IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 005929

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

1. I, Coroner Sarah Gebert, having investigated the death of Christopher Kuric and without holding an inquest, make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

   a) the identity of the deceased was Christopher Kuric, born 1 March 1972;

   b) the death occurred on 9 October 2024 at Box Hill Hospital, 8 Arnold Street, Box Hill, Victoria, from aspiration pneumonia in a man with end stage Huntington's disease; and

   c) the death occurred in the circumstances described below.

2. Christopher was 52 years old at the time of his death and resided in specialist residential care.[1]

3. Christopher's mother passed away in 2002 due to Huntington's disease. At this time, Christopher moved from South Australia to Queensland to reside with his father. Following Christopher's diagnosis of Huntington's disease, he moved to Melbourne to reside closer to his two sisters. At about this time, Christopher's symptoms included chronic fatigue, involuntary movements, depression and paranoia.

[1] 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, as in this case.

4. Christopher worked as a bricklayer and resided alone in Templestowe. In 2011, he moved in with his sister, Gorana Kuric. In 2016, and due to his deteriorating health, Christopher moved to Manalin House.

5. In 2018, Christopher moved to Contemporary House in Burwood East, which was a supported accommodation facility for people with progressive neurological conditions, managed by Yooralla. By this time, Christopher was wheelchair bound and had lost the ability to speak. He primarily communicated through hand gestures and vocalisations. Yooralla staff provided assistance for all his personal care needs and his meals.

6. Gorana said that Yooralla made Christopher comfortable and took him to outings such as fishing and soccer. He was also regularly seen by medical specialists, but his health continued to decline.

7. According to Redner Bay-os, a registered nurse at Yooralla, Christopher received ongoing support from a speech pathologist, dietician, and occupational therapist for mealtime management due to his impaired ability to swallow, for which a range of strategies were implemented around meal texture, support, and positioning during meals. An initial Mealtime Management Plan was completed in 2022, with reassessment in February, June, July and September 2024, when a further decline in his swallow was observed.

Circumstances of death

8. In late August 2024, Yooralla informed Gorana that Christopher was struggling with his breathing and had been diagnosed with COVID-19. He was admitted to hospital for a short period before being discharged back to Yooralla. At about this time, Gorana was advised that she should start thinking about palliative care for her brother.

9. On 26 September 2024, Christopher was observed to be coughing and unable to clear oral secretions. His vital signs were checked, and his oxygen levels were recorded as 85-87 percent. He was reviewed by a locum doctor via video consultation and was prescribed an oral antibiotic. The locum doctor also advised staff to send Christopher to hospital if his coughing worsened and if oxygen levels dropped below 85 percent, or if he experienced shortness of breath/distress.

10. On 27 September 2024, Christopher was observed to be lethargic and less responsive during lunch. He was subsequently transported to Box Hill Hospital following an aspiration event. In hospital, Christopher was administered antibiotics for aspiration pneumonia.

11. Despite treatment, he continued to deteriorate, and he was transitioned to palliative care. Christopher sadly passed away at 10.30am on 9 October 2024.

Medical cause of death

12. Forensic Pathologist, Dr Judith Fronczek, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 11 October 2024 and provided a written report of her findings dated 14 October 2024.

13. The post-mortem examination was consistent with the reported circumstances.

14. Dr Fronczek provided an opinion that the medical cause of death was *"1(a) Aspiration pneumonia in a man with end stage Huntington's disease"* and was due to *natural causes*.

15. I accept Dr Fronczek's opinion.

I convey my sincere condolences to Christopher's family and friends for their loss.

Publication and distribution

Pursuant to section 73(1B) 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:

Gorana Kuric, senior next of kin
Eastern Health
Yooralla
First Constable Gemma Webb, Victoria Police, Coroner's Investigator

Signature:

Coroner Sarah Gebert

Date: 10 October 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.