IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2023 000259

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

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

Deceased:	Georgios Stamkos
Delivered on:	7 August 2024
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	7 August 2024
Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Counsel assisting the coroner:	Grace Horzitski, Senior Coroner's Solicitor
Key words:	In care, compulsory patient, food bolus, dysphagia

INTRODUCTION

1. On 13 January 2023, Georgios Stamkos was 68 years old when he died in hospital after choking on food on the background of a history of dysphagia (difficulty swallowing).

2. Mr Stamkos was born in Greece and moved to Australia as a child. He had been married to his wife, Irene, for 36 years and they had one son together. Mr Stamkos worked as a delivery driver for his sister's company until 1995 when he retired. His wife remembered him as a beautiful person with a beautiful heart.

3. According to Mr Stamkos' general practitioner, Dr Leslie Pinto, his medical history included longstanding type 2 diabetes mellitus, stage 3 chronic kidney disease, hypertension, severe sleep apnoea, chronic anaemia and thrombocytopaenia, chronic severe back pain, fatty liver disease, and bipolar disorder. He was under the care of a number of specialists to assist with these conditions.

4. Mr Stamkos' psychiatrist, Dr Samir Ibrahim, explained that Mr Stamkos had been diagnosed with bipolar disorder at a young age. He had his first admission as a child at Larundel Hospital and had since had further other admissions over the years to different hospitals. He had seen multiple mental health professionals and had been treated with a variety of pharmacological interventions.

INVESTIGATION AND SOURCES OF EVIDENCE

5. This finding draws on the totality of the coronial investigation into the death of George Stamkos including evidence contained in the coronial file comprising statements from Mr Stamkos' treating practitioners and the Coroner's Investigator and the autopsy report from the Victorian Institute of Forensic Medicine (**VIFM**).

6. All of this material, together with the inquest transcript, will remain on the coronial file.[1] In writing this finding, I do not purport to summarise all the material and evidence but will only refer to it in such detail as is warranted by its forensic significance and the interests of narrative clarity.

[1] From the commencement of the *Coroners Act 2008* (**the Act**), that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act. Unless otherwise stipulated, all references to legislation that follow are to provisions of the Act.

PURPOSE OF A CORONIAL INVESTIGATION

7. The purpose of a coronial investigation of a *"reportable death"*[2] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[3]

8. Mr Stamkos' death falls within the definition of reportable death, specifically section 4(2)(a) of the Act which includes (relevantly) an unexpected or unnatural death and section 4(2)(d) which includes a death of a person who, immediately before death, was a patient within the meaning of the *Mental Health and Wellbeing Act 2022* (Vic). Furthermore, it is uncontroversial that immediately before death, Mr Stamkos was a person placed in custody or care as defined in section 4(2)(c) of the Act and that an inquest was therefore mandated as part of the coronial investigation by section 52(2)(b) of the Act.

9. 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 proximate and causally relevant to the death, and not all those circumstances which might form part of a narrative culminating in death.[4]

10. The broader purpose of any 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.[5]

11. Coroners are empowered to report to the Attorney-General in relation to 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

[2] The term is exhaustively defined in section 4 of the Act. Apart from a jurisdictional nexus with the State of Victoria a reportable death includes deaths that appear to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury; and, deaths that occur during or following a medical procedure where the death is or may be causally related to the medical procedure and a registered medical practitioner would not, immediately before the procedure, have reasonably expected the death (section 4(2)(a) and (b) of the Act). Some deaths fall within the definition irrespective of the section 4(2)(a) characterisation of the 'type of death' and turn solely on the status of the deceased immediately before they died – section 4(2)(c) to (f) inclusive.
[3] Section 67(1).
[4] 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.)
[5] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, compared with the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

health or safety or the administration of justice.[6] These are effectively the vehicles by which the coroner's prevention role can be advanced.[7]

12. Coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.[8]

IDENTITY OF THE DECEASED

13. On 13 January 2023, Georgios Stamkos, born 18 June 1954, was visually identified by his wife, Irene Stamkos, who signed a formal Statement of Identification to this effect.

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

MEDICAL CAUSE OF DEATH

15. Forensic Pathologist, Dr Joanne Ho, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 17 January 2023 and provided a written report of her findings dated 15 May 2023.

16. Dr Ho noted that Mr Stamkos was witnessed to be choking and had a history of dysphagia. She explained that an airway obstruction is a blockage in any part of the airway. The airway conveys inhaled air from the nose and mouth into the lungs and an obstruction may partially or totally prevent inhalation. Given the prolonged period between the initial event, medical intervention and the autopsy, there were no features at autopsy to confirm an airway obstruction and findings are based of the clinical circumstances.

17. The post-mortem examination showed bronchopneumonia within the right lung, with a focal area suggestive of aspiration. There was lobar pneumonia within the left lung. Dr Ho explained that pneumonia causes the air sacs in the lungs to fill with fluid and pus, which causes respiratory difficulty or even respiratory failure and death. Besides respiratory failure, a pneumonia of this extent will induce a severe systemic inflammatory response, which may

[6] See sections 72(1), 67(3) and 72(2) regarding reports, comments, and recommendations respectively.
[7] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and 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.
[8] Section 69(1). However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69 (2) and 49(1).

cause metabolic derangement, septic shock, and eventual death. The cause of his pneumonia is likely secondary to aspiration.

18. The examination also showed an enlarged heart (cardiac hypertrophy). Dr Ho explained that cardiac hypertrophy is enlargement of the heart, not in keeping with normal physiological change in an individual. Increased heart mass is correlated with increased cardiac mortality and morbidity. The cause of his enlarged heart is unknown. The most common cause is hypertension.

19. It was noted that Mr Stamkos had a T9-10 unstable 3 column fracture on an ante-mortem CT scan. An MRI showed no spinal cord compression or cord injury. This was also confirmed at autopsy. However, given the clinical impression of a suspected choking and subsequent aspiration pneumonia, the thoracic spine fractures have unlikely caused or contributed to his death.

20. There were no other injuries identified on the post-mortem examination which may have caused or contributed to death.

21. Dr Ho provided an opinion that the medical cause of death was *"1(a) Complications of a witnessed airway obstruction from food bolus in a man with dysphagia"*.

22. I accept Dr Ho's opinion.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

23. From March to September 2022, Mr Stamkos' mental state was noted to be stable. His psychiatric medications at this time were risperidone, Latuda (lurasidone), sodium valproate, and Benztrop (benzatropine).

24. Between 15 and 26 October 2022, Mr Stamkos was admitted to the Northen Hospital for investigation of symptoms of confusion, lethargy, and urinary incontinence. He was diagnosed with liver cirrhosis and was treated for hepatic encephalopathy.[9]

25. During this admission, he received input from Speech Pathology who noted that he was presenting with mild oropharyngeal dysphagia and could tolerate a diet of soft and bite sized foods and moderately thick fluids. Mr Stamkos was discharged home on 26 October 2022 with lactulose and was referred to the outpatient gastroenterology clinic.

[9] The loss of brain function when a damaged liver does not remove toxins from the blood.

26. In early November 2022, Mr Stamkos advised his general practitioner that he was experiencing swallowing difficulties and that he was under the care of a speech pathologist who advised him to consume thickened fluids and avoid dry foods. Dr Pinto noted that there was no record of Mr Stamkos reporting swallowing difficulties prior to this time.

27. On 8 November 2022, Mr Stamkos was admitted to the Northern Hospital in the setting of worsening confusion and cough, thought to be due to aspiration pneumonia. He also provided a history of choking on food and fluids since the start of 2022.

28. He was subsequently admitted under the medical team for management of multifactorial delirium secondary to valproate toxicity, and also commenced on antibiotics for the potential pneumonia.

29. Mr Stamkos' valproate medication was ceased, and he was reviewed by the Psychiatry Team. He was also reviewed by Speech Pathologists and was initially placed on a modified diet of extreme thick fluids and pureed food, which he appeared to tolerate without clinical evidence of further aspiration. This was upgraded to soft bite sized food and moderately thick fluids with plan to further assess for silent aspiration via a videofluroscopy study.

30. On 15 November 2022, Mr Stamkos underwent a videofluroscopic swallow study, which demonstrated reduced epiglottic deflection and impaired pharyngeal contraction due to osteophytes (bone spurs) at the C3/4 level. There was a risk of silent aspiration noted with all food consistencies tried and therefore a recommendation was made for Mr Stamkos to be nil by mouth. A nasogastric tube was inserted for feeds.

31. On 24 November 2022, Mr Stamkos was transferred to St Vincent's Hospital for further assessment and potential surgical intervention for the osteophytes. He was also investigated for delirium however the medical team considered there was no evidence of decompensated liver disease or hepatic encephalopathy. Mr Stamkos exhibited a relapse of bipolar disorder during this admission in the context of valproate cessation. It was decided that Mr Stamkos was not a candidate for surgery, and he was transferred back to the Northern Hospital on 30 November 2022.

32. Mr Stamkos returned to the Northern Hospital under the Medical Team. He had a one-on-one nursing special during his admission due to verbal and physical aggression, falls risks, and sexually disinhibited behaviours. He was noted to be experiencing a relapse of his bipolar disorder.

33. On 2 December 2022, Mr Stamkos was placed on an Assessment Order and a Temporary Treatment Order under the *Mental Health and Wellbeing Act 2022* (Vic). He was recommenced on sodium valproate with gradual titration over the course of his admission.

34. Over the following days, Mr Stamkos was reviewed by Speech Therapy clinicians and trialled on moderately thickened fluids. According to Dr Yana Sunderland, Division Director Medicine at Northern Health:

> *On 6 December 2022 the Medical team had a long discussion with Mr Stamkos' wife, the medical treatment decision maker, regarding his dysphagia. The Medical team advised that Mr Stamkos was to continue on nasogastric feeds as recommended by Speech Pathology as his swallow had not improved, however Mr Stamkos' wife requested that he revert to oral solid food intake. This was in keeping with the wishes that Mr Stamkos was expressing though he did not have capacity to understand the risks associated with this due to his BPAD [bipolar] and delirium. The Medical team advised that this was up to the family to decide if they wanted to risk feeding against medical advice and accept the risk of aspiration pneumonia. Mr Stamkos' wife confirmed that she was not willing to take the risk at this stage.*

35. On 9 December 2022, Mr Stamkos self-removed his nasogastric tube, which had become blocked. Other options to cope with Mr Stamkos' ongoing dysphagia, such as the insertion of a percutaneous endoscopic gastrostomy (**PEG**), were discussed with Mr Stamkos' family. However, they were not agreeable to the suggestion of a long-term PEG and emphasised that eating solid food was important to Mr Stamkos. It was subsequently agreed that Mr Stamkos would continue with the nasogastric tube for the time being.

36. However, later that day Mr Stamkos refused reinsertion of the nasogastric tube. He was therefore placed on a pureed diet with plans to increase this if tolerated without complication.

37. Over the following days, Mr Stamkos exhibited aggressive behaviour. Following discussions with Mr Stamkos' family, an application was made for urgent electroconvulsive treatment (**ECT**). On 14 December 2022, the Mental Health Tribunal granted 12 treatments of ECT over 12 weeks.

38. On 15 December 2022, Mr Stamkos experienced a fall with head strike, resulting in acute mid-thoracic pain and left shoulder deformity. As he did not tolerate spinal precautions and was intact from a neurological standpoint, it was decided that he would be managed symptomatically. He experienced a further fall on 17 December 2022 without apparent injury.

39. On 19 December 2022, Speech Pathology assessed Mr Stamkos and considered he was suitable for unrestricted amounts of pureed food and moderately thickened fluids with supervision.

40. On 22 December 2022, the Mental Health Tribunal granted an Inpatient Treatment Order under the *Mental Health and Wellbeing Act 2022* up until 21 June 2023. Mr Stamkos remained on the medical ward due to his nutritional needs and the requirement of close monitoring of his bloods and oral intake.

41. On 29 December 2022, Mr Stamkos was reviewed by Speech Pathology and was assessed for gradual upgrade to a minced moist diet and mildly thickened fluids.

42. On 31 December 2022, Mr Stamkos experienced a further fall without injury.

43. On 6 January 2023, Speech Pathology upgraded Mr Stamkos to a soft and bite sized diet with mildly thickened fluids.

44. Later that day, Mr Stamkos was transferred to the inpatient psychiatry ward (**NPU**) for ongoing management of bipolar disorder.

45. On 10 January 2023, Mr Stamkos was pushed by a fellow patient but did not sustain any injuries as a result.

46. At about 1.00pm that day, Mrs Stamkos visited her husband, bringing him some food as Mr Stamkos had requested 'normal' food. Staff attempted to provide Mr Stamkos with pre-made thickened drinks however this was rejected. Mr Stamkos subsequently experienced difficulty with swallowing the food, and Mrs Stamkos alerted hospital staff and requested water.

47. Mr Stamkos was advised to have some thickened fluids to alleviate the choking, but he refused. Continuing to choke, Mr Stamkos collapsed onto the floor. Hospital staff administrated cardiopulmonary resuscitation and called a Code Blue at 1.59pm. His airway was suctioned and, following return of spontaneous circulation at 2.35pm, he was transferred to the Intensive Care unit.

48. The following day, the treating team met with Mr Stamkos' family and experienced that he had suffered a cardiac arrest with reduced oxygen to the brain but were unable to confirm the extent to the brain injury at the time.

49. On 12 January 2023, Mr Stamkos underwent a CT scan of the brain and chest, which showed evidence of moderate tension pneumothorax, multiple rib fractures likely secondary to cardiopulmonary resuscitation, and an incidental finding of T9-10 spinal fracture. The CT also suggested aspiration pneumonia. Later that day, an intercostal drain was inserted to address pneumothorax.

50. At 11.30pm that evening, Mr Stamkos' condition deteriorated, and he was transitioned to comfort care the following day. Mr Stamkos sadly passed away at 1.55pm on 13 January 2023.

FURTHER INVESTIGATION

51. As part of my investigation, I obtained advice from the Coroners Prevention Unit (**CPU**) as to how Northern Health managed Mr Stamkos' known history of dysphagia.[10]

Background

52. By way of background, the CPU noted that Mr Stamkos had a known history of dysphagia, functional decline, and mental health illness with previous episodes of aspiration pneumonia with impaired swallowing function.

53. His medical conditions were unstable in the months prior to his death with delirium, hepatic encephalopathy[11], relapse of bipolar disease, worsening dysphagia, falls risk, and aggressive and disinhibited behaviour.

54. He had regular review of his allowed diet[12] and dietary texture modifications. His overall management was compounded by escalating behavioural disturbance, falls with suspected spinal injury, COVID-19 infection, and behaviour[13] that required management in the psychiatric unit.[14]

55. On 10 January 2023, Mr Stamkos had a cardiac arrest during a supervised lunch with his wife. Mrs Stamkos reported that he was choking on a sandwich prior to his arrest. After

[10] 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. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.
[11] Liver failure.
[12] Mr Stamkos was considered unsafe for all oral diet and required nasogastric feeding for periods when he was more acutely unwell.
[13] Electroconvulsive treatment was recommended.
[14] On 22 December 2022, the Mental Health Tribunal granted an Inpatient Treatment Order.

cardiopulmonary resuscitation was performed, Mr Stamkos had a return of circulation and was transferred to the Intensive Care Unit and passed away several days later.

Prescribing texture modified diets to persons with dysphagia

56. The CPU explained that impairment to swallowing function (dysphagia) increases a person's risk of upper airway obstruction (choking on food boluses) and aspiration pneumonia (food entering lungs).

57. Swallowing function may fluctuate with a person's co-existent medical condition and their level of consciousness, often requiring frequent reassessments in medically unstable patients. Safe swallowing techniques are prescribed by a speech pathologist who advise on dietary texture modification to minimise these risks, or to advise against any oral intake (nil by mouth).

58. A review of the medical record and the hospital statements show that safe swallowing techniques and texture modification of diet[15] was actively sought and adhered to by the treating team at Northern Hospital.

59. The CPU advised that a review of the medical record and the hospital statements showed that the explanation of the dysphagia and the risk of feeding and possible consequences were described to Mr Stamkos' family in a meeting on 6 December 2022. Following this meeting, the family elected to maintain Mr Stamkos as 'nil by mouth' and to reinstitute a nasogastric feeding tube.[16]

60. Over the following weeks, Mr Stamkos' swallowing function improved to allow the speech pathologist to reintroduce oral diet and recommended a texture modification upgrade. The last change was made on 6 January 2023 to allow *"soft and bite sized diet with mildly thickened fluids"*.[17]

61. The hospital records and the statement provided by Dr Sunderland describe that family were advised on a number of occasions not to provide external food to Mr Stamkos. However, it appears that Mr Stamkos asked his wife to bring food from home. The peanut butter sandwich

[15] Providing thickening to fluids decreases risk of aspiration (spilling into lungs), and softening fluid (pureed, moist etc) will additionally decrease the risk and distress of upper airway obstruction (choking).
[16] Unfortunately, Mr Stamkos did not tolerate the insertion of a feeding tube, and this was abandoned.
[17] Pureed diet allowed on 12 December, minced moist diet on 29 December prior to last upgrade.

that preceded the choking event was not prepared by the hospital and hence it is unknown whether this was 'soft and bite sized' as per the speech pathologist's recommendation.

Conclusion

62. The CPU did not identify any prevention opportunities with the care provided by Northern Health. The available evidence demonstrates the education provided to family regarding the texture modification and dietary advice prescribed for Mr Stamkos occurred on several occasions.

63. I accept and agree with the CPU's advice.

NORTHERN HEALTH INTERNAL REVIEW

64. Following Mr Stamkos' death, Northern Health conducted an internal review which did not identify any issues of clinical concern.

65. Dr Sunderland noted that Mr Stamkos' family were informed on various occasions about the risks associated with Mr Stamkos eating regular food rather than food that complied with the Speech Pathology reviewed undertaken periodically given his background dysphagia. It is Northern Health's usual process to provide patients and visitors who intend to bring in external food with a pamphlet to educate them on Northern Health's policy around food safety.

66. The treating team were made aware by Mr Stamkos' family of his preference to consume solid foods, and as such Mr Stamkos received ongoing Speech Pathology input on the ward to address his swallowing issues. Nonetheless, Mr Stamkos' swallowing issues were multifactorial, and his mental state and mania were challenging factors in having him comply with the diet prescribed by Speech Pathology.

FINDINGS AND CONCLUSION

67. The applicable standard of proof for coronial findings is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications. [18]

68. Having applied the applicable standard of proof to the available evidence, I make the following findings pursuant to section 67(1):

    (a) the identity of the deceased was Georgios Stamkos, born 18 June 1954;

    (b) the death occurred on 13 January 2023 at Northern Hospital Epping, 185 Cooper Street, Epping, Victoria;

    (c) the cause of Mr Stamkos' death was complications of a witnessed airway obstruction from food bolus in a man with dysphagia; and

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

69. While I am satisfied that Mr Stamkos choked on food brought into the hospital by his wife, which did not align with recommendations of the speech pathologist, the available evidence also supports a finding that Mr Stamkos repeatedly insisted on eating 'normal' food.

70. Mr Stamkos' family outlined to clinical staff at the hospital that this was an important part of life for him, and they understood the risks. In this jurisdiction, it is not uncommon to see patients place a high value on maintaining enjoyment of their food – which can be one aspect of life over which they are able to maintain control.

71. I am satisfied that Northern Health explained the risk of non-approved food to Mr Stamkos and his family and this is a risk that Mr Stamkos and his family understood.

72. I convey my sincere condolences to Mr Stamkos' family for their loss.

[18] *Briginshaw v Briginshaw (1938) 60 C.L.R. 336 especially at 362-363. "The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…".*

PUBLICATION OF FINDING

73. Pursuant to section 73(1) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

DISTRIBUTION OF FINDING

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

Irene Stamkos, senior next of kin

Northern Health

Senior Constable Charlie Gill, Victoria Police, Coroner's Investigator

Signature:

Deputy State Coroner Paresa Antoniadis Spanos

Date: 07 August 2024

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.