



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2024 007505

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

Section 67 of the Coroners Act 2008

Inquest into the Death of Jimmy Declus

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| Deceased: | Jimmy Delcus |
| Delivered on: | 1 April 2026 |
| Delivered at: | Coroners Court of Victoria, 65 Kavanagh Street, Southbank |
| Hearing date: | 26 March 2026 |
| Findings of: | Coroner Catherine Fitzgerald |
| Counsel assisting the coroner: | Ms Olivia Collings, Coroner's Solicitor |
| Keywords: | SDA death; death in care; Specialised Disability Accommodation; choking. |

INTRODUCTION

1. On 27 December 2024, Jimmy Delcus was 56 years old when he died following a choking episode.
2. Mr Delcus received funding under the National Disability Insurance Scheme (NDIS). At the time of his death, he lived in Specialist Disability Accommodation (SDA) in Reservoir and received Supported Independent Living (SIL) services from Aruma.
3. Mr Delcus is survived by his family including his twin sister, Vicky, and siblings, Cathy, Mary and Steve.

THE CORONIAL INVESTIGATION

4. Mr Delcus' death was reported to the coroner as it fell within the definition of a reportable death under the *Coroners Act 2008 (the Act)*.¹ His death was unexpected and unnatural. Mr Delcus was also a 'person placed in custody or care' pursuant to the definition in section 4 of the Act as he was a 'prescribed person or a person belonging to a prescribed class of person'. This was due to his status as an 'SDA resident residing in an SDA enrolled dwelling'.² His death was not due to natural causes and an inquest was therefore held in relation to his death, pursuant to section 52(2)(b) of the Act.
5. The role of a coroner is to independently investigate reportable deaths to establish, if possible, the identity of the deceased, the cause of death, and the circumstances in which the death occurred. The purpose of a coronial investigation is to establish facts, not to cast blame or determine criminal or civil liability.
6. 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 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.³

¹ Section 4(1), (2)(c) of the Act.

² Pursuant to Reg 7(1)(d) of the *Coroners Regulations 2019*, a "prescribed person or a prescribed class of person" includes a person in Victoria who is an "SDA resident residing in an SDA enrolled dwelling", as defined in Reg 5. I have received information that Mr Delcus resided at an address where the residents meet these criteria.

³ *Harmsworth v The State Coroner* [1989] VR 989; *Clancy v West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

7. 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.
8. Victoria Police assigned an officer to be the coronial investigator for the investigation of Mr Delcus' death. The coronial investigator conducted inquiries on my behalf and submitted a coronial brief of evidence. This finding draws on the totality of the coronial investigation including evidence contained in the coronial brief. Whilst I have reviewed all the material on the coronial file, 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.⁴

BACKGROUND

9. During his childhood, Mr Delcus received diagnoses of autism, an intellectual disability and schizoaffective disorder. He was non-verbal and required constant care. His medical history included vulnerability to infections and pneumonia, which led to several hospitalisations for the latter. He also required the use of a stoma bag.
10. Mr Delcus did not have a history of choking incidents or a diagnosis of dysphagia. However, he had a Behavioural Support Plan implemented by Aruma which referred to the need to manage behaviours such as taking food from others, eating too fast and overeating. He was also required to eat relatively soft foods due to his stoma bag.
11. Mr Delcus enjoyed meals, going for walks or sitting quietly with his books, magazines and catalogues. He also had an interest in planes and enjoyed going to the airport or the Air Show. Mr Delcus received regular 1:1 support to access community activities and he attended a group program on weekdays. He kept in regular contact with his family members.

⁴ 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.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

12. On 27 December 2024, Mr Delcus' care worker took him out for a day of planned activities in the community. At around 10:30 am, they arrived at Bundoora Park and Mr Delcus ate two bananas.
13. At around 12:45pm, the care worker contacted a local restaurant and ordered lunch for Mr Delcus. They collected the lunch order, then returned to Bundoora Park and ate lunch in an undercover area.
14. The care worker was aware of Mr Delcus' tendency to '*grab food quickly as soon as it is in front of him*' and so '*told him to eat slowly*'. The care worker also cut the lunch into small pieces for him.
15. Whilst eating lunch, Mr Delcus unexpectedly stood up and started running around whilst he had a mouthful of food. When he sat back down, the care worker noticed that he was choking. The care worker administered back blows, but this did not dislodge the food. Mr Delcus continued to choke and his face and lips started to blue, at which time the care worker contacted emergency services for ambulance attendance.
16. A bystander saw what was occurring and assisted the care worker to provide cardiopulmonary resuscitation when Mr Delcus became non-responsive. Ambulance Victoria paramedics arrived and they continued resuscitation efforts. However, Mr Delcus could not be revived and he was declared deceased.

IDENTITY OF THE DECEASED

17. On 2 January 2025, Jimmy Delcus, born 24 April 1968, was visually identified by his sister, Mary Brett.
18. Identity is not in dispute and requires no further investigation.

MEDICAL CAUSE OF DEATH

19. Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine conducted an external examination of Mr Delcus' body on 30 December 2024 and provided a written report of his findings dated 2 January 2025.
20. Dr Burke also considered the reported circumstances of the death and provided an opinion that the medical cause of death was 1(a) *Aspiration of food bolus*.

21. I accept Dr Burke's opinion as to the cause of death.

FINDINGS AND CONCLUSION

22. Having investigated the death of Jimmy Delcus, and having held an inquest in relation to his death on 26 March 2026, I find that:

- (a) the identity of the deceased was Jimmy Delcus, born 24 April 1968,
- (b) the death occurred on 27 December 2024, at Playground Drive, Bundoora Victoria 3083, Victoria;
- (c) the medical cause of death was 1a: *Aspiration of food bolus*; and
- (d) the death occurred in the circumstances described above.

23. I have considered the status of Mr Delcus as a person '*in custody or care*' at the time of his death and the factual matrix in which his death occurred. I am satisfied that Mr Declus' behavioural issues with food were recognised by those who cared for him and managed appropriately. It was not foreseeable that he would suffer a choking incident in the manner which occurred, and there was nothing which could have been done to prevent it. The death of Mr Delcus was a tragic accident, and I have not identified any issues with the care provided to him.

24. I convey my sincere condolences to the family of Mr Delcus for their loss.

ORDERS AND DIRECTIONS

25. 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.

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

Ms Vicky Delcus, senior next of kin

Aruma

Senior Constable Ryan Gustilo, Victoria Police, Coroner's Investigator

Signature:



Coroner Catherine Fitzgerald

Date: 1 April 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 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.
