



IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

Court Reference: COR 2019 2230

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 60(2)*

*Section 67 of the Coroners Act 2008*

Amended pursuant to *section 76 of the Coroners Act 2008* on 8 November 2019

Findings of:	Simon McGregor, Coroner
Deceased:	<b>Robert Szlamowicz</b>
Date of birth:	14 October 1960
Date of death:	2 May 2019
Cause of death:	1(a) Aspiration pneumonia 1(b) End stage down syndrome
Place of death:	Barwon Health <sup>1</sup> - University Hospital Geelong (Intensive Care Unit) located at Bellarine Street, Geelong Victoria 3220

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<sup>1</sup> Typographical error relating to spelling of Barwon Health. Identified internally. Amended to reflect correct spelling.

## INTRODUCTION

1. Robert Szlamowicz was a 58-year-old man who had the medical condition, trisomy 21, otherwise known as down syndrome. He resided at Stradbroke House located at 6-8 Stradbroke Street, Norlane Victoria 3214 at the time of his death.
2. Mr Szlamowicz died from aspiration pneumonia and end stage down syndrome at the Barwon Health<sup>2</sup>- University Hospital Geelong (the Hospital), Intensive Care Unit (ICU), located on Bellarine Street, Geelong Victoria 3220 on 2 May 2019.

## THE PURPOSE OF A CORONIAL INVESTIGATION

3. Mr Szlamowicz's death was reported to the Coroner as it appeared unexpected, unnatural or to have resulted, directly or indirectly, from an accident and so fell within the definition of a reportable death in the *Coroners Act 2008*.
4. 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.
5. 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.
6. After considering all the material obtained during the coronial investigation, I determined that I had sufficient information to complete my task as coroner and that further investigation was not required. 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.
7. In the coronial jurisdiction facts must be established on the balance of probabilities.<sup>3</sup>

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<sup>2</sup> Typographical error relating to spelling of Barwon Health. Identified internally. Amended to reflect correct spelling on 7 November 2019.

<sup>3</sup> This is 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.

8. In considering the issues associated with this finding, I have been mindful of Mr Szlamowicz's basic human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

## **BACKGROUND**

9. Mr Szlamowicz had recurrent admissions to hospital for functional decline and aspiration pneumonia, with rapid deterioration in swallow reflex. On 27 April 2019, after experiencing further deterioration with severe right sided pneumonia, he presented to the Hospital.<sup>4</sup>
10. A speech pathologist assessment indicated that Mr Szlamowicz had no swallow reflex at all, with a high aspiration risk, regardless of his feeding regime.<sup>5</sup>
11. Mr Szlamowicz was treated initially with antibiotics and oxygen therapy. There was a planned discussion with Mr Szlamowicz's guardian regarding ongoing treatment options, given his lack of suitability for either gastrointestinal or parental supplemental nutrition.<sup>6</sup>
12. On 30 April 2019, Mr Szlamowicz deteriorated further and he was admitted to the ICU for oxygen and blood pressure support.<sup>7</sup>

## **CIRCUMSTANCES IN WHICH THE DEATH OCCURRED**

13. After 48 hours of therapy and multiple discussions with Mr Szlamowicz's guardian, a medical consensus was reached that, given deterioration in swallowing function indicated an irreversible underlying pathology and poor quality of life moving forward, Mr Szlamowicz would be palliated.<sup>8</sup>
14. Mr Szlamowicz died on 2 May 2019 at 7.14pm.<sup>9</sup>

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<sup>4</sup> E-Medical Deposition Form, Case Reference Number: 2019002230, Coronial Brief.

<sup>5</sup> Ibid.

<sup>6</sup> Ibid.

<sup>7</sup> Ibid.

<sup>8</sup> Ibid.

<sup>9</sup> Ibid.

## IDENTITY AND CAUSE OF DEATH

15. On 8 May 2019, Sally L Williams visually identified the body of her client, Robert Szlamowicz, born 14 October 1960. Identity is not in dispute and requires no further investigation.
16. On 5 May 2019, Dr Michael Burke, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an external examination of Mr Szlamowicz's body and reviewed a post mortem computed tomography (CT scan) and the Police Report of Death for the Coroner. Dr Burke provided a written report, dated 7 May 2019, in which he formulated the cause of death as:  
  
*'I(a) Aspiration pneumonia  
I(b) End stage down syndrome'.*
17. Dr Burke commented that the postmortem CT scan showed some increasing lung markings and that there was an atrophic brain. The external examination was unremarkable.
18. There was no evidence to suggest that Mr Szlamowicz's death was due to anything other than natural causes.
19. I accept Dr Burke's opinion as to cause of death.

## FINDINGS AND CONCLUSION

20. Pursuant to section 73(1B) of the Act, I direct that this finding be published on the Internet.
21. I express my sincere condolences to Mr Szlamowicz's family for their loss.
22. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:
  - (a) The identity of the deceased was Robert Szlamowicz, born 14 October 1960;
  - (b) The death occurred on 2 May 2019 at the Barwon Health<sup>10</sup>- University Hospital Geelong (Intensive Care Unit) located at Bellarine Street, Geelong Victoria 3220 from aspiration pneumonia and end stage down syndrome; and
  - (c) The death occurred in the circumstances described above.

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<sup>10</sup> Typographical error relating to spelling of Barwon Health. Identified internally. Amended to reflect correct spelling on 7 November 2019.

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

- (a) Mr Ron Slamowicz, senior next of kin
- (b) State Trustees, interested party
- (c) Mrs Lorraine Judd, Barwon Health<sup>11</sup>, interested party
- (d) Senior Constable Sarah Boore, Coroner's Investigator

Signature:



**SIMON McGREGOR**  
**CORONER**

Date: 7 November 2019



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<sup>11</sup> Ibid.