IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 002087

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Susan Elizabeth Czudar
Date of birth:	7 February 1962
Date of death:	18 April 2025
Cause of death:	1a: Aspiration pneumonia in a woman with acquired brain injury 1b: Cerebrovascular disease
Place of death:	Eastern Health Wantirna 251 Mountain Highway Wantirna Victoria 3152
Keywords:	Specialist Disability Accommodation, supported independent living, disability, natural causes

INTRODUCTION

1. On 18 April 2025, Susan Elizabeth Czudar[1] was 63 years old when she died at Eastern Health Wantirna Palliative Care Unit.

2. At the time of her death, Susan resided in a Specialist Disability Accommodation (**SDA**) dwelling in Ferntree Gully. She was a participant in the National Disability Insurance Scheme and received Supported Independent Living provided by disability service provider, Nextt.

3. Susan had been married to her husband, Louis Czudar, for 38 years. Together they had two children, a son and a daughter. Susan was a very active person, engaged in the Hungarian community and enjoyed gardening until she suffered a catastrophic health event in 2017.

4. In December 2017, Susan was diagnosed with a subarachnoid haemorrhage due to a ruptured brain aneurysm and underwent surgery at the Alfred Hospital. At a routine three-month follow up appointment, a second aneurysm was found and subsequently 'coiled'.[2]

5. In 2019, her original aneurysm repair deteriorated, and she required further medical intervention. During this procedure, Susan had an allergic reaction to the contrast dye that was used during the procedure, which led to her suffering contrast-induced encephalopathy (**CIE**).[3]

6. Susan's health continued to deteriorate, and she suffered multiple strokes and seizures, which resulted in an acquired brain injury and severe difficulty in communicating. She required support and assistance with daily living activities and the use of a wheelchair for mobility.

7. Susan's medical history also included osteoporosis, sleep apnoea, epilepsy, lumbar spine fractures, dermatitis, Graves' disease, diabetes and peripheral vision loss.

THE CORONIAL INVESTIGATION

8. Susan's death fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**) as she was a '*person placed in custody or care*' within the meaning of the Act, as a

[1] Referred to throughout my finding as 'Susan' unless more formality is required.
[2] A neurosurgical or neuroradiological interventional process of inserting metal coils to pack the aneurysm site to prevent leak or rupture.
[3] Contrast-induced encephalopathy (**CIE**) is a rare but well-documented complication of iodinated contrast administration. It occurs when contrast agents cross the blood-brain barrier, leading to temporary brain swelling and altered mental status.

person in Victoria who was an '*SDA resident residing in an SDA enrolled dwelling'* immediately prior to her death.[4]

9. This category of death is reportable to ensure independent scrutiny of the circumstances leading to death given the vulnerability of this cohort and is reflected in the definition of a '*person places in custody or care*' in section 3(1) of the Act, read in conjunction with Regulation 7 of the *Coroners Regulations 2019*.

10. 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.

11. There is a requirement under section 52(2)(b) of the Act to hold an Inquest into the death a person who was in custody or care immediately prior to passing, though pursuant to sections 52(3A) of the act, the coroner is not required to hold an Inquest if the coroner considers the death was due to natural causes. I exercise my discretion under this provision not to hold an Inquest in the present case on the basis that Susan's passing was due to natural causes and there are no further issues I have identified that require the hearing of *viva voce* evidence.

12. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Susan's death. The Coronial Investigator conducted inquiries on the Court's behalf, including taking statements from witnesses – such as family, the forensic pathologist and treating clinicians, and submitted a coronial brief of evidence.

13. This finding draws on the totality of the coronial investigation into the death of Susan Elizabeth Czudar including evidence contained in the coronial brief and information from the National Disability Insurance Agency (**NDIA**). 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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[4] *Coroners Regulations 2019* (Vic), r 7(1)(d).

[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.

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

Circumstances in which the death occurred

14. On 20 March 2025, Susan was admitted to the Angliss Hospital in Ferntree Gully with a fever and reduced conscious state due to a Covid-19 infection. She was admitted for medical management.

15. The medical staff noted a six-month decline in her swallowing ability. A videofluoroscopic swallow study (**VFSS**),[6] conducted as an outpatient in February 2025, revealed a high aspiration risk with pureed foods and thickened fluids. This risk indicated the need for a percutaneous endoscopic gastrostomy (**PEG**)[7] tube for safe feeding and hydration.

16. The identified risk of aspiration prompted the treating team to facilitate a discussion with Susan's family regarding her quality of life, potential risks of continued oral feeding and goals of future medical care. The family opted to continue oral feeding and transition to comfort-based care.

17. On 25 March 2025, Susan was transferred to Wantirna Hospital Palliative Care Unit for ongoing symptom management. She temporarily improved and achieved sufficient medical stability that a discharge from hospital was feasible.

18. Unfortunately, on 16 April 2025, Susan experienced an acute episode of oxygen desaturation to 85% with associated tachycardia. This was attributed to an aspiration event and treated with supplemental oxygen. Given the previously agreed goals of care, Susan was recommenced on a palliative care pathway, including administration of comfort medications.

19. At 6:45pm on 18 April 2025, Susan died comfortably in the presence of her family.

Identity of the deceased

20. On 18 April 2025, Susan Elizabeth Czudar, born 7 February 1962, was visually identified by her son, Michael Czudar.

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

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[6] A moving X-ray procedure that captures swallowing mechanisms in real-time.

[7] A flexible tube inserted into the stomach through the abdominal wall for the delivery of liquid nutrition, fluids, and medications directly to patients who are unable to safely chew or swallow due to medical conditions like stroke.

Medical cause of death

22. On 21 April 2025, Forensic Pathologist Associate Professor Linda Iles (**A/Prof Iles**) from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination, interpreted a post-mortem computed tomography (**CT**) scan and reviewed medical evidence provided by Eastern Health. A/Prof Iles provided a written report of her findings dated 23 April 2025.

23. The post-mortem examination confirmed past intracranial intervention,[8] left posterior cerebral artery stroke and bilateral lung opacification.[9]

24. A/Prof Iles provided an opinion that the medical cause of death was *'1(a) aspiration pneumonia in a woman with acquired brain injury, 1(b) cerebrovascular disease.'*

25. A/Prof Iles concluded that the cause of death was due to natural causes. She noted that the acquired brain injury was the result of a cerebrovascular accident, and that the aspiration was a physiological consequence of her brain injury.

26. I accept A/Prof Iles' opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Susan Elizabeth Czudar, born 7/02/1962;

    b) Susan's death occurred on 18/04/2025 at Eastern Health Wantirna, 251 Mountain Highway, Wantirna, Victoria 3152 from *1a: Aspiration pneumonia in a woman with acquired brain injury and 1b: Cerebrovascular disease*; and

    c) her death occurred in the circumstances described above.

28. The available evidence does not support a finding that there was any want of clinical management or care on the part of the disability service provider, or clinical staff at Eastern Health, that caused or contributed to Susan's death.

[8] A metal signal indicated the presence of an aneurysm coil.
[9] Meaning that areas in both lungs appear 'whiter' than normal. This occurs when air in the lungs is replaced by fluid, pus, blood, inflammation, or scarring.

29. Having considered all the available evidence, I find that Susan's death was from natural causes and that no further investigation is required. As such, I have exercised my discretion under section 52(3A) of the Act not to hold an inquest and to finalise the investigation of Susan's death by way of a written finding.

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:

Louis Czudar, Senior Next of Kin

National Disability Insurance Agency

Eastern Health

Leading Senior Constable Nathan Cayzer, Victoria Police, Coronial Investigator

Signature:

Coroner Ingrid Giles

Date: 18 August 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.