IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 007678

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Amended on 30 June 2026 pursuant to section 76 of the ***Coroners Act 2008***

Findings of:	Coroner Simon McGregor
Deceased:	FVH
Date of birth:	1982
Date of death:	1 November 2025
Cause of death:	1a : ASPIRATION OF FOOD BOLUS
Place of death:	19 Salicki Avenue Epping Victoria 3076
Keywords:	Food bolus; Aspiration

* Paragraph 9 was amended to correct the application of a missing pseudonym.

INTRODUCTION

1. On 1 November 2025, FVH was 43 years old when he passed away following an inadvertent choking incident during an outing with his family. At the time of his death, FVH lived in Donnybrook with his parents, ITJ and TRJ.

2. FVH's treating General Practitioner, confirmed that he was diagnosed with Astrom Syndrome from a very young age, the condition resulted in FVH losing hearing in both of his ears, blindness from retinitis pigmentosa and insulin resistance.[1] FVH developed Obsessive Compulsive Disorder and anxiety as an adult and remained in the care of his parents for all of his life.[2]

THE CORONIAL INVESTIGATION

3. FVH's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

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. Victoria Police assigned Senior Constable Joel McDonald to be the Coronial Investigator for the investigation of FVH's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

7. This finding draws on the totality of the coronial investigation into the death of FVH including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only

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[1] *Coronial Brief*, Statement of Dr Usha Venkataraman.
[2] Ibid.

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.[3]

8. In considering the issues associated with this finding, I have been mindful of FVH's 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.

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

Circumstances in which the death occurred

9. In the evening of 1 November 2025, FVH was attending a restaurant at 19 Salicki Avenue in Epping to celebrate an event with his family. FVH's parents and his sister were present during the event.[4]

10. During the event, food was served to the guests including FVH and as was usual practice, his father, TRJ, would cut and prepare his food. TRJ cut a piece of chicken and gave this to FVH to chew and eat.[5] As FVH was chewing on the chicken, he began to choke and became unresponsive. Emergency services were contacted and Police members and Ambulance paramedics arrived on scene to assist FVH around 11:00 pm. Attending paramedics were unable to revive FVH and he was pronounced deceased at 11:09 pm. [6]

Identity of the deceased

11. On 5 November 2025, FVH, born in 1982, was visually identified by their sibling, KWT.

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

Medical cause of death

13. Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 3 November 2025 and provided a written report of his findings dated 14 November 2025.

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[3] 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.

[4] *Coronial Brief*, Statement of Senior Constable Joel McDonald.

[5] Ibid.

[6] Ibid.

14. The post-mortem examination revealed evidence of an abraded injury to the sternum but this in keeping with attempted cardiopulmonary resuscitation.

15. Post-mortem CT scans evidenced minor focal coronary artery calcification and foreign material in the airway.

16. Dr Burke provided an opinion that the medical cause of death was 1(a) ASPIRATION OF FOOD BOLUS and I accept his opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was FVH, born in 1982;

    b) the death occurred on 1 November 2025 at 19 Salicki Avenue, Epping, Victoria, 3076, from 1(a) ASPIRATION OF FOOD BOLUS; and

    c) the death occurred in the circumstances described above.

18. Having considered all of the circumstances, I am satisfied that FVH's death was not preventable and that his care was reasonable and appropriate.

I convey my sincere condolences to FVH's family for their loss.

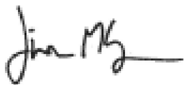
Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Senior Next of Kin

Senior Constable Joel McDonald, Coronial Investigator

Signature:



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Coroner Simon McGregor

Date: 30 June 2026

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 investigation. 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.