IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 006349

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:	Philip Sopikiotis
Date of birth:	11 January 1969
Date of death:	4 November 2022
Cause of death:	1(a) Aspiration pneumonia complicating seizures in a man with trisomy 21 and suspected Alzheimer's dementia (palliated)
Place of death:	The Alfred Hospital, 55 Commercial Road, Melbourne, Victoria
Keywords:	In care; disability services; natural causes

[1] This document is an amended version of the Finding into the death of Philip Sopikiotis dated 13 December 2022. The Finding has been amended pursuant to section 76A of the *Coroners Act 2008* to insert paragraphs 1 to 22 to include circumstances of Mr Sopikiotis' death.

INTRODUCTION

1. On 4 November 2022, Philip Sopikiotis was 53 years old when he passed away at The Alfred Hospital. At the time of his death, Mr Sopikiotis resided in a residential care facility at 18 Liscard Street, Elsternwick, operated by Life Without Barriers. His move to the facility coincided with his revised National Disability Insurance Scheme (**NDIS**) plan dated 3 June 2022. Mr Sopikiotis previously lived in Ashburton with his mother, who also fulfilled the role of his carer.

2. Mr Sopikiotis' medical history included Trisomy 21, ventricular septal defect, gout, and according to a recent computed tomography (**CT**) scan, suspected Alzheimer's disease.

THE CORONIAL INVESTIGATION

3. Mr Sopikiotis' 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 13 December 2022, having commenced an investigation into Mr Sopikiotis' 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 Sopikiotis' death satisfied the definition of a reportable death in section 4(2)(c) of the Act as Mr Sopikiotis 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 Sopikiotis' 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 Philip Sopikiotis. 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.[2]

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

Circumstances in which the death occurred

9. At approximately 1.40am on 24 October 2022, Mr Sopikiotis was found unresponsive on his bathroom floor by a carer, having suffered an unwitnessed fall in the context of a suspected seizure.

10. Emergency services were contacted and at approximately 2.40am, Mr Sopikiotis was transferred to the Alfred Hospital. He initially regained consciousness, however upon arrival to the emergency department, Mr Sopikiotis suffered a generalised tonic-clonic seizure.

11. Mr Sopikiotis did not suffer any further seizures during his admission; however, his admission was complicated by likely aspiration pneumonia. Subsequent imaging revealed features of chronic aspiration.

12. Mr Sopikiotis underwent an electroencephalogram (**EEG**), which revealed encephalopathy in a likely recovery phase post-seizure, with no clear features of prolonged seizure-like state absent convulsions.

13. Following a review by the Epilepsy team, Mr Sopikiotis' prescribed dose of valproate for mood was up-titrated and he was commenced on antibiotics. On 1 November 2022, his condition deteriorated and he became hypotensive and hypoxic.

14. Treating clinicians trialled Mr Sopikiotis on active management with fluids and antibiotics, however his condition continued to decline. Following discussions between treating clinicians and his family, active treatment was withdrawn and on 2 November 2022, he was commenced

[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.

on a palliative pathway. Mr Sopikiotis was subsequently pronounced deceased at 11.55am on 4 November 2022.

Identity of the deceased

15. On 4 November 2022, Philip Sopikiotis, born 11 January 1969, was visually identified by his brother, George Sopikiotis.

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

Medical cause of death

17. Forensic Pathologist Dr Chong Zhou from the Victorian Institute of Forensic Medicine conducted an examination on 7 November 2022 and provided a written report of her findings dated 8 November 2022.

18. Dr Zhou reviewed a post-mortem CT scan, which revealed bilateral increased lung markings and bibasal areas of consolidation consistent with the development of aspiration pneumonia.

19. Dr Zhou provided an opinion that the medical cause of death was 1(a) Aspiration pneumonia complicating seizures in a man with trisomy 21 and suspected Alzheimer's dementia (palliated). Dr Zhou considered that Mr Sopikiotis' death was due to natural causes.

20. I accept Dr Zhou's opinion.

FINDINGS

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

    a) the identity of the deceased was Philip Sopikiotis, born 11 January 1969;

    b) the death occurred on 04 November 2022 at the Alfred Hospital, 55 Commercial Road, Melbourne, Victoria, from aspiration pneumonia complicating seizures in a man with trisomy 21 and suspected Alzheimer's dementia (palliated); and

    c) the death occurred in the circumstances described above.

22. As noted above, Mr Sopikiotis' 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 Sopikiotis 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 Sopikiotis' 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:

Panagiota Sopikiotis, Senior Next of Kin

Wendy Grant, Alfred Health

First Constable Riley Norman, Coroner's Investigator

Signature:

Coroner David Ryan

Date : 09 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.