1991, he took over the business and continued working there until 1994. In this period, George married his former wife, Olga Eleftheriou, and together they had one daughter in 1992. After working at the fruit shop, George took on various roles, including painting and decorating and working in the retail industry. In 1994, George and Olga separated but maintained an amicable relationship.[3]

4. In around 1999, George commenced a relationship with his de facto partner, Anastasia Bounas, and resided with her in their Caroline Springs home from around 2003 until 2023.[4]

5. In around 2012, those close to George noticed a deterioration in his physical and mental health, most notably in the form of unusual sporadic body movements.[5] His symptoms were investigated and he was diagnosed with Huntington's Disease, an inherited, progressive neurodegenerative disorder that results in movement, cognitive and psychiatric symptoms. As the condition progresses, people with this condition develop impaired gait, posture and

[1] SDA enrolled dwelling is defined under the *Residential Tenancies Act 1997* (Vic). The definition, as applicable at the time of George's death, is a permanent dwelling that provides long-term accommodation for one or more SDA residents, that is enrolled as an SDA dwelling under relevant NDIS (Specialist Disability Accommodation) Rules in force at the relevant time. An SDA resident means a person who is an NDIS participant funded to reside in an SDA enrolled dwelling, or who receives continuity of supports under the Commonwealth Continuity of Support Program in respect of specialist disability services for older people (from 1 July 2021, the Disability Support for Older Australians program). The definition of SDA resident was amended on 1 July 2024 pursuant to the *Disability and Social Services Regulation Amendment Act 2023* to extend to include persons who are residing, or propose to reside, in an SDA dwelling under an SDA residency agreement or residential rental agreement.

[2] NDIS Plan dated 17 May 2023.

[3] Statement of Olga Eleftheriou, Coronial Brief.

[4] Ibid.

[5] Ibid.

balance (resulting in recurrent falls) and difficulty with speech or swallowing (which may result in aspiration events).[6]

6. In early 2023, George sustained serious injuries in an unwitnessed fall at his home. He was admitted to Sunshine Hospital on 21 January 2023 and was found to be suffering from multiple spinal fractures and rhabdomyolysis.[7] During his admission, George was diagnosed with osteoporosis based on his fracture from a fall at standing height and also experienced intermittent episodes of sinus bradycardia. He received medical care and remained an inpatient until 19 June 2023.[8] By the end of this admission, Anastasia felt she was not able to provide the level of care and support that George needed at home, so Western Health supported Mr Platakis with an application for increased NDIS funding and he was discharged to the Avaward Street specialist accommodation where he resided until his passing.[9] After his fall, George was largely unable to communicate verbally.[10]

7. George's Care Plan specified that he required carer assistance with all tasks of daily living and personal care, 24-hour supervision, and frequent carer assistance to reposition him appropriately in bed and prevent him rolling out. He was acknowledged to be at very high risk of falls due to his involuntary body movements, and to require a modified diet because of his risk of choking. A floor-level bed, hybrid mattress and crash mats were used to mitigate his risk of falls and injury. George was noted as being unable to consistently express his wants or needs, though he was sometimes able to indicate 'thumbs up' or 'thumbs down'. Care staff were instructed to provide gentle reassurance to him if he became restless or agitated.[11]

THE CORONIAL INVESTIGATION

8. George's death fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**) as a 'person placed in custody or care' within the meaning of the Act, because he was a person receiving funding for Supported Independent Living (**SIL**) and residing in an SDA enrolled dwelling immediately prior to his death. This category of death is reportable to ensure

[6] Statement of Olga Eleftheriou, Coronial Brief; Appendix 2 – Autopsy report, Coronial Brief.
[7] Statement of Dr John Katsoulis dated 31 October 2024. Rhabdomyolysis is a condition in which damaged skeletal muscle tissue breaks down rapidly. The breakdown products of damaged muscle cells are released into the bloodstream; some of these, such as the protein myoglobin, are harmful to the kidneys and may lead to kidney failure. The severity of the symptoms, which may include muscle pains, vomiting and confusion, depends on the extent of muscle damage and whether kidney failure develops.
[8] Statement of Dr John Katsoulis dated 31 October 2024; Exhibit 6 – Western Health patient discharge summary dated 19 June 2023, Coronial Brief.
[9] Statement of Dr John Katsoulis dated 31 October 2024.
[10] Statement of Dr John Katsoulis dated 31 October 2024; Statement of Olga Eleftheriou, Coronial Brief.
[11] Exhibit 3 – Activate Community Services Care Plan and Daily Routine, Coronial Brief.

independent scrutiny of the circumstances leading to death given the vulnerability of this cohort and the level of power and control exercised by those who care for them. The Coroner is required to investigate the death, and publish their findings, even if the death has occurred as a result of natural causes.

9. 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.

10. 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.

11. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of George's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, carers, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

12. This finding draws on the totality of the coronial investigation into the death of George Platakis 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.[12]

13. In considering the issues associated with this finding, I have been mindful of George's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

[12] 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

14. On 12 November 2023, George suffered an unwitnessed fall and was found by care staff in his bed at around 7:00 am with bruising and swelling around both eyes and a small wound to his left eyebrow. He was conveyed by ambulance to the Royal Melbourne Hospital Emergency Department and was found to have suffered injuries to his face, but returned to his residence a short time later and resumed his usual routine.[13]

15. On 22 November 2023, carers assisted George with his breakfast of wheetbix and cordial and observed that he ate well. He was then assisted with his morning bathing, dressing and linens. At around 8:30 am, as the carers went about cleaning George's room, they noticed that he appeared to be having difficulty breathing. The carers immediately called 000 and followed the instructions of the call-taker.[14] Ambulance Victoria paramedics arrived a short time later, but George was unable to be revived and was formally pronounced deceased at 8:50 am.[15]

Identity of the deceased

16. On 27 November 2023, George Platakis, born 17 January 1969, was visually identified by his stepsister, Danilia Kiremitciyan.

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

Medical cause of death

18. Specialist Forensic Pathologist Dr Victoria Francis from the Victorian Institute of Forensic Medicine conducted an autopsy on 28 November 2023 and provided a written report of her findings dated 17 April 2024.

19. The post-mortem examination revealed changes in keeping with his clinical history of Huntington's Disease.

[13] Exhibit 5 – Royal Melbourne Hospital Emergency Treatment Summary dated 12 November 2023.
[14] Statements of Kuldeep Brar and Maninder Sharma, Coronial Brief.
[15] Ambulance Victoria Verification of Death Form dated 22 November 2023.

20. Dr Francis found diffuse pneumonia throughout the right lung and changes in keeping with chronic aspiration pneumonia. Post-mortem microbiology swabs showed the presence of *Klebsiella pneumoniae ssp pneumoniae*[16] in both lungs.

21. George's lungs were also found to be emphysematous with chronic bronchitis. Chronic obstructive pulmonary disease (**COPD**) is characterised by emphysema (permanent enlargement of small airspaces) and chronic bronchitis (small airway inflammation). Cigarette smoking is the most important risk factor for developing this disease, but other air pollutants may also contribute. People with this condition suffer from increasing shortness of breath. Progression of the disease is associated with pulmonary hypertension and cardiac failure, as well as recurrent infections and respiratory failure.

22. There were findings in keeping with multiple falls including an organising subdural haematoma[17] and bilateral older rib fractures.

23. Postmortem biochemistry showed a significantly elevated C-reactive protein. C-reactive protein is a molecule that increases in the blood stream in response to inflammation, particularly infections.

24. On the basis of her findings, Dr Francis provided an opinion that the medical cause of George's death was (1a) klebsiella pneumoniae pneumonia in a man with Huntington's Disease, with a contributing factor of (2) chronic obstructive pulmonary disease.

25. I accept Dr Francis's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was George Platakis, born 17 January 1969;

    b) the death occurred on 22 November 2023 at 18 Avaward Street, Wyndham Vale, Victoria 3024, from (1a) klebsiella pneumoniae pneumonia in a man with Huntington's Disease, with a contributing factor of (2) chronic obstructive pulmonary disease; and

    c) the death occurred in the circumstances described above.

[16] A type of bacteria that can cause serious infections such as pneumonia and bloodstream infections.
[17] A blood clot that forms between layers in the protective coverings of the brain.

27. The available evidence does not support a finding that there was any want of clinical management or care on the part of Activate Community Care staff that caused or contributed to George's death.

28. Having considered all the available evidence, I find that George's death was from natural causes and that no further investigation is required. As such, I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into his death, and to finalise the investigation of George's death in chambers.

I convey my sincere condolences to George's family, friends and carers 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:

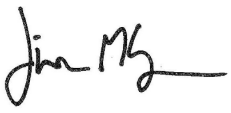
Anastasia Bounas, Senior Next of Kin

Danilia Kiremitciyan, Stepsister

Kaliopie Platakis, Daughter

Sergeant Carolyn Reiss, Coronial Investigator

Signature:



Coroner Simon McGregor

Date: 31 March 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.