IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 5993

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: BARTOSZ ZGADZAJ

Finding Of:	**AUDREY JAMIESON, CORONER**
Delivered On:	**7 August 2019**
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street, Southbank 3006
Hearing Date:	7 August 2019
Assistant:	Hayley Challender, Solicitor to Coroner Jamieson

TABLE OF CONTENTS

I, AUDREY JAMIESON, Coroner having investigated the death of **BARTOSZ ZGADZAJ**

AND having held an inquest in relation to this death on 7 August 2019

at MELBOURNE

find that the identity of the deceased was **BARTOSZ ZGADZAJ**

born on 8 May 1978

and the death occurred on 28 November 2017

at Footscray Hospital 160 Gordon St, Footscray, Victoria 3011

from:

1 (a) HYPOXIC ISCHAEMIC ENCEPHALOPATHY COMPLICATING ACUTE UPPER AIRWAY OBSTRUCTION BY FOOD BOLUS

in the following summary of circumstances:

1. Bartosz Zgadzaj was 39 years of age at the time of his death. Mr Zgadzaj suffered cerebral palsy and an intellectual disability. He lived with his mother Maria Zgadzaj for the majority of his adult life. In 2016, he moved into Department of Health and Human Services (DHHS) shared supported accommodation (the Group Home) in Marigold Avenue, Altona North.

2. On 24 November 2017 at approximately 6.00pm, Mr Zgadzaj was eating an evening meal in the communal kitchen in his home. A staff member was feeding a resident at the dinner table. Mr Zgadzaj placed his plate in the sink and then went to sit on a couch in the living room. A short time later, another staff member returned from assisting another resident in their bedroom. The second staff member saw that Mr Zgadzaj had not finished his meal, there was food around his mouth and his pallor was grey; he was unresponsive. Staff immediately commenced cardiopulmonary resuscitation (CPR)

3. Emergency Services were contacted, and Mr Zgadzaj was transported to Footscray Hospital (Western Health) by ambulance. The Emergency Department Clinical Sheet stated that copious, solid food-boluses were removed from Mr Zgadzaj's oropharynx after he had been sedated. He was admitted to the Intensive Care Unit (ICU) with an

admission diagnosis of cardiorespiratory arrest secondary to aspiration of food bolus. He was placed on ventilatory support.

4. On 25 November 2017 at 12.00pm, Mr Zgadzaj underwent a bronchoscopy to clear significant soiling in his right-lower and right-middle lung lobes. Despite successful re-inflation of his right lung fields, Mr Zgadzaj's condition did not improve. After discussion with his family, medical staff commenced palliative care and Mr Zgadzaj died on 28 November 2017. His family consented to Mr Zgadzaj being an organ donor.

JURISDICTION

5. On 27 November 2017, after Mr Zgadzaj's palliation, Western Health staff completed an E-Medical Deposition Form (E-Med Dep.) and provided it the Court in anticipation of his death. Mr Zgadzaj's death was reportable as it was, *inter alia*, unexpected and unnatural.[1]

6. Immediately before his death, Mr Zgadzaj was '*in care*' pursuant to section 3 of the *Coroners Act 2008 (Vic)* [the Act]. Section 52(2)(b) of the Act mandates the holding of an inquest into a death if the death or cause of death occurred in Victoria and the deceased person was, immediately before death, a person placed in care. A Coroner is not required to hold an inquest into a death which occurred in the circumstances set out above if they consider that the death was due to natural causes.[2]

PURPOSE OF A CORONIAL INVESTIGATION

7. The Coroners Court of Victoria is an inquisitorial jurisdiction.[3] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[4] The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances but is confined to those circumstances sufficiently

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[1] *Coroners Act 2008* (Vic) s 4.

[2] Ibid s 52(3A).

[3] Ibid s 89(4).

[4] Ibid s 67(1).

proximate and causally relevant to the death and not merely all circumstances which might form part of a narrative culminating in death.[5]

8. The broader purpose of coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by Coroners, generally referred to as the 'prevention' role.[6] Coroners are also empowered to report to the Attorney-General on a death; 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 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.[7] These are effectively the vehicles by which the prevention role may be advanced.[8] It is not the Coroner's role to determine criminal or civil liability arising from the death under investigation. Nor is it the Coroner's role to determine disciplinary matters.

STANDARD OF PROOF

9. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining whether a matter is proven to that standard, I should give effect to the principles enunciated in *Briginshaw v Briginshaw*.[9] These principles state that in deciding whether a matter is proven on the balance of probabilities, in considering the weight of the evidence, I should bear in mind:

- the nature and consequence of the facts to be proved;
- the seriousness of an allegation made;
- the inherent unlikelihood of the occurrence alleged;
- the gravity of the consequences flowing from an adverse finding; and

[5] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy v West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).

[6] The 'prevention' role is now explicitly articulated in the Preamble and Purposes of the Act, in contrast to the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

[7] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations respectively.

[8] See also sections 73(1) and 72(5) of the Act which requires publication of coronial findings, comments, recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

[9] (1938) 60 CLR 336.

- if the allegation involves conduct of a criminal nature, weight must be given to the presumption of innocence, and the court should not be satisfied by inexact proofs, indefinite testimony or indirect inferences.

10. The effect of the 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.

FORENSIC PATHOLOGY INVESTIGATION

Identification

11. On 27 November 2017, Maria Zgadzaj completed a Statement of Identification for her son, Bartosz Zgadzaj, who was born on 8 May 1978.

12. Identity is therefore not in dispute and requires no further investigation.

13. I find, as a matter of formality, that Bartosz Zgadzaj, born on 8 May 1978, died in the Critical Care Unit of Footscray Hospital, Footscray, on 28 November 2017.

Medical Cause of death

14. Dr Matthew Lynch, Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM), performed an external examination upon the body of Bartosz Zgadzaj, reviewed a post mortem computed tomography (CT) scan, the E-Med Deposition and referred to the Victoria Police Report of Death, Form 83.

15. Dr Lynch noted that his external examination yielded results which were consistent with the known mechanism of death. Post mortem CT scanning detected left renal cysts and increased lung markings. Toxicological analysis of post mortem blood detected midazolam (~0.01 mg/L), a short acting benzodiazepine used intravenously in intensive care patients. Dr Lynch formulated the medical cause of Mr Zgadzaj's death as hypoxic ischaemic encephalopathy complicating acute airway obstruction by food bolus.[10]

[10] Hypoxic ischaemic encephalopathy (HIE) is a brain dysfunction which occurs where the brain does not receive enough oxygen or blood flow over a period.

BACKGROUND

16. Mr Zgadzaj's medical history included cerebral palsy and a moderate intellectual disability. He had limited communication; he used gestures and vocalisations. Mr Zgadzaj was able to understand simple instructions in both English and Polish. His medical history also included some painful oedema in his legs which was combatted with the use of compression socks. At the time of his death, Mr Zgadzaj used non-prescription medication to treat oedema and constipation.

17. Mr Zgadzaj's family supported and cared for him throughout his life, including after he moved into the Group Home in August 2016. Mr Zgadzaj was frequently taken out to dinner with his brother and stayed the night at his mother's home on multiple occasions throughout the week.

DISIBILITY SERVICES COMMISSIONER REPORT

18. On 28 November 2017, the Court notified the Disability Services Commissioner (DSC) of Mr Zgadzaj's death, as he was a person with a disability who was receiving disability services or regulated disability services at the time of his death. Subsequent to this notification, the DSC undertook a *Disability Act 2006* (Vic) section 128I Referral Investigation.

19. The DSC was established under the *Disability Act 2006* (Vic) [the *Disability Act*]. The DSC is an independent oversight body for the Victorian disability sector. The *Disability Amendment Act* 2017 [the *Disability Amendment Act*] enhanced the role and powers of the DSC, allowing greater investigation, inquiry and inspection powers. The Commissioner may conduct investigations into allegations of abuse, assault, and neglect.

20. On 16 January 2019, the DSC provided its *Final Section 128I Investigation Report* in relation to Mr Bartosz Zgadzaj[11] (the DSC Report) to the Court, pursuant to section 132ZB of the *Disability Amendment Act*. Upon provision of the report, the

[11] Reference number IR2018/0507.

Commissioner requested that I comply with certain conditions for further use and disclosure of the same.[12]

21. The DSC Report raised many concerns in relation to the care and treatment of Mr Zgadzaj at the Group Home, some of which appeared to amount to missed opportunities to prevent the circumstances of his death. I determined that the following issues fell under the auspices of the Coronial jurisdiction and required further investigation:

    a. The adequacy of supervision provided to Mr Zgadzaj while he ate his food;

    b. The lack of appropriate swallowing assessments;

    c. The lack of discussion with his family about his choking risk, and

    d. Preventative or restorative measures taken by DHHS after Mr Zgadzaj's death.

CORRESPONDENCE FROM MR ZGADZAJ'S FAMILY

22. Mr Zgadzaj's family raised concerns in relation to the care and treatment he received from the DHHS Group Home. In a letter to the Court dated 29 November 2017, Mr Zgadzaj's brother Martin wrote that he '*made it clear to* (the Group Home) *that Bartosz needed for his food to be pre cut and he needed to be monitored during meal times as sometimes he would try rushing while eating*'.[13] Martin Zgadzaj was concerned that his brother may not have had adequate staff supervision, as he had been found unconscious and unresponsive while eating.

CORONERS PREVENTION UNIT REVIEW AND FURTHER INVESTIGATION

23. In light of the concerns raised by Mr Zgadzaj's family and the DSC Report, I requested that the Coroners Prevention Unit (CPU)[14] assist me in this matter. Specifically, I

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[12] Disability Services Commissioner Arthur Rogers, *Cover Letter to Final Section 128I Investigation Report IR2018/0507*, dated 16 January 2019.

[13] Martin Zgadzaj, *Family Letter of Concerns*, dated 29 November 2017, p 1.

[14] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the Coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations, as well as assisting in monitoring and evaluating the effectiveness of the recommendations. The CPU comprises a team with training in medicine, nursing, law, public health and the social sciences.

requested that the CPU review the circumstances of Mr Zgadzaj's death and formulate appropriate questions to put to DHHS at first instance.

Department of Health and Human Services Correspondence

24. On 26 March 2019, the Court sent a letter to Deputy Secretary of West Division DHHS Paul Smith. The letter informed Mr Smith that a mandatory Inquest into the Death of Bartosz Zgadzaj must be held pursuant to section 52(2)(b), as he was 'in care' at the time of his death and his death was not due to natural causes. The letter indicated that a number of concerns had been raised during the course of the Coronial Investigation, including the provision of the DSC Report. I requested that Mr Smith provide a response to a series of questions requiring further information about the outstanding concerns held in relation to Mr Zgadzaj's death.

25. On 30 April 2019, Mr Smith replied to my letter and responded to each of the questions posed.

Services Provided to Mr Zgadzaj

26. Mr Smith informed me that no information about Mr Zgadzaj's swallowing issues or choking risks was provided to DHHS at the time he entered the Department's care on 29 August 2016. On 9 December 2016, three months after he entered the facility, a dietician assessment of Mr Zgadzaj was completed. The assessment may yield recommendations for mealtime support. In this instance, the dietician recommended that Mr Zgadzaj's food be cut into "bite-sized" pieces and that staff remain with him while he ate his meal.

27. Mr Smith stated that a Nutrition and Swallowing Issue Checklist (NASIC) was also completed through the Department and was supported by Mr Zgadzaj's treating doctor. He explained that a NASIC is completed as part of the resident's annual Comprehensive Health Assessment Program (CHAP). A NASIC identifies if there are any swallowing concerns and if there are any further assessments required.

28. Mr Smith acknowledged that Mr Zgadzaj's choking and swallowing risks had been identified by some of the assessments conducted at the facility. However, when asked about the assessments conducted for Mr Zgadzaj, he only referenced the NASIC and dietician assessment; there was no reference to a Speech Pathologist Assessment.

Additionally, Mr Smith stated that it was not clear if the care staff of the Group Home were made aware of the outcome of Mr Zgadzaj's assessment nor if they followed the recommendations made subsequent to the dietician's assessment conducted in December 2016. Mr Smith also stated that, at the time of Mr Zgadzaj's death, there was no training for staff in relation to management of residents' swallowing and choking risks.

Actions Taken in Response to Mr Zgadzaj's Death

29. Mr Smith informed me that DHHS worked in close conjunction with the DSC to support the Commissioner's investigation into Mr Zgadzaj's death. The Department did not conduct a separate, internal investigation. However, DHHS did conduct two "Promoting Better Practice" Audits at the facility to assess compliance with the *Disability Act*. The audits were conducted for all residents, as well as general practice, at the facility.

30. Mr Smith indicated that outcome of both audits led to extensive changes at the Altona North Group Home. Mr Smith informed me of the following actions, *inter alia*, taken in response to the Promoting Better Practice Audits:

    a. Communication assessments were conducted for all residents;

    b. Dysphasia training was provided to all staff on three occasions, and

    c. Ongoing file reviews and random auditing was conducted.

31. Mr Smith also stated that there were significant changes to ongoing practice at the Group Home which included, *inter alia*:

    a. NASICs are conducted as part of the entry and exit process to the facility;

    b. All swallowing risks are referred to a Speech Pathologist for assessment;

    c. New casual staff are rostered 30 minutes earlier for adequate induction time;

    d. Staff induction proforma includes "health alerts" for residents, and

    e. Ongoing file reviews and random auditing.

State-wide Audits & Changes

32. In February 2019, DHHS undertook a state-wide audit of all NASICs and cross-referenced mealtime assistance plans to ensure congruence. Any ongoing issues were to remain monitored by Assistant Directors of the Department.

33. Mr Smith also stated that the Department's Residential Services Practice Manual had been updated to ensure timely assessment and documentation of patient health risks. DHHS now requires each Entry, Exit, Relocation and Residential Statement (EERRS) to include procedures for formal handover of the resident's healthcare needs, including any further assessments required. The EERRS also require swallowing and choking assessments for all new residents to DHHS supported facilities, including a current NASIC. The Practice Manual mandates, *inter alia*, the completion of a NASIC within seven days of a resident entering a residential service.

Prevention of Similar Deaths

34. Mr Smith stated that the Department was confident that swallowing and choking risks would now be managed in a way that would not lead to a fatal outcome. He stated that the newly instituted processes ensured that: swallowing and choking assessments were conducted; healthcare plans were formulated and executed in a timely manner; risks were communicated amongst staff and family members; staff and residents were supported. He also indicated that staff now had the capacity to identify an area of potential risk so that it could be rectified.

SUMMARY INQUEST

35. DHHS made concessions which were consistent with the Findings contained in the DSC Report, obviating any need to hear witness evidence. I determined that this matter would be appropriately finalised by way of a Form 37 *Finding into Death with Inquest* and to hand-down my Findings at the conclusion of a Summary Inquest. Interested Parties were informed of my determination by way of a Summary Inquest Notice dated 10 July 2019.

COMMENTS

Pursuant to section 67(3) of the Coroners Act 2008 (Vic), I make the following comments connected with the death:

1. The Department of Health and Human Services failed, at numerous points, to provide necessary services and assistance to Mr Zgadzaj. He was a vulnerable person who was not provided with a safe and supportive environment with respect to a specific, significant aspect of his disability. These failings directly led to Mr Zgadzaj's untimely death.

2. Mr Zgadzaj was not referred for a swallowing assessment by a speech pathologist after entering the Department's care in August 2016. It is not clear whether staff were made aware of the dietician's assessment and recommendations to cut Mr Zgadzaj's food into "bite-sized" portions and supervise his eating. There was no staff training in relation to managing a resident's choking risks during the time that he lived in the Group Home. A Nutrition and Swallowing Issue Checklist was completed for Mr Zgadzaj but evidently not well-understood or utilised by staff when he choked on his food on 24 November 2017.

3. I note Mr Smith's indication that the Department of Health and Human Services was not provided any information in relation to Mr Zgadzaj's choking risks when he entered the Group Home in 2016. However, I accept that Martin Zgadzaj did convey to staff that his brother's meals needed to be cut up for him, at some point during his stay at the Group Home. This highlights the importance of communicating with family and other care-givers in the disability services setting, as well as documenting and relaying any relevant information to other staff members. I endorse, *inter alia*, the Department of Health and Human Services' initiative to introduce Nutrition and Swallowing Issue Checklists at the entrance and exit of residents who present with swallowing issues or choking risks, which would necessitate discussion with family.

4. The Department of Health and Human Services have made substantial concessions to the Court in relation to their failures in the provision of disability services to Mr Zgadzaj. The Court has been informed of the preventative measures taken since his death. These include two internal audits at the Group Home in Altona North, resulting in extensive changes at the facility. Additionally, the Department of Health and Human

Services undertook a state-wide audit to ensure that residents' mealtime assistance plans were consistent with their Nutrition and Swallowing Issue Checklists. In light of the changes and concessions made by the Department, I have not identified further opportunities for prevention which may be contained in coronial Recommendations.

5. I thank Mr Zgadzaj's family for their participation in the coronial process. They provided Mr Zgadzaj with significant support throughout his life and remained deeply involved in his care after he moved into the Group Home in Altona North. I acknowledge the immense distress and grief they must have endured due to his death.

FINDINGS

Having investigated the death of Bartosz Zgadzaj and having held an Inquest into his death, I make the following Findings pursuant to section 67(1) of the *Coroners Act 2008* (Vic):

1. I find that the identity of the deceased is Bartosz Zgadzaj, who was born on 5 May 1978 and who died on 28 November 2017 at Footscray Hospital, 160 Gordon Street, Footscray, Victoria 3011.

2. I further find that Bartosz Zgadzaj resided in Department of Health and Human Services shared supported accommodation in Altona North. As such, I find that he was 'in care' immediately before his death pursuant to the definition contained in section 3 of the *Coroners Act 2008* (Vic).

3. AND I further find that Bartosz Zgadzaj choked on food in the context of being unsupervised while eating a meal on 24 November 2017.

4. AND I further find that Bartosz Zgadzaj ought to have been supervised and assisted by staff of the share accommodation where he lived whenever he ate food.

5. AND I further find that there is clear and cogent evidence that Bartosz Zgadzaj's death was preventable.

6. I acknowledge and accept the restorative and preventative measures implemented by the Department of Health and Human Services in response to Bartosz Zgadzaj's death.

7. I accept and adopt the medical cause of death formulated by Dr Matthew Lynch and I find that Bartosz Zgadzaj died from hypoxic ischaemic encephalopathy complicating acute airway obstruction by food bolus.

Pursuant to section 73(1) of the *Coroners Act 2008* (Vic), I order that this Finding be published on the internet.

I direct that a copy of this Finding be provided to the following:

Maria Zgadzaj

Martin Zgadzaj

The Department of Health and Human Services

The Disability Services Commissioner

Signature:

AUDREY JAMIESON
CORONER
Date: **7 August 2019**