IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 006734

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

*Section 67 of the **Coroners Act 2008***

Inquest into the Death of Anthony Dzaja

Delivered On:	30 April 2025
Delivered At:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank, Victoria, 3006
Hearing Dates:	30 April 2025
Findings of:	Coroner Ingrid Giles
Counsel Assisting the Coroner	Kajhal McIntyre, Senior Coroners Solicitor
Keywords	In Care; Specialist Disability Accommodation; SDA; National Disability Insurance Scheme; NDIS; Acquired Brain Injury; ABI; Palliative Care

INTRODUCTION

1. On 4 December 2023, Anthony Dzaja was 44 years old when he died at Gandarra Palliative Care ward, Queen Elizabeth Centre, Ballarat Base Hospital.

2. Anthony lived with epilepsy and cognitive impairment, secondary to an acquired brain injury (**ABI**) which he had sustained as the result of a motor vehicle accident in 1997. He suffered regular tonic clonic seizures which worsened in the final years of his life. Anthony's medical history also included lymphocytic colitis and gastritis.

3. While Anthony had experienced impacts of his ABI throughout his life, his condition progressively deteriorated during the final years and months of his life. From 17 September 2021 until his death, Anthony attended the Emergency Department at Ballarat Base Hospital 19 times and was admitted on 11 occasions.

4. At the time of his death, Anthony was a National Disability Insurance Scheme (**NDIS**) participant and resided in Specialist Disability Accommodation (**SDA**) operated by eQuality Support.

5. Anthony was engaged to his partner, Jennifer Smith (**Jennifer**), with whom he had been in a relationship for approximately 9 years.

THE CORONIAL INVESTIGATION

6. Anthony's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). This is because, immediately before his death, Anthony was a person 'in care' within the definition under section 3 of the Act, as he was a person in Victoria who was an SDA resident residing in an SDA enrolled dwelling.[1]

7. This category of death is reportable to ensure independent scrutiny of the circumstances leading to death given the vulnerability of this cohort and the level of power and control

[1] The *Coroners Regulations 2019* were amended on 11 October 2022 to create a new category of person considered to be 'in care' under Regulation 7 of the *Coroners Regulations 2019*, being a 'person in Victoria who is an SDA resident residing in an SDA enrolled dwelling'. The amendments also introduced an associated reporting obligation under Regulation 8 for a person who: (ii) is funded to provide an SDA resident with daily independent living support; and (ii) has reasonable grounds to believe that the resident's death has not been reported to a coroner or the Institute.

exercised by those who care for them. The coroner is required to investigate the death, and publish their findings, even if the death has occurred as a result of natural causes.[2] The coroner is also required to hold an inquest into the death,[3] except in circumstances where the coroner considers that the death was due to natural causes.[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. Victoria Police assigned Senior Constable Sean Jackson to be the Coronial Investigator for the investigation of Anthony's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as Anthony's partner, the forensic pathologist, carers and clinicians, and investigating officers – and submitted a coronial brief of evidence.

11. This finding draws on the totality of the coronial investigation into the death of Anthony Dzaja 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] Section 73(1B) of the Act.
[3] Section 52(2)(b) of the Act.
[4] Section 52(3A) of the Act.
[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 provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

BACKGROUND

12. On 31 December 1997, Anthony was 18 years old when he was involved in an accident in which he was struck by a motor vehicle while a pedestrian. Tragically, Anthony's then-girlfriend died in the collision, while Anthony sustained injuries including an acquired brain injury (**ABI**). The motor vehicle accident was subject to an investigation by Victoria Police.

13. Anthony's subsequent partner, Jennifer, described that following the collision, Anthony "*had to learn to walk, talk and eat all over again*". He also reportedly experienced cognitive impairment, including difficulties with his short-term memory and organisational skills.

14. Despite these injuries, Jennifer describes that Anthony was still "*very well*" at the time that she met him in approximately 2014. The couple met while they were both volunteering at a gift shop in Bacchus Marsh. Jennifer describes that at this stage, Anthony presented as "*very talkative,*" and was still able to walk and drive a car. She understands that Anthony had developed epilepsy shortly before, or around, the year that they met.

15. While Anthony volunteered at the gift shop, he did not have paid employment and received payments from the Transport Accident Commission (**TAC**) for his daily care and support needs, treatment therapy, medical expenses, continence products and related consumables, and equipment needs.

16. From approximately 2016, Jennifer describes that Anthony's condition began to deteriorate.

17. After suffering a significant seizure which led to a hospital admission, it was determined that Anthony required additional care and support, and he subsequently moved into a property funded by the TAC.

18. Jennifer describes from this time onwards, Anthony's seizures became "*worse and more frequent*," and that he was commenced on medications.

19. Over the years following, Anthony further declined in both his cognition and functioning. Anthony had deteriorated from being able to access the community independently, to

becoming reliant on carers for most aspects of care. Jennifer observed that Anthony became forgetful and she noticed that he was "*doing odd things*". Later, after sustaining injuries in a fall, Jennifer described that Anthony's mobility was reduced and he could no longer walk or use his hands.

20. In October 2021, Anthony was admitted to the Brain Disorder Unit (**BDU**) at Austin Health to investigate his cognitive decline and associated behaviours of concern. Medical investigations were completed by his general practitioner, neuropsychiatrist and neurologist, which resulted in a diagnosis of Major Neurological Disorder.[6]

21. In November 2021, Anthony was discharged from the BDU and moved into an NDIA-funded SDA residence in Delacombe, where he received Supported Independent Living (**SIL**) support provided by eQuality Support.

22. Anthony's cognition and mobility continued to decline. During the period from September 2021 until March 2022, Anthony was able to mobilise with a 4-wheel frame with the assistance of 1-2 Disability Support Workers (**DSWs**). He was able to communicate his basic needs and wants and was tolerating a regular diet and fluids but required assistance with personal care.

23. On 16 March 2022, Anthony's DSWs observed that he was very pale and unsteady. Anthony was transported to Ballarat Base Hospital and admitted for further investigations. During his admission, Anthony had several seizures. Brain imaging showed an increase in white matter indicating neurodegenerative changes. However, no direct cause was identified. Anthony was discharged on 21 April 2022, in circumstances where his physical and cognitive baseline had deteriorated.

24. Upon his return home, Anthony's carers noted that his support needs had increased. Anthony required the use of a mobile sit-to-stand aid to transfer as he was unable to walk.

[6] I note that Anthony's partner has indicated in her statement that he was diagnosed with aphasia, but that other records before the Court indicate that Anthony was diagnosed only with a major neurological disorder, with no direct cause identified.

Anthony's verbal output had also deceased to basic "yes" and "no" responses, and he now required feeding and drinking assistance.

25. Over the following year, Anthony became increasingly unwell. Anthony began having large tonic clonic seizures, resulting in regular transfers to Ballarat Base hospital for assessment. Anthony's carers described that with each seizure, he deteriorated further both physically and cognitively. In January 2023, Anthony lost the ability to stand and became reliant on hoist transfers. By June 2023, Anthony's swallowing had deteriorated to the extent that he was placed on a minced moist diet and moderately thick fluids.

26. In July 2023, eQuality Support engaged Ballarat Hospice Care to provide community palliative care and advice. Anthony also continued to be supported by his community allied health team, which included an Occupational Therapist and Physiotherapist who provided regular reviews and assisted eQuality Support with training and care plans.

27. Jennifer described that during the final months of his life, Anthony spent his days lying in bed watching television as he "*couldn't do much else*". Anthony was "*sleeping all day, every day*" and lost a lot of weight, despite the best efforts of herself and his carers who "*tried so hard to feed him and look after him*". A palliative care team was arranged who would attend on a daily basis, including to administer pain relief.

28. On 8 September 2023, Anthony was reviewed by his neurologist who noted that despite all measures undertaken, Anthony had continued to deteriorate. The neurologist suggested that in the instance of any further medical episodes, comfort care measures should be instituted.

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

Circumstances in which the death occurred

29. On 22 November 2023 at 4.43am, Anthony had a large tonic clonic seizure which lasted six minutes. The seizure was witnessed by his disability support workers (**DSWs**) who called an ambulance. Anthony was subsequently brought by ambulance to the Emergency Department at Ballarat Base Hospital.

30. Jennifer noted that prior to this incident, she observed that Anthony had a "*sharp cough*" and was "*weaker than usual*".

31. Upon assessment, Anthony's treating team at Ballarat Base Hospital formed an impression of hypoxic respiratory failure due to aspiration pneumonia, following a generalised tonic clonic seizure on a background of known epilepsy secondary to an ABI.

32. Anthony was commenced on 15L of oxygen via a non-rebreather mask and intravenous antibiotics.

33. He was reviewed by the Intensive Care Unit (**ICU**) Outreach team who considered that he was not appropriate for ICU admission and unlikely to tolerate non-invasive ventilation.

34. After being treated with intravenous antibiotics for over 48 hours, Anthony had not made a meaningful recovery. As such, in discussion with his partner and carers, a decision was made on 23 November 2023 to transition Anthony to comfort care measures only.

35. On 24 November 2023, Anthony was transferred to the Gandarra Palliative Care ward in the Queen Elizabeth Centre. He was commenced on a syringe driver of midazolam for seizure prophylaxis and morphine for pain. Despite this, Anthony had a further generalised tonic clonic seizure on 1 December 2023.[7]

36. Anthony died three days later on 4 December 2023 at Gandarra Palliative Care ward, Queen Elizabeth Centre.

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[7] While Anthony was an inpatient at Gandarra Palliative Care Unit, two incidents were lodged in the Grampians Health Ballarat VHIMS system:

a) On 1 December 2023, treating clinicians discovered that an old Norspan medication patch had not been removed within the appropriate timeframe. The incident was notified to the treating doctor and reviewed by the Quality Team. It was recorded on the VHIMS system that there was no harm sustained, no associated risk and that no further action was required.
b) On 3 December 2023 at 6pm, it was identified that the syringe driver (morphine/midazolam) was displaying the wrong syringe. The syringe driver was stopped and changed in accordance with the new order. The incident was reviewed by the Quality Team and an email was sent to all staff as a reminder to check the syringe type when setting up the syringe driver and attending to 4 hourly checks. It was recorded on the VHIMS system that there was no harm sustained, no associated risk, and no further action was required.

In circumstances in which Anthony was receiving advanced palliative care and in which both incidents were thoroughly reviewed, I am satisfied that the incidents described above did not cause, or contribute, to his death, and therefore, no further investigation is warranted.

Identity of the deceased

37. On 4 December 2023, Anthony Dzaja, born 20 April 1979, was visually identified by his fiancée, Jennifer Smith.

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

Medical cause of death

39. On 5 December 2023, Forensic Pathologist Dr Brian Beer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination and reviewed a post mortem computed tomography (**CT**) scan and relevant materials, including the Medical Deposition and the Victoria Police Report of Death (**Form 83**). Dr Beer provided a written report of his findings dated 13 December 2023.

40. Dr Beer noted that the external examination showed findings in keeping with Anthony's known clinical history.

41. The post mortem CT scan reflected a remote craniotomy with metal clips, cerebral atrophy and hydrocephalus. Anthony's chest showed no clear lung consolidation, and his abdomen showed a fatty liver and common bile duct clip. There were no fractures.

42. Taking into account all information available at that time, Dr Beer provided an opinion that a reasonable formulation for the medical cause of death was:

> *1(a) Complications following seizure on a background of acquired epilepsy*
>
> *1(b) Acquired Brain Injury secondary to head injuries sustained in a motor vehicle accident.*

43. I accept Dr Beer's opinion.

FINDINGS AND CONCLUSION

44. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Anthony Dzaja, born 20 April 1979;

b) the death occurred on 4 December 2023 at Ballarat Base Hospital 1 Drummond Street North, Ballarat, Victoria 3350, from *1(a) complications following seizure on a background of acquired epilepsy* and *1(b) acquired brain injury secondary to head injuries sustained in a motor vehicle accident*; and

c) the death occurred in the circumstances described above.

45. Having considered all of the circumstances, I am satisfied that Anthony died as the result of the predictable progression of his long term medical conditions, including regular tonic clonic seizures on a background of epilepsy secondary to an ABI sustained at a relatively young age.

46. While I recognise that Anthony, as an SDA resident residing in an SDA enrolled dwelling, was reliant on others for his day-to-day care, I am satisfied that Anthony's death was not caused or contributed to by any issues related to the quality of care provided to him. Rather, it appears on the evidence that Anthony had access to a high quality of care provided by an extensive and multidisciplinary care team, who took proactive steps to investigate and manage Anthony's deteriorating conditions over many years, and to instigate comfort care only when this reflected Anthony's best interests.

47. It is further clear that Anthony was well supported by his partner Jennifer, who loved and cared for him under challenging circumstances until the time of his death.

48. In these circumstances, I have not identified any opportunities for prevention.

I convey my sincere condolences to all who loved and cared for Anthony.

ORDERS AND DIRECTIONS

In accordance with section 73(1B) of the Act, I order that this finding be published on the Internet.

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

Jennifer Smith, Senior Next of Kin

eQuality Support

Grampians Health

Senior Constable Sean Jackson, Coronial Investigator

Signature:

Coroner Ingrid Giles

Date: 30 April 2025

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 inquest. 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.