IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 6241

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the Coroners Act 2008

Findings of:	**JUDGE SARA HINCHEY, STATE CORONER**
Deceased:	**ADAM SLOMCZEWSKI**, born 17 February 1971
Delivered on:	13 September 2017
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	13 September 2017
Counsel assisting the Coroner:	Leading Senior Constable Sonia Reed

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HER HONOUR:

BACKGROUND

1. Mr Adam Slomczewski was born in Poland on 17 February 1971. He resided with his parents and one of his two brothers, Mr Peter Slomczewski, in Hastings.

2. Mr Slomczewski had a lengthy criminal history, and spent considerable periods of time in prison for various crimes including but not limited to theft, robbery, burglary, attempted burglary and heroin possession.

3. Mr Slomczewski was treated by general practitioner Dr Henry Monkus at the Chadstone Road Clinic in Malvern East. He was prescribed Tramadol to assist with pain management for a back injury. Mr Slomczewski had a history of using illicit drugs heroin, speed and ice.

THE PURPOSE OF A CORONIAL INVESTIGATION

4. Mr Slomczewski's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria and was unexpected and not from natural causes.[1]

5. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[2] The purpose of a coronial investigation is independently to investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

6. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[3] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

7. The expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

8. For coronial purposes, the phrase "*circumstances in which death occurred*," refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the

[1] Section 4 *Coroners Act 2008.*
[2] Section 89(4) *Coroners Act 2008.*
[3] *Keown v Khan* (1999) 1 VR 69.

death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

9. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the Court's "*prevention*" role.

10. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;

    (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

    (c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice. These powers are the vehicles by which the prevention role may be advanced.

11. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[4] 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 that they caused or contributed to the death.

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

Identity of the Deceased pursuant to section 67(1)(a) of the Act

12. On 12 December 2015, a right thumb print was taken from the deceased. Subsequently, a Victoria Police Deceased (Fingerprint) Identification Report was provided to the Court identifying the deceased to be Adam Slomczewski, born 17 February 1971.

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

Medical cause of death pursuant to section 67(1)(b) of the Act

14. On 12 December 2015, Dr Malcolm Dodd, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy of Mr Slomczewski's body. Dr Dodd

[4] (1938) 60 CLR 336.

provided a written report, dated 24 March 2016, which concluded that Mr Slomczewski died from cardiac arrhythmia in the setting of a struggle, neck compression and amphetamine use.

15. Dr Dodd commented that examination of the eyes failed to disclose evidence of petechial haemorrhage. Further, Dr Dodd noted that petechial haemorrhages are often seen in as a consequence of neck compression.

16. External examination showed no evidence of significant trauma. A minute abrasion on the inner left eye, abrasions to the left fifth finger, and a small area of bruising on the left third finger were noted.

17. Internal examination did not identify evidence of significant naturally occurring disease other than the observed liver changes under the microscope which were consistent with chronic persistent hepatitis and hepatitis C.

18. Toxicological analysis of post mortem specimens taken from Mr Slomczewski identified the presence of tramadol (~5.0mg/L), methylamphetamine (~0.49mg/L) and amphetamine (~0.04mg/L).

19. Dr Dodd commented that it is well described that life threatening reactions to methamphetamine can occur. These reactions include agitation, fever, aggression and violence, and use of amphetamine can rapidly lead to very high body temperature with elevated heart rate and blood pressure. Further, Dr Dodd noted the toxicology report stated that irregular heart rate (arrhythmia) is possible at high concentrations particularly on exertion or in times of stress.

20. I accept the cause of death proposed by Dr Dodd.

Circumstances in which the death occurred pursuant to section 67(1)(c) of the Act

21. On 11 December 2015 at approximately 9.00am Ms Jessica Page left her home located at 26 Cassia Grove, Frankston to attend work.

22. At approximately 11.00am, Mr Slomczewski left his home in Hastings and went to catch a bus to Frankston. Mr Slomczewski told his mother he had a doctor's appointment in Frankston at 11.45am.[5] Mr Slomczewski's doctor, Dr Henry Monkus reported that Mr

[5] Coronial brief, statement of Margaret Slomczewski, dated 11 December 2015, 150.

Slomczewski did not have an appointment scheduled for that day and noted he was last seen at the Chadstone Road Clinic on 12 August 2015.[6]

23. At approximately 1.00pm, Mr Slomczewski attended 1 Pericoe Street, Frankston where Mr Brian Young resided with his partner Ms Karen Coe. Mr Slomczewski attended to return a jacket belonging to Mr Adam Coe, Ms Coe's son and Mr Slomczewski's friend who passed away in late October 2015. Slomczewski did not stay long, dropping off the jacket and then leaving. Mr Young left the house to go to work shortly after Mr Slomczewski left.[7]

24. After his visit to Mr Young, Mr Slomczewski walked to the home of Ms Page in Cassia Grove located near Mr Young's home. Mr Slomczewski entered the property through a window and proceeded to pack items belonging to Ms Page's family in two bags.

25. Shortly after 1.00pm, Ms Page returned home from work, parked her car in the driveway and opened the garage roller door to enter the house through the garage. Ms Page walked through into the workshop area and found the workshop door leading to the back yard open. Ms Page walked through the back yard toward the rear landing of the house. Ms Page observed her son's cricket bag at the top of the stairs near the rear door of the house, and noted the bag contained items including screwdrivers belonging to her son.[8]

26. Ms Page went to enter the house and observed the flyscreen door was closed but the rear door of the house was open. Ms Page then saw Mr Slomczewski standing inside the rear of the house. He opened the flyscreen door toward Ms Page and walked out carrying a football bag over his shoulder. Mr Slomczewski pushed Ms Page with the football bag, picked up the cricket bag from the ground, and walked down the rear stairs.[9]

27. Ms Page followed Mr Slomczewski as he walked to the front yard, loudly shouting "no" as she followed him. Mr Slomczewski stopped in the front yard, placed the two bags onto the ground, and turned to Ms Page attempting to hit her. Mr Slomczewski told her to "*shut the fuck up, shut up*", hit Ms Page on the head multiple times and pushed her to the ground, attempting to choke Ms Page with his hands.[10]

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[6] Coronial brief, statement of Dr Henry Monkus, dated 2 June 2016, 170.
[7] Coronial brief, statement of Brian Young, dated 5 February 2016, 158-159.
[8] Coronial brief, statement of Jessica Page, dated 14 December 2015, 111-112.
[9] *Ibid*, 113.
[10] Above n 8, 113-114.

28. Mr Slomczewski forced Ms Page to her feet and pushed her through the back yard and into the house. Mr Slomczewski demanded money, and that she give him her car keys. Ms Page told him she had nothing to give him.[11]

29. Mr Russell Harrison, a neighbour of Ms Page, heard "*blood curdling screams*" of a female coming from Ms Page's property. Mr Harrison walked to the footpath beside Ms Page's home and observed a person run behind Ms Page's home. Mr Harrison jumped Ms Page's fence and ran to Ms Page's back yard. As he approached the rear door, he observed Ms Page pinned back against a wall by Mr Slomczewski. Ms Page shouted for Mr Harrison to help. Mr Harrison asked Mr Slomczewski what he was doing, at which time Mr Slomczewski released his grip on Ms Page and ran toward the front door.[12]

30. Mr Harrison told Ms Page to run and then pursued Mr Slomczewski to the front door, where Mr Slomczewski was stopped as he was unable to open the secured screen door. Mr Harrison intended to contain Mr Slomczewski within the house until police arrived. He put both of his hands up in an open display and told Mr Slomczewski to "*just stop.*"[13]

31. Mr Slomczewski lunged at Mr Harrison and caught him in a headlock. The two men grappled and Mr Harrison fell to the floor. Mr Slomczewski pushed Mr Harrison onto his back, straddled him and began to choke him. Mr Harrison believed that Mr Slomczewski was trying to kill him. Mr Harrison pushed his right thumb into Mr Slomczewski's left eye socket, causing him to release Mr Harrison's throat. The two men continued to struggle with each other, with Mr Harrison eventually pinning Mr Slomczewski to the coffee table in the lounge room with Mr Harrison's body weight resting on him.[14]

32. Mr Harrison held Mr Slomczewski in this position for approximately 30 seconds until Mr Slomczewski stated "*alright, I give up*". Mr Harrison released the pressure from his hold and went to stand up, but Mr Slomczewski tried to throw his elbow at Mr Harrison's head. Mr Harrison managed to block Mr Slomczewski's elbow and pushed his body weight back onto Mr Slomczewski. Mr Harrison placed him into a sleeper hold restraint. He held Mr Slomczewski in this position for approximately 30 seconds, during which Mr Slomczewski continued to punch out at Mr Harrison.[15]

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[11] Above n 8, 114.
[12] Coronial brief, statement of Russell Harrison, dated 12 December 2015, 531.
[13] *Ibid*, 531-532.
[14] Above n 12, 532.
[15] Above n 12, 532.

33. Mr Harrison heard sirens in the distance, and at this time Mr Slomczewski stated that he could not breathe. Knowing that help was near, Mr Harrison immediately released Mr Slomczewski from the hold. Shortly after Mr Harrison released Mr Slomczewski, he went limp. Mr Harrison believed the sleeper hold had worked, and laid Mr Slomczewski down on the floor.[16]

34. Victoria Police officers attended the scene. On checking Mr Slomczewski's condition, cardiopulmonary resuscitation was commenced and Ambulance Victoria paramedics were called to attend.[17]

35. Paramedics arrived at 1.48pm and following 30 minutes of advanced resuscitation procedures there was no return of spontaneous circulation nor other signs of life. Mr Slomczewski was declared deceased at 2.27pm.[18]

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

36. One of the purposes of the *Coroners Act 2008* is to contribute to the reduction of the number of preventable deaths and fires through the findings of the investigation of deaths and fires, and the making of recommendations, by coroners.[19] Further, section 7 of the Act requires that I avoid unnecessary duplication of inquiries and investigations.

37. The circumstances of Mr Slomczewski's death were the subject of a thorough investigation by the Victoria Police Homicide Squad. Detective Inspector Michael Hughes submitted a Preliminary Brief of Evidence to the Office of Public Prosecutions seeking a formal legal opinion as to whether criminal charges could be laid against Mr Harrison in relation to Mr Slomczewski's death. On 19 July 2016, the Office of Public Prosecutions provided a legal advice opining that there would be no reasonable prospect of Mr Harrison being convicted of any offence in relation to the death or injury of Mr Slomczewski.

38. On review of the available evidence contained in the Coronial Brief, I did not identify any prevention matters arising from the circumstances of Mr Slomczewski's death.

39. In the context of the purposes of the Act and the criminal investigation already undertaken, it is unnecessary for me to pursue any further investigation or make any further comments or recommendations in this matter.

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[16] Above n 12, 533.
[17] Coronial brief, statement of Leading Senior Constable Sarah Brown, dated 12 December 2015, 186-187.
[18] Coronial brief, statement of Cara Alphey, dated 19 December 2015, 173.
[19] *Coroners Act 2008* (Vic) s 1(c).

FINDINGS AND CONCLUSION

40. Having investigated the death of Mr Slomczewski and having held an Inquest in relation to his death on 13 September 2017, at Melbourne, I make the following findings, pursuant to section 67(1) of the Act:

    (a) that the identity of the deceased was Adam Slomczewski, born 17 February 1971;

    (b) that Mr Slomczewski died on 11 December 2015, at 26 Cassia Grove, Frankston, from cardiac arrhythmia in the setting of struggle, neck compression and amphetamine use; and

    (c) that the death occurred in the circumstances set out above.

41. I convey my sincerest sympathy to Mr Slomczewski's family and friends.

42. Pursuant to section 73(1) of the Act, I order that this Finding be published on the internet.

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

    (a) Mr Mark Slomczewski and Mrs Margaret Slomczewski, Senior Next of Kin; and

    (b) Detective Senior Constable Anthony Harwood, Coroner's Investigator, Victoria Police.

Signature:

JUDGE SARA HINCHEY
STATE CORONER
Date: 13 September 2017