FINDINGS of Coroner Simon Cooper following the holding of an inquest under the *Coroners Act* 1995 into the death of:

AGIS KONSTANTINIDIS

Contents

Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Agis Konstantinidis with an inquest held at Hobart in Tasmania make the following findings.

Hearing Date

5 June 2020

Representation

Counsel Assisting the Coroner: J Ansell

I find, pursuant to Section 28(1) of the *Coroners Act* 1995, that:

a) The identity of the deceased is Agis Konstantinidis;
b) Mr Konstantinidis died in the circumstances set out below;
c) The cause of Mr Konstantinidis' death was aspiration pneumonia due to a combination of dementia and pulmonary fibrosis; and
d) Mr Konstantinidis died on 17 September 2018 at the Roy Fagan Centre, Kalang Avenue, Lenah Valley, Tasmania.

Background

1. Mr Konstantinidis was born in Kalamata, Greece on 28 June 1928 and was aged 90 years at the time of his death. A retired farmer and store keeper, Mr Konstantinidis had been very ill for some time leading up to his death.

2. He married Vasiliki in February 1950 and the couple had two children together – Dimitra and George. Mrs Konstantinidis died in a road traffic crash in 1988. Her death had a profound and lasting impact upon Mr Konstantinidis. It saw the beginning of a significant health decline for him. He commenced to suffer depression and was, thereafter, treated with prescription antidepressant medication.

Health

3. In 2015, Mr Konstantinidis moved into the Guilford Young Grove aged care facility in Sandy Bay. From the beginning of 2018 his health commenced to deteriorate. Early in that year he suffered a fall which necessitated a period of hospitalisation. The pain he suffered as a consequence of the fall appears to have heightened his depression.

4. In June 2018 Mr Konstantinidis cut his wrists in an apparent suicide attempt. He was hospitalised for approximately two weeks after that incident.

5. He made another suicide attempt in August 2018 when he drank a quantity of methylated spirits. The methylated spirits rendered him unconscious. Again, he was hospitalised. Following his release from hospital he did not return to the aged care facility but instead was transferred to the Roy Fagan Centre (RFC) subject of an emergency guardianship order.[1]

6. He was medically assessed as a consequence of that order, and it was confirmed that Mr Konstantinidis was suffering advanced lung disease. The lung disease was terminal.

7. After consultation with family and in light of his particular frailty, a decision was made by the medical staff of the RFC to treat him with comfort medication and palliate him.

8. Just after 1.00pm on 17 September 2018 he was found dead in his bed by one of the medical staff. He had last been seen alive 25 minutes earlier.

Investigation

9. The fact of Mr Konstantinidis' death was reported in accordance with the requirements of the *Coroners Act* 1995. I attended the Roy Fagan Centre in the company of a police officer later the same afternoon and inspected his body. His body was then formally identified and transferred by mortuary ambulance to the Royal Hobart Hospital where an autopsy was carried out.

10. The forensic pathologist who carried out the autopsy, Dr Christopher Lawrence, provided a report which was tendered at the inquest.[2] Dr Christopher Lawrence expressed the opinion, which I accept, that Mr Konstantinidis died as a consequence of aspiration pneumonia due to pulmonary fibrosis and dementia. In plain English, Mr Konstantinidis had an infection of the lungs due to chronic lung disease and dementia.

[1] See Exhibit C9.
[2] Exhibit C6.

11. Because at the time of his death Mr Konstantindis was the subject of an order made under the provisions of the *Guardianship and Administration Act* 1995 an inquest in relation to his death was mandatory. The investigation and inquest focused upon his care, treatment and supervision whilst he was subject to that order at the RFC.

12. The medical records kept at the RFC in relation to Mr Konstantinidis was obtained and examined. The records themselves were tendered at the inquest.[3]

13. An affidavit was obtained from Mr Konstantinidis' daughter. Her affidavit was also tendered at the inquest.[4]

14. Advice was sought from the Office of the Public Guardian. Ms Kim Barker, the Public Guardian, indicated that she had no concerns in relation to Mr Konstantinidis' management or the circumstances surrounding his death.

Report pursuant to Section 28(5) of the *Coroners Act* 1995

15. The evidence tendered at the inquest satisfies me to the requisite legal standard that the care, supervision and treatment of Mr Konstantinidis was of an appropriate and high standard. It is evident that nothing more could have been done for him.

Conclusion

16. The circumstances of Mr Konstantinidis' death do not require me to make any comments or recommendations pursuant to section 28 of the *Coroners Act* 1995.

17. I wish to convey my sincere condolences to Mr Konstantinidis' family and loved ones on their loss.

Dated: 19 June 2020 at Hobart in State of Tasmania.

Simon Cooper
Coroner

[3] Exhibit C7.
[4] Exhibit C11.