IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 005711

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	John Michael Jurdeczka
Date of birth:	26 March 1962
Date of death:	28 September 2024
Cause of death:	1a : HYPOXIC ISCHAEMIC ENCEPHALOPATHY COMPLICATING CARDIAC ARREST IN SETTING OF ACUTE UPPER AIRWAY OBSTRUCTION BY FOOD BOLUS
Place of death:	Angliss Hospital 39 Albert St Upper Ferntree Gully Victoria 3156
Keywords:	Death in Care; SDA Resident; Food Bolus

INTRODUCTION

1. On 28 September 2024, John Michael Jurdeczka was 62 years old when he passed at the Angliss Hospital in Upper Ferntree Gully after experiencing an inadvertent choking incident during an outing from his usual residential in care facility operated by Scope Australia Limited (**Scope**) at 4 Lavender Street, Ringwood, Victoria 3134.

2. John grew up in Altona North and was the youngest of three children to mother Hilda and father Edmund. John's older sisters, Barbara and Christine, were John's next of kin following Edmund's death in 2019 and Hilda's death in 2020.[1]

3. John was diagnosed with Autism at a young age. He had learning difficulties and did not attend school as there were, at the time, no schools suited to his disabilities. John was not able to communicate effectively and had learning difficulties.[2] John had a fascination with trains and would occasionally run away from home to the nearby train lines.[3]

4. In approximately 1970, when John was 8 years old, Edmund and Hilda could no longer cope and care for John and he moved into a supported living service at the Kew Cottages. John lived at Kew Cottages until it was damaged by fire in 1996. He then moved to supported accommodation in Balwyn.[4]

5. In approximately 2011, John moved to a specialist disability home in Lavender Street in Ringwood. This was a facility owned by the Victorian Government that provided supported independent living and had been staffed by Disability Support Workers from Scope since 2019. John resided at this facility until his death. There were four other residents living at Lavender Street with John, who also received supported independent living services from Scope.[5] John had previously lived with three of the residents at Kew Cottages.[6]

6. John received 24 hour care from Scope which included support with regard to active daily living and administration of medication for both his physical and mental health conditions.[7] There were seven permanent staff members who supported John at his home and also casual

[1] Coronial Brief, page 9, paragraph 2. Statement of Barbara Jurdeczka.
[2] Coronial Brief, page 9, paragraph 3. Statement of Barbara Jurdeczka.
[3] Coronial Brief, page 9, paragraph 5. Statement of Barbara Jurdeczka.
[4] Coronial Brief, page 9, paragraph 6. Statement of Barbara Jurdeczka.
[5] Coronial Brief, page 9, paragraph 7. Statement of Barbara Jurdeczka.
[6] Coronial Brief, page 27, paragraph 15. Statement of Lisa Maree Evans.
[7] Coronial Brief, page 28, paragraph 16. Statement of Lisa Maree Evans.

or agency staff as required. A staff member known as the House Supervisor was responsible for ensuring all support requirements were being met and relevant paperwork was completed.[8]

7. John had a history of behaviours of concern that were generally triggered by changes to his daily activities including new staff and being around people that were not familiar to him and new environments.[9] John also received support from a multi-disciplinary team of practitioners. This included but was not limited to a Psychiatrist, Neurologist, an Occupational Therapist, Speech Pathologist, Behaviour Support Practitioner, Physiotherapist, Podiatrist, Continence nurse and a General Practitioner.[10]

8. John had a Mealtime Management Plan which was prepared by Speech Pathologist Jackie Ring from Better Rehab, dated the 5 November 2023 and was in place at the time of John's passing.[11] John also had a Behaviour Support Plan, which was prepared by his Behaviour Support Practitioner Matthew Ferguson from RUBIX Support and was funded under John's NDIS plan.[12]

9. John's Mealtime Management Plan stated that John was assessed as being able to eat level 7 easy to chew food.[13] This category suggested that John had a strong enough chewing ability to break down soft/tender foods into pieces without help, that he did not experience any swallowing problems and had no increased risk of choking.[14]

10. The Mealtime Management Plan outlined a number of risk reduction strategies that Disability Support Workers were required to adhere to, including, assistance to prepare John's food and drink, as well as close supervision for all meal times. Staff used verbal prompts to encourage small amounts of food at a time and a slow rate of intake. John used a teaspoon for meal times to moderate his mouthful size. Staff also ensured that John was alert at meal times, and to discontinue meals if there were signs of fatigue or drowsiness. Staff were also encouraged to reduce distractions during meal times and to support John to sit upright and to keep his head in a neutral position.[15] John also required staff to cut up all of his food into bite-sized pieces

[8] Coronial Brief, page 28, paragraph 17. Statement of Anne Maree Evans.
[9] Coronial Brief, page 28, paragraph 19. Statement of Anne Maree Evans.
[10] Coronial Brief, page 28, paragraph 20. Statement of Anne Maree Evans.
[11] Coronial Brief, page 30, paragraph 34. Statement of Anne Maree Evans.
[12] Coronial Brief, page 29, paragraph 29. Statement of Anne Maree Evans.
[13] Coronial Brief, page 20, paragraph 6(a - b) Statement of Koshy Panicker. Page 14, paragraph 6 (a – b) Statement of Baljit (Ben) Singh Kanwar.
[14] Coronial Brief, page 30, paragraph 35(b) Statement of Anne Maree Evans.
[15] Coronial Brief, page31, paragraph 36 (a – f) Statement of Anne Maree Evans.

that were approximately 1.5cm x 1.5cm. His fluids did not need to be modified though staff were to encourage small, single sips.[16]

11. The Mealtime Management Plan listed the following warning signs of aspiration while eating and drinking. These included, coughing, throat clearing, any shortness of breath, a wet or gurgly voice and redness to Johns' face.[17] When these warning signs were observed, Support Workers were directed to stop the meal time and wait until John recovered before giving any further food or fluid. If John experienced a choking episode, Support Workers were to call "000" and commence first aid.[18]

12. John's support plans were kept in the office of the Lavender Street residence. Disability Support Workers had access to John's support plans and were expected to read and sign the document before the start of a shift to acknowledge that they had reviewed and familiarised themselves with his individual needs and agreed to follow the plan.[19]

13. In addition to the plans, Disability Support Workers were provided with training on how to support individuals with Mealtime Management Plans and Behaviour Support Plans. This sometimes involved face-to-face training from the Speech Pathologist or Behaviour Support Practitioner but is generally in the form of online modules/courses, which Disability Support Workers are required to complete regularly.[20]

14. John became a patient of East Ringwood Clinic under Dr. Dilip Hoole on the 29 December 2006.[21] Under Dr. Hoole's care, John was actively treated for Epilepsy (no seizures since 2005), an intellectual disability, generalised periodontal disease, obsessive compulsive disorder, moderate to severe autism, urinary incontinence, osteoarthritis, an iron deficiency, gastro-oesophageal reflux disease, insomnia, dysphagia, constipation, dermatitis, hyperkalaemia, weight loss, left eye blindness (cataract and retinal detachment), right cataract removal an intraocular lens implant and dry eye syndrome.[22] John suffered from a left retinal detachment in late 2023 resulting in blindness in that eye. As a consequence of this, John was

[16] Coronial Brief, page 31, paragraph 37. Statement of Anne Maree Evans.
[17] Coronial Brief, page 31, paragraph 38 (a – e) Statement of Anne Maree Evans.
[18] Coronial Brief, page 31, paragraph 39, Statement of Anne Maree Evans.
[19] Coronial Brief, page 21, paragraph 7. Statement of Koshy Panicker. Page 29, paragraph 30. Statement of Anne Maree Evans.

[20] Coronial Brief, page 31, paragraph 8. Statement of Koshy Panicker.
[21] Coronial Brief, page 34, paragraph 4. Statement of Dr. Dilip Hoole
[22] Coronial Brief, page 35 – Past history. Statement of Dr. Dilip Hoole.

more prone to bumping into objects, tripping and sustaining various minor injuries.[23] Even prior to his eye problems, John had an unsteady gait and was issued hip protecters from his physiotherapist.[24] John suffered from a respiratory infection in February 2024, from which he recovered well.[25] Apart from these medical issues, John's chronic medical problems had been stable in the six months prior to his death.[26] He was prescribed varying medications which are listed in full on the statement provided by Dr. Hoole.[27]

15. John did not have any choking episodes in the months prior to his death, however he had a past history of dysphagia for which he had a management plan to minimise the risk. John also was prone to silent pneumonia with the suspected cause being the aspiration of food.[28]

THE CORONIAL INVESTIGATION

16. John'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. The death of a person in care or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes.

17. Because John was an SDA resident residing in an SDA enrolled dwelling at the time of his death, her passing was determined to be 'in care'[29] and, as such, is subject to a mandatory inquest, pursuant to section 52(2) of the Act.[30]

18. 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.

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[23] Coronial Brief, page 36, paragraph 1. Statement of Dr. Dilip Hoole.
[24] Coronial Brief, page 36, paragraph 4. Statement of Dr. Dilip Hoole.
[25] Coronial Brief, page 36, paragraph 2. Statement of Dr. Dilip Hoole.
[26] Coronial Brief, page 36, paragraph 3. Statement of Dr. Dilip Hoole.
[27] Coronial Brief, page 34. Medications. Statement of Dr. Dilip Hoole.
[28] Coronial Brief, page 36, paragraph 5(1 – 2) Statement of Dr. Dilip Hoole.

[30] See Regulation 7(1)(d) of the *Coroners Regulations 2019*.

19. 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.

20. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of John'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.

21. This finding draws on the totality of the coronial investigation into the death of John Michael Jurdeczka 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.[31]

22. In considering the issues associated with this finding, I have been mindful of John'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

23. On 25 September 2024, John was taken out on a daytrip from the Lavender Street facility with two other residents to Maroondah Reservoir Park, Healesville by two casual Scope Support Workers, Baljit Singh Kanwar and Koshy Panicker.[32]

24. Koshy had been employed by Scope since December 2022 as a casual Disability Support Worker.[33] Koshy holds a Certificate IV in Disability Support, an Advanced Diploma in Community Sector Management, a level 1 First Aid Certificate including CPR, and is currently undertaking a Diploma in Mental Health. Koshy has 15 years of experience in the

[31] 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.
[32] Coronial Brief, page 21, paragraph 9. Statement of Koshy Panicker.
[33] Coronial Brief, page 19, paragraph B. Statement of Koshy Panicker.

disability support industry, including the two years at Scope.[34] Koshy had worked 12 shifts at the Lavender Street facility, with only 2 or 3 shifts supporting John.[35]

25. Baljit had been employed by Scope since January 2023 as a casual Disability Support Worker.[36] Baljit holds a Certificate III in Aged Care and Disability, Certificate IV in Disability Support[37], and a level 1 First Aid Certificate including CPR.[38] Prior to starting with Scope, Baljit had approximately 11 months experience as a Support Worker.[39] Baljit had worked 8 to 9 shifts at the Lavender Street facility[40], and had never worked a shift supporting John.[41]

26. Koshy stated that John was known to be very quick with his movements and that support workers often told him to stop and slow down. Koshy was aware that John was known to be a fast eater and that he is given his food in small pieces.[42]

27. Baljit was told by other Scope staff members that John had an obsession with food, specifically that he tried to steal food while attending his day program and that he had a tendency to grab at food and eat it very quickly, sometimes without chewing. Baljit was also told that John would sometimes try to sneak into the kitchen. Baljit was instructed by the House Supervisor that John should be constantly supervised and should not be permitted to enter the kitchen alone. Neither worker had ever previously witnessed this behaviour first hand.[43] They did not recall John behaving differently to normal, except that he expressed a preference on his clothing for the day which was unusual.[44]

28. Baljit drove the bus containing Koshy, John and two other residents to Maroondah Reservoir Park in Healesville. Upon arrival the weather was poor with heavy rain and wind, so they did not leave the bus.[45] Instead, they travelled to the Shell Reddy Express service station, located

[34] Coronial Brief, page 19, paragraph C. Statement of Koshy Panicker.
[35] Coronial Brief, page 20, paragraph 1 and 2. Statement of Koshy Panicker.
[36] Coronial Brief, page 13, paragraph B. Statement of Baljit (Ben) Singh Kanwar.
[37] Coronial Brief, page 13, paragraph C. Statement of Baljit (Ben) Singh Kanwar.
[38] Coronial Brief, page 26, paragraph 5. Statement of Anne Maree Evans.
[39] Coronial Brief, page 13, paragraph B. Statement of Baljit (Ben) Singh Kanwar.
[40] Coronial Brief, page 14, paragraph 1. Statement of Baljit (Ben) Singh Kanwar.
[41] Coronial Brief, page 14, paragraph 3. Statement of Baljit (Ben) Singh Kanwar.
[42] Coronial Brief, page 20, paragraph 6. Statement of Koshy Panicker.
[43] Coronial Brief, page 14, paragraph 5. Statement of Baljit (Ben) Singh Kanwar.
[44] Coronial Brief, page 15, paragraph 9. Statement of Baljit (Ben) Singh Kanwar.
[45] Coronial Brief, page 15, paragraph 11. Statement of Baljit (Ben) Singh Kanwar.

on the 123 Maroondah Highway, Healesville to purchase some food for John and the other residents.[46]

29. Koshy stated that ordinarily they would try and find an outdoor area that is not noisy or crowded to have meals however they were somewhat constrained by timing in that clients have a specific mealtime, and if they are hungry, their behaviours can escalate. On this occasion, they had a snack in the bus because of the poor weather. As it was already 12:00pm, the clients needed to eat, and the bus was the safest place for this.[47]

30. Baljit stated that it is not unusual to have snacks and/or mealtime in the bus if the weather was poor, and they have done this on prior occasions, so it was appropriate to have a snack in the bus.[48]

31. Koshy left the bus, went into the store and purchased some banana bread and coffee for John and one other resident, the third resident required a different diet and was asleep at the time.[49] Upon return, Koshy handed one of the coffees and banana bread to Baljit and asked him to feed it to John slowly. Koshy moved to the front of the bus where another resident was seated to assist with their snack.[50]

32. Baljit opened the packet of banana bread and John grabbed the banana bread out of his hand. In response, Baljit slapped the banana bread from John's hand to prevent him from eating it himself, and the banana bread fell to the floor.[51] John quickly grabbed the banana bread off the floor and immediately put it in his mouth.[52]

33. Baljit called out to Koshy for assistance, then they both attempted to remove the banana bread from John's mouth but found this difficult as he was in a difficult position and his hands were flailing around and he was pushing them away.[53] John then attempted to swallow the banana bread but it became lodged in his throat, blocking his airway.[54]

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[46] Coronial Brief, page 21, paragraph 11. Statement of Koshy Panicker.
[47] Coronial Brief, page 21, paragraph 12. Statement of Koshy Panicker.
[48] Coronial Brief, page 15, paragraph 12. Statement of Baljit (Ben) Singh Kanwar.
[49] Coronial Brief, page 21, paragraph 13. Statement of Koshy Panicker.
[50] Coronial Brief, page 21, paragraph 14. Statement of Koshy Panicker.
[51] Coronial Brief, page 15, paragraph 13. Statement of Baljit (Ben) Singh Kanwar.
[52] Coronial Brief, page 15, paragraph 14. Statement of Baljit (Ben) Singh Kanwar.
[53] Coronial Brief, page 15, paragraph 15. Statement of Baljit (Ben) Singh Kanwar. Page 22, paragraph 16. Statement of Koshy Panicker.
[54] Coronial Brief, page 22, paragraph 15. Statement of Koshy Panicker.

34. Baljit called "000" requesting Ambulance but could not provide the call taker with the address so he went into the service station and asked the staff member, also asking if they had a defibrillator, which they did not.[55] Meanwhile, Koshy was attempting back blows between John's shoulder blades, however due to the positioning in the bus, found this extremely difficult and they were unsuccessful.[56]

35. The Ambulance call taker advised Baljit to remove John from the bus to make the medical assistance easier. Koshy and Baljit attempted this however they were unable to move him as he had gone limp and the floor was wet from the rain and spilt coffee.[57] Baljit ran back inside the store and the staff member came out and assisted. Together they were able to remove John from the bus.[58]

36. The call taker asked Baljit to remove John's shirt to assist with access for a defibrillator and to check John's mouth to remove any remnants of banana bread.[59] After completing this, Koshy and Baljit were about to start CPR when the first Ambulance crew arrived and initiated CPR, approximately 2 or 3 minutes after the "000" call.[60]

37. Several other Ambulance crews arrived shortly afterwards and worked on John for a significant period. Baljit contacted the Lavender Street House Supervisor who came to the scene straight away with John's client file which they provided to the paramedics.[61]

38. John was intubated and transported to Box Hill Hospital emergency department by Ambulance, arriving at 1:45 PM.[62] Hospital staff called John's sisters Christine and Barbara, who were on holidays in Spain at the time.[63]

39. John was transferred to the Intensive Care Unit at Angliss Hospital, Upper Ferntree Gully with CT brain imaging showing signs of early hypoxic brain injury.[64]

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[55] Coronial Brief, page 16, paragraph 16. Statement of Baljit (Ben) Singh Kanwar.
[56] Coronial Brief, page 22, paragraph 17 & 18. Statement Koshy Panicker.
[57] Coronial Brief, page 16, paragraph 17. Statement of Baljit (Ben) Singh Kanwar.
[58] Coronial Brief, page 16, paragraph 18. Statement of Baljit (Ben) Singh Kanwar.
[59] Coronial Brief, page 22, paragraph 20. Statement of Koshy Panicker.
[60] Coronial Brief, page 16, paragraph 19. Statement of Baljit (Ben) Singh Kanwar. Page 22, paragraph 21. Statement of Koshy Panicker.
[61] Coronial Brief, page 16, paragraph 21. Statement of Baljit (Ben) Singh Kanwar.
[62] E-Medical Deposition. Summary – 1st paragraph.
[63] Coronial Brief, page 10, paragraph 17. Statement of Barbara Jurdeczka.
[64] E-Medical Deposition. Summary – 2nd paragraph.

40. At 1:37 p.m. on the 27 September 2024, John underwent brainstem testing and was found to be clinically brain dead.[65] Hospital staff advised Christine and Barbara who asked the hospital to wait for them to return to Australia on 30 September so they could be with John when he passed. Hospital staff informed them that John was a serious risk of having a cardiac arrest the longer they waited.[66]

41. On the 28 September 2024, John's ventilator was removed and John passed away. Christine and Barbara were virtually present via video link.[67] John's time of death was recorded as 6:57 p.m. John's funeral was at Altona Memorial Park on 15 October 2024.[68]

Identity of the deceased

42. On 1 October 2024, John Michael Jurdeczka, born 26 March 1962, was visually identified by his sister Christine Jurdeczka.

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

Medical cause of death

44. Senior Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 1 October 2024 and provided a written report of his findings the next day.

45. The examination was consistent with the history given, and no other independent causes of death were identified. The postmortem CT scan revealed reveals bilateral pneumonic changes, consistent with chest infection, and a swelling of the brain referred to as *cerebral oedema*.

46. Toxicological analysis of post/ante-mortem samples identified the presence of therapeutic doses of Morphine, 7-Aminoclonazepam,[69] Sertraline,[70] Atenolol,[71] Valproic Acid,[72]

[65] E-Medical Deposition. Summary – 4th parargraph.
[66] Coronial Brief, page 11, paragraph 18. Statement of Barbara Jurdeczka.
[67] Coronial Brief, page 11, paragraph 19. Statement of Barbara Jurdeczka. E-Medical Deposition – Summary 5th paragraph.
[68] Coronial Brief, page 11, paragraph 22. Statement of Barbara Jurdeczka.
[69] A urinary metabolite of nitrazepam, a benzodiazepine used to treat insomnia.
[70] An antidepressant.
[71] Heart medication.
[72] An anticonvulsant.

Midazolam,[73] and pain relievers known as Paracetamol and Lignocaine, but did not identify the presence of any alcohol or other common drugs or poisons.

47. Dr Lynch provided an opinion that the medical cause of death was 1(a) HYPOXIC ISCHAEMIC ENCEPHALOPATHY COMPLICATING CARDIAC ARREST IN SETTING OF ACUTE UPPER AIRWAY OBSTRUCTION BY FOOD BOLUS, and I accept his opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was John Michael Jurdeczka, born 26 March 1962;

    b) the death occurred on 28 September 2024 at Angliss Hospital, 39 Albert St, Upper Ferntree Gully, Victoria, 3156, from 1(a) HYPOXIC ISCHAEMIC ENCEPHALOPATHY COMPLICATING CARDIAC ARREST IN SETTING OF ACUTE UPPER AIRWAY OBSTRUCTION BY FOOD BOLUS; and

    c) the death occurred in the circumstances described above.

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

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

[73] A pre-operative sedative.

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:

Christine Jurdeczka, Senior Next of Kin

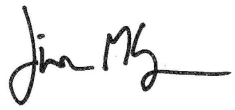
Bridget Linton, Minter Ellison

Naomi Baquing, Scope Australia

Yvette Kozielski, Eastern Health

Senior Constable Robert Billing, Coronial Investigator

Signature:



Coroner Simon McGregor

Date: 17 July 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 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.