IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2022 000559

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the ***Coroners Act 2008***

Findings of:	Coroner Paresa Antoniadis Spanos
Deceased:	John Sloots
Date of birth:	18 September 1963
Date of death:	28 January 2022
Cause of death:	1(a) Aspiration pneumonia in a man with Down's Syndrome and dementia
Place of death:	Maroondah Hospital, Davey Drive, Ringwood East, Victoria
Key words:	In care, aspiration pneumonia, palliative care

INTRODUCTION

1. On 28 January 2022, John Sloots was 58 years old when he passed away in hospital. At the time, Mr Sloots lived at Aruma Disability Services in Alexandra.

2. Mr Sloots was born with Down's Syndrome. His brother, Eppo Sloots, described their idyllic childhood in Mitcham, where they grew up surrounded by animals. During childhood, Mr Sloots developed a passion for the St Kilda football club and listened to every game on the radio. In his adult years, Mr Sloots worked at Nadavoc Industries for about 25 years, where his tasks including packaging items for shipping.

3. Mr Sloots's mother sadly passed away in 2000. At about this time, he stopped working to spend time at home with his father. However, three years later, his father also passed away. Thereafter, Mr Sloots lived in a granny flat at the rear of his brother's property, being supported by Eppo Sloots and his wife, Shelley. He started working again, this time at the GV Centre in Shepparton.

4. After some time, it became apparent that Mr Sloots needed extra care and support that his family could not provide to him. In 2009, he moved to a facility run by the then Department of Health and Human Services. In 2012, he moved to another facility.

5. Between 2015 and 2017, Mr Sloots's health and behaviour began to deteriorate. He was eventually diagnosed with dementia. This in turn gradually affected his independence and increased his care needs.

THE CORONIAL INVESTIGATION

6. Mr Sloots's 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. However, if a person satisfies the definition of a *person placed in care* immediately before death, the death is reportable even if it appears to have been from natural causes.[1]

7. While Mr Sloots's death was reported to the Coroner, I note with concern that, as funding for disability services shifted from the Department of Families, Fairness and Housing (**DFFH**) to the National Disability Insurance Scheme (**NDIS**), the definition of a person placed in custody

[1] See the definition of 'reportable death' in section 4 of the *Coroners Act 2008* (**the Act**), especially section 4(2)(c) and the definition of 'person placed in custody or care' in section 3(1) of the Act.

or care in section 3(1) of the Act to include 'a person under the control, care or custody of the Secretary to the Department of Human Services or the Secretary to the Department of Health' no longer adequately captured the group of vulnerable people in receipt of disability services as envisaged by the legislation when it was passed. Where the deaths of those people are from natural causes and not otherwise reportable, then, although this cohort is as vulnerable as ever, their deaths and the circumstances in which they died – including the quality of their care – would not be subjected to coronial scrutiny.[2] [3] [4]

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.

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. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Sloots's death. The Coroner's 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 Mr Sloot's death, 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.[5]

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[2] On 11 October 2022, this lacuna in the legislation has recently been rectified when amendments to the Coroners Regulations 2019 came into effect. Sub-regulation 7(1)(d) provides that a 'person placed in custody or care' now includes *"a person in Victoria who is an SDA resident residing in an SDA enrolled dwelling"*. Mr Sloots would now likely meet the new definition of person placed in custody or care.

[3] 'SDA resident' has the same meaning as in the *Residential Tenancies Act 1997* (Vic) and captures a person who is an SDA recipient (that is, an NDIS participant who is funded to reside in an SDA enrolled dwelling).

[4] 'SDA enrolled dwelling' also has the same meaning as in the *Residential Tenancies Act 1997* and is defined as a: *"long-term accommodation for one or more SDA resident and enrolled as an SDA dwelling under the National Disability Insurance Scheme (Specialist Disability Accommodation) Rules 2016 of the Commonwealth as in force from time to time or under other rules made under the National Disability Insurance Scheme Act 2013 of the Commonwealth."*

[5] 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

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

Identity of the deceased

12. On 28 January 2022, John Sloots, born 18 September 1963, was visually identified by his carer, Margaret Nicol, who signed a formal Statement of Identification to this effect.

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

Medical cause of death

14. Forensic Pathologist, Dr Judith Fronczek, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection on 31 January 2022 and provided a written report of her findings dated 2 February 2022.

15. No suitable ante-mortem specimens were able to be obtained from the admitting hospital for routine toxicological analysis.

16. Dr Fronczek provided an opinion that the medical cause of death was due to natural causes, namely *"1(a) Aspiration pneumonia in a man with down's syndrome and dementia"*.

17. I accept Dr Fronczek's opinion.

Circumstances in which the death occurred

18. By early 2020, Mr Sloots's health had deteriorated to a point where he was unable to get in and out of bed, was scared to use the bathroom by himself, and refused to leave his room. He required around the clock care. In August 2021, Mr Sloots moved to a high care facility in Mackenzie Street, Alexandra, managed by Aruma Disability Services.

19. From late 2020 to late 2021, Mr Sloots suffered bronchitis on a number of occasions and suffered at least two falls without injury.

20. On 10 January 2022, Mr Sloots complained of difficulty breathing. He was assessed by Ambulance Victoria paramedics and deemed suitable for management at home.

21. On 15 January 2022, Mr Sloots experienced further shortness of breath, hypoxia, and decreased conscious state. He was subsequently admitted to Box Hill Hospital where he was

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provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

treated for pneumonia. It was established that Mr Sloots had a longstanding swallowing impairment, which had been deteriorating. A speech pathologist assessed him to be at a high risk of aspiration with any form or oral intake.

22. During his admission, hospital staff discussed Mr Sloots's management with his brother. It was agreed that Mr Sloots had entered a palliative phase of life and would not be administered curative treatment if he suffered a medical episode. He was subsequently discharged back to the Mackenzie Street facility on 21 January 2022.

23. On the morning of 23 January 2022, care staff found Mr Sloots breathing but unresponsive. He was taken to Alexandra Hospital and discharged the same day.

24. On 24 January 2022, Mr Sloots's oxygen saturation levels fell to below 90 percent, and he was taken to Maroondah Hospital where he was found to be extremely unwell and in respiratory distress due to ongoing and recurrent aspiration pneumonia. His family decided that he would be provided with comfort care only.

25. Mr Sloots remained in hospital and kept as comfortable as possible until he passed away at 12.49pm on 28 January 2022.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was John Sloots, born 18 September 1963;

    (b) the death occurred on 28 January 2022 at Maroondah Hospital, Davey Drive, Ringwood East, Victoria;

    (c) the cause of Mr Sloots's death was aspiration pneumonia in a man with Down's Syndrome and dementia; and

    (d) the death occurred in the circumstances described above.

I convey my sincere condolences to Mr Sloots'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:

Eppo Sloots, senior next of kin

Eastern Health

Constable Daniel Egginton, Victoria Police, Coroner's Investigator

Signature:

Coroner Paresa Antoniadis Spanos

Date: 06 December 2022

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.