



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 005594

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

Section 67 of the Coroners Act 2008

Inquest into the Death of Tracie Lyndal Markwick

Deceased:	Tracie Lyndal Markwick
Delivered on:	10 September 2025
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	9 September 2025
Findings of:	Coroner Sarah Gebert
Counsel assisting the coroner:	Olivia Collings, Solicitor
Key words:	In care, disability care, choking

INTRODUCTION

1. On 23 September 2024, Tracie Lyndal Markwick was 54 years old when she died following a choking episode. At the time of her death, Tracie lived on Hobson Street in Greensborough, Victoria.
2. Tracie was born to parents Joy Burns and Hugh Markwick, and raised with her sisters Kellie and Caitlin. During Tracie's childhood, she received diagnoses of an intellectual disability, congenital dislocation of both hips and hypothyroidism.¹
3. From a young age, around 12 years old, Tracie lived in supported accommodation. At the time of her death,² she resided in supported accommodation provided by Life Without Barriers (**LWB**) and required supervision for all daily tasks.³ Tracie regularly attended day placement at the Ivanhoe Diamond Valley Centre (**IDVC**) and enjoyed barbeques, seeing her family, and going shopping.⁴
4. At the time of her death, Tracie had diagnoses of schizophrenia, obsessive compulsive disorder (**OCD**) and dysphagia in addition to those mentioned above.⁵

History of choking

5. On 9 March 2021, Tracie had a '*minor choking incident*' when she took a crumpet from another resident's plate.⁶
6. Tracie attended her general medical practitioner (**GP**) following the incident and had a '*minor cough due to her throat being irritated*'. She did not develop any additional symptoms in the following days and no further medical treatment was required.⁷

¹ Statement of Hugh Marwick, coronial brief (**CB**) at p.4.

² Statement of Hugh Marwick, CB at p.6.

³ Statement of Nigel Phillips, CB at p.12.

⁴ Ibid.

⁵ Above n 3.

⁶ Statement of Nigel Phillips, CB at p.13-14.

⁷ Ibid.

Mealtime Assessment and Management Plan

7. Tracie was supported by several health practitioners, including a speech pathologist, Yuchan Sun (**Mr Sun**). In September 2023, LWB referred Tracie to Mr Sun for the purpose of a mealtime assessment and management plan. On 27 September 2023, Mr Sun conducted a mealtime assessment of Tracie at her Greensborough accommodation.⁸
8. Mr Sun developed a mealtime management plan (**MMP**) and determined that Tracie was at '*mild-to-moderate*' risk of choking. According to the MMP, Tracie's food needed to be cut into small and regular sizes and be '*easy to chew*'. She required close monitoring during and after mealtime, and to remain upright for 30 minutes after eating. Tracie was known to eat quickly and needed to be reminded '*to slow down when eating*'.⁹
9. According to the MMP, Tracie was also at risk of eating non-food items '*such as perfumes, toothpaste, lipstick and other hazardous chemicals*'. Tracie had a corresponding Behaviour Support Plan which included strategies such as '*having these items out of sight or locked in cupboards*'.¹⁰
10. Prompted by the MMP and Tracie's choking episode in March 2021, LWB staff documented in her file to ensure that no food was left within her reach.¹¹
11. On 27 September 2023, LWB and the IDVC were provided with copies of Tracie's MMP.¹²
12. As part of the required annual review, Tracie's MMP was updated on 15 July 2024. Tracie still had '*mild-to-moderate*' dysphagia. The updated MMP was sent to LWB and its staff received education on these changes.¹³

⁸ Statement of Yuchan Sun, CB at p.16.

⁹ Statement of Nigel Phillips, CB at p.13; My Mealtime Profile, Court File (CF).

¹⁰ Statement of Nigel Phillips, CB at p.13.

¹¹ Statement of Nigel Phillips, CB at p.14.

¹² Statement of Yuchan Sun, CB at p.17.

¹³ Ibid.

INVESTIGATION AND SOURCES OF EVIDENCE

13. This finding draws on the totality of the coronial investigation into the death of Tracie Lyndal Markwick including evidence contained in the coronial file comprising her medical records; statements contained within the coronial brief; the inspection report and toxicology report from the Victorian Institute of Forensic Medicine (VIFM).
14. All of this material, together with the inquest transcript, will remain on the coronial file.¹⁴ 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.

PURPOSE OF A CORONIAL INVESTIGATION

15. The purpose of a coronial investigation of a '*reportable death*'¹⁵ is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.¹⁶ Tracie's death clearly falls within the definition of reportable death, specifically section 4(2)(c) of the Act which includes (relevantly) a death of a person who immediately before death was a person placed in *custody or care*.
16. 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

¹⁴ 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.

¹⁵ 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.

¹⁶ Section 67(1).

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.¹⁷

17. 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.¹⁸
18. 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 health or safety or the administration of justice.¹⁹ These are effectively the vehicles by which the coroner's prevention role can be advanced.²⁰
19. 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.²¹

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

20. On 23 September 2023, Tracie spent the day at the IDVC. At approximately 2.55 pm, IDVC staff were in the reception area waiting for Tracie and other residents to be picked up in taxis to return to their Greensborough accommodation.²²
21. Tracie entered a small adjoining room and promptly returned to the main reception area. As she did so, an IDVC staff member noticed she had '*something white sitting in her*

¹⁷ 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.)

¹⁸ 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'.

¹⁹ See sections 72(1), 67(3) and 72(2) regarding reports, comments, and recommendations respectively.

²⁰ 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.

²¹ 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).

²² Statement of Catherine Steuenton, CB at p.19.

mouth'.²³ Tracie began coughing and staff commenced '*back thrusts*' to attempt to dislodge the item.²⁴ Staff brought over a chair, so they could '*lean Tracie over and continue back thrusts*'.²⁵ Emergency services were called.

22. Staff continued to assist Tracie including attempting to scrape the food from her mouth, however, she '*started to go unconscious*', became unsteady and eventually, unresponsive.²⁶ At the emergency services call taker's instructions, IDVC staff commenced cardiopulmonary resuscitation (CPR).²⁷
23. At around 3.05 pm, Ambulance Victoria paramedics arrived at the IDVC and attended to Tracie. Paramedics continued resuscitation efforts however, Tracie was in cardiac arrest for approximately 30 minutes and continued effort was determined to be futile.²⁸
24. At about 3.40 pm, Tracie was declared deceased.²⁹
25. The item which she ate may have been a bread roll as the Ambulance Victoria Patient Care records refers to the possibility of Tracie having removed a bread roll from a bin. Further inquiries with the Coroner's Investigator about where the item was obtained, who advised that in speaking with staff the item was unknown. He said that at no point did any of the staff witness Tracie pick up any food or object and put it in her mouth. The only time they were aware she had something in her mouth was when she started struggling to breathe.

IDENTITY OF THE DECEASED

26. On 26 September 2024, Tracie Lyndal Markwick, born 29 January 1970, was visually identified by her father, Hugh Markwick, who signed a formal Statement of Identification to this effect.
27. Identity is not in dispute and requires no further investigation.

²³ Statement of Catherine Stuenton, CB at p.20.

²⁴ Statement of Catherine Stuenton, CB at p.20; statement of Hibo Ali, CB at p.26-28.

²⁵ Statement of Melissa Laedwig, CB at p.29.

²⁶ Statement of Catherine Stuenton, CB at p.20.

²⁷ Statement of Melissa Laedwig, CB at p.29.

²⁸ 5 Day Report, NDIS Quality and Safeguards Commission, CB at p.38.

²⁹ 5 Day Report, NDIS Quality and Safeguards Commission, CB at p.37.

MEDICAL CAUSE OF DEATH

28. Forensic Pathologist, Dr Victoria Francis of the Victorian Institute of Forensic Medicine (VIFM), conducted an inspection on 24 September 2024 and provided a written report of her findings dated 8 November 2024.
29. The post-mortem computed tomography (CT) revealed food material in the oropharynx with no obvious obstruction in the trachea or main bronchi.
30. Routine toxicological analysis of post-mortem samples detected amisulpride³⁰ (~ 0.9 mg/L), clomipramine³¹ (~ 0.5 mg/L) and olanzapine³² (~ 0.05 mg/L).
31. Dr Francis provided an opinion that the medical cause of death was “*1(a) choking on a food bolus in a woman with an intellectual disability and other medical comorbidities*”.³³
32. I accept Dr Francis’ opinion.

CORONERS PREVENTION UNIT

33. I sought the assistance of the Coroners Prevention Unit (CPU) to understand whether IDVC staff acted appropriately when responding to Tracie’s choking.³⁴
34. The CPU provided me with relevant guidelines, namely the Australian and New Zealand Committee on Resuscitation, *Guideline 4 – Airway (the ANZCOR Guideline)*.³⁵ The ANZCOR Guideline ‘*applies to all persons who need airway management*’ including ‘*when a person is unconscious, has an obstructed airway, or needs rescue breathing*’.³⁶

³⁰ Dopamine D2 antagonist receptor (commonly used in treatment of schizophrenia).

³¹ A tricyclic anti-depressant.

³² An anti-psychotic.

³³ The cause of death was amended from an earlier report dated 15 October 2024.

³⁴ 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.

³⁵ Accessible at: <https://www.anzcor.org/assets/anzcor-guidelines/guideline-4-airway-220.pdf>.

³⁶ The ANZCOR Guideline, at p.1.

35. Regarding the management of Foreign Body Airway Obstruction (**FBAO**), chest thrusts or back blows '*are effective for relieving FBAO in conscious adults*' and are recommended over the use of abdominal thrusts (such as the Heimlich Manoeuvre).³⁷
36. If a patient is unconscious, the ANZCOR Guideline '*suggests that rescuers consider the manual extraction of visible items in the mouth*'.³⁸
37. The CPU identified that IDVC staff performed back thrusts, CPR and attempted to manually remove the food from Tracie's mouth. It concluded that the IDVC staff acted reasonably and with care.

FINDINGS AND CONCLUSION

38. Pursuant to section 67(1) of the Act I make the following findings:
- a. the identity of the deceased was Tracie Lyndal Marwick, born 29 January 1970;
 - b. the death occurred on 23 September 2024 at the Ivanhoe Diamond Valley Centre, 88 McNamara Street, McLeod, Victoria, from choking on a food bolus in a woman with an intellectual disability and other medical comorbidities; and
 - c. the death occurred in the circumstances described above.
39. It is apparent that Tracie was at risk of taking food or other items to consume, outside her specially prepared meals, and this had been recognised by her carers. However, on this this occasion it appears that there was no opportunity to have intervened and prevented the tragic outcome.
40. I accept the opinion provided by the CPU and find that IDVC staff responded promptly when Tracie began choking and that they administered reasonable and appropriate care.

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

³⁷ The ANZCOR Guideline, at p.6.

³⁸ The ANZCOR Guideline, at p.9.

ORDERS AND DIRECTIONS

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

I direct that this finding be distributed to:

Hugh Markwick, Senior Next of Kin

Joy Burns, Senior Next of Kin

Life Without Barriers

Ivanhoe Diamond Valley Centre

Senior Constable Sheldon Malcolm, Victoria Police, Coronial Investigator

Signature:



Coroner Sarah Gebert

Date: 10 September 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 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.
