IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 005719

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Andrew Phillip John Kursinskis
Date of birth:	2 August 1964
Date of death:	26 October 2021
Cause of death:	1a: Complications following food aspiration in a man with multiple co-morbidities
Place of death:	Monash Medical Centre, 246 Clayton Road, Clayton, Victoria, 3168

INTRODUCTION

1. On 26 October 2021, Andrew Phillip John Kursinskis was 57 years old when he died following a choking incident involving a meal of chicken schnitzel. At the time of his death, Andrew lived in a Supported Disability Accommodation (**SDA**) dwelling managed by Life Without Barriers (**LWB**) at 64 Koonawarra Street, Clayton (**Koonawarra House**).

2. Andrew had diagnoses of intellectual disability, pica,[1] dysphagia,[2] epilepsy and autism. As a result of these disabilities, he received support from the National Disability Insurance Scheme (**NDIS**) and was a registered NDIS participant. Due to his diagnosis of dysphagia, Andrew required a mealtime management plan (**MMP**).

3. The NDIS Quality and Safeguards Commission determine that any NDIS participant requiring a MMP should have one in accordance with the NDIS Practice Standards and Quality Indicators 2021.[3]

4. A swallowing assessment was completed by speech therapist Narelle Arthur for Andrew, in November 2019 and again in February 2021. Following the first assessment in November 2019, the recommendation was for Andrew's diet to consist of *'soft and bite-sized foods'*, with no changes following the subsequent assessment in February 2021.

5. On 9 February 202, Ms Arthur emailed a copy of Andrew's MMP and a copy of a '*soft and bite sized'* brochure to the Koonawarra House manager, Andrew's support coordinator, and his day program manager.[4] Mr Nigel Phillips, the Regional Director of LWB, confirmed that Andrew's MMP was displayed on a cupboard in the kitchen area of the house, for staff to refer to when preparing food and drinks and noted that plans are written in '*simple language making it easy to be understood by those required to be familiar with it*.'[5]

6. The MMP contained information regarding the requirements for the texture and size of foods appropriate for Andrew, advising; '*Andrew's food should be soft tender and moist…bite sized pieces no bigger than 15mmx15mm in size. Food can be mashed/broken down with pressure from fork.'*[6] The plan provided instruction that food should pass both the size and softness

[1] Pica is a mental health condition where a person compulsively swallows non-food items. It's especially common in children and with certain conditions.
[2] Dysphagia is the medical term for difficulty swallowing
[3] NDIS Practice Standards and Quality Indicators 2021, Version 4, Mealtime Management, p. 17
[4] Screenshot of email sent from Narelle Arthur to Koonawarra House Manager Michael Murray, dated 9 February 2021
[5] Statement of Nigel Phillips, Regional Director Life Without Barriers, p. 2/5.
[6] Mealtime Management Plan, Andrew Kursinskis, completed by Narelle Arthur, February 2019

tests and indicated that softness should be tested by pressing down on the piece of food with a fork until the '*thumbnail blanches white'*. A diagram indicated that food should remain squashed with fork indentations remaining on the squashed food and should not regain its shape following the softness test.

THE CORONIAL INVESTIGATION

7. Andrew'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. In addition, I considered that Andrew's situation was analogous to a person 'in care'.

8. Since 2019, funding for disability services in Victoria has shifted from the Department of Families, Fairness and Housing to the National Disability Insurance Scheme. This shift meant that the definition of *person placed in custody or care* in section 3(1) of the *Coroners Act 2008* to include 'a person under the control, care or custody of the Secretary to the Department of Human Services or the Secretary to the Department of Health' was no longer sufficient to capture the group of vulnerable people in receipt of disability services that the legislature had intended.

9. The *Coroners Regulations 2019* were amended on 11 October 2022 to create a new category of person considered to be 'in care' under Regulation 7 of the Coroners Regulations 2019, being a 'person in Victoria who is an SDA resident residing in an SDA enrolled dwelling'. The amendments also introduce an associated reporting obligation under Regulation 8 for a person who: (ii) is funded to provide an SDA resident with daily independent living support; and (ii) has reasonable grounds to believe that the resident's death has not been reported to a coroner or the Institute.

10. While Andrew was not formally 'in care' at the time of his death on 26 October 2021, he was an SDA resident in an SDA-enrolled dwelling. If reported today, his death would be considered to be an 'in care' death that requires additional steps be taken in the coronial process, including that an inquest (public hearing) be held unless the coroner considers the death was due to natural causes, and that the present Findings be published on the Internet.

11. 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.

12. 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.

13. Victoria Police assigned Sergeant Kernal Brkic to be the Coronial Investigator for the investigation of Andrew'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.

14. This finding draws on the totality of the coronial investigation into the death of Andrew Phillip John Kursinskis 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.[7]

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

Circumstances in which the death occurred

15. On 26 October 2021 at 5.35 pm, Andrew was served dinner which included a chicken schnitzel. At about 6.00 pm, a disability support worker noted that Andrew was having trouble breathing and proceeded to give him back blows and abdominal thrusts.

16. The disability support worker observed Andrew become unconscious and fall to the ground. Support staff commenced compulsory pulmonary resuscitation (**CPR**) whilst contacting 000 emergency services. Andrew was able to regain consciousness and started breathing on his own.

17. Ambulance paramedics arrived at 6.15 pm and Andrew was transported to Monash Hospital for treatment.

[7] 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.

18. Upon arrival at Monash Hospital, Andrew developed further problems breathing and became hypoxic required assisted ventilation. He continued to show no improvement, and his condition was complicated by extensive comorbidities including previous aspiration, refractory epilepsy, autism and pica. Treating clinicians decided to remove Andrew's ventilation and he passed away at 9.10 pm.

Identity of the deceased

19. On 26 October 2021, Andrew Phillip John Kursinskis, born 2 August 1964, was visually identified by his treating medical practitioner, Dr Michael Murray, who completed a Statement of Identification.

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

Medical cause of death

21. Forensic Pathologist Dr Judith Fronczek from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination of the body of Andrew Kursinskis on 28 October 2021. Dr Fronczek considered materials including the Victoria Police Report of Death for the Coroner (**Form 83**), e-Medical Deposition Form completed by Monash Medical Centre, medical records of East Bentleigh Medical Group and post-mortem computed tomography (**CT**) scan and provided a written report of her findings dated 29 October 2021.

22. The findings at external examination of the body were consistent with the history.

23. Toxicological analysis of post mortem samples identified the presence of levetiracetam (~24 mg/L),[8] valproic acid (~19 mg/L)[9] and 7-Aminoclonazepam (~0.01mg/L).[10]

24. Dr Fronczek provided an opinion that the medical cause of death was 1(a) COMPLICATIONS FOLLOWING FOOD ASPIRATION IN A MAN WITH MULTIPLE CO-MORBIDITIES.

[8] Levetiracetam is an antiepileptic used for the control of partial onset seizures.
[9] Valproic acid (dipropylacetic acid, divalproex, sodium valproate) is indicated for epilepsy, and as an adjunct in mania and schizophrenia where other therapy is inadequate.
[10] 7-Aminoclonazepam is a metabolite of clonazepam which is a nitrobenzodiazepine indicated for the treatment of seizures.

CORONERS PREVENTION UNIT REVIEW

25. Having identified that Andrew's death occurred whilst he was living in specialist disability accommodation, I requested that the Coroners Prevention Unit (**CPU**)[11] investigate the circumstances of his death and advise me as to appropriateness of care provided to Andrew. The CPU requested further statements from LWB, dietary records and case notes for Andrew.

Management of Andrew's dysphagia and MMP

26. In a statement provided to the Court, Ms Arthur advised that at the February 2021 assessment, she observed staff using Andrew's MMP appropriately, making note of food size and softness, appropriately using thickened drink between mouthfuls, and physically prompting Andrew to slow down and not overfill his mouth.

27. During the February 2021 assessment, Koonawarra House staff reported to Ms Arthur that Andrew tolerated the MMP instructions at each meal, and that there had been no signs of aspiration with oral intake since the previous assessment in November 2019.

28. Ms Arthur confirmed that the food prepared on the day of the assessment met the criteria for '*soft and bite sized'* food. Based on this assessment and communication with staff, Ms Arthur formed the opinion that staff were consistently preparing appropriate meals for Andrew in line with his MMP. Ms Arthur advised that she did not suggest any education or training session for staff following the February assessment, as she believed staff were following the MMP. Ms Arthur further explained that the emerging pandemic and move towards lockdown restrictions may have impacted on her decision to not offer face to face training for staff.

29. Ms Arthur advised that staff were not provided with a list of foods that meet the '*soft and bite sized*' descriptor, as this can lead to staff only offering a very limited range of foods (often restricted to foods contained in the list), which can lead to issues such as 'food fatigue' and nutritional deficiencies. Rather, staff were provided with a description of the characteristics of soft and bite sized food. The MMP and brochure did not specify that crusty and crispy foods should be avoided, however did note some foods and drinks that should be avoided (jelly, icy poles and ice cream) due to these becoming too thin in the mouth.

[11] 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.

30. The information in the MMP and *'soft and bite sized'* brochure appear to be adapted from the '*International Dysphagia Diet Standardisation Initiative* (**IDDSI**)' '*Soft and Bite Sized'* patient handout.[12] The IDDSI handout does not specify that chicken schnitzel is a food that should be avoided where there is a requirement for soft and bite sized foods, but does advise that food that is tough or fibrous, and food with a crust or skin formed during cooking should be avoided. It further explains that a knife should *not* be required to cut food that meets this definition.

31. The Court received a statement from LWB under hand of Regional Director Mr Nigel Phillips, who advised that staff were not provided with the *'soft and bite sized'* brochure, following Ms Arthur sending it to the Koonawarra House manager, however all relevant information regarding the size and softness test contained in the brochure was also incorporated into the MMP, so it is unlikely that lack of dissemination of the brochure to staff contributed to staff misunderstanding of the MMP. Mr Phillips also advised that staff were provided with Andrew's MMP and were required to '*familiarise themselves'* with the plan. Mr Phillips confirmed that the plan was displayed on the cupboard in the kitchen area where staff prepared food and drinks.

32. Mr Phillips indicated that he was not aware of any training or education sessions regarding Andrew's MMP being delivered to staff following either the 2019 or 2021 assessments.

33. The CPU provided me with advice regarding the appropriateness of the chicken schnitzel in line with the MMP, expressing concern that the types of foods served at Koonawarra House and other SDA residences operated by LWB may not be compliant with relevant MMPs, and the adequacy of training regarding MMPs.

Communication with Life Without Barriers

34. The Court wrote to LWB, via their legal representation, to advise that I had considered the available evidence and the advice of the CPU and was concerned that the chicken schnitzel meal provided to Andrew was not in line with the MMP, and that this raised the concern that other LWB supported residents with similar requirements for soft and bite sized foods were receiving meals that were not appropriate for their needs.

[12]https://iddsi.org/IDDSI/media/images/ConsumerHandoutsPaed/6_Soft_Bite_Sized_Paeds_consumer_handout_30Jan2019.pdf

35. In response, LWB provided a statement from Ms Poshkant Sharma, the disability support worker who prepared the chicken schnitzel and assisted Andrew with eating.

36. Ms Sharma stated that she did not recall receiving any training in relation to Andrew's MMP but did not believe this was of consequence – she said all residents have MMPs and it is common knowledge that all staff are required to understand them, and they are also discussed at monthly staff meetings. In relation to Andrew specifically, she was very familiar with his needs having worked with him four or five times per week since 2019.

37. Ms Sharma stated that the chicken schnitzel was a pre-prepared, frozen schnitzel with a fine crumb that she baked until it was cooked tender (not crispy) and chopped into small, bite sized pieces. She was confident that it was prepared in accordance with the MMP.

38. Ms Sharma noted that chicken schnitzel was one of Andrew's favourite meals and she had prepared and assisted him to eat it on several occasions prior without issue.

OPINION OF ASSOCIATE PROFESSOR DEBBIE PHYLAND

39. I sought an independent expert opinion from Speech Pathologist A/Prof Debbie Phyland. A/Prof Phyland provided a report dated 22 November 2024.

40. A/Prof Phyland was asked to respond to the following questions:

- Please outline Andrew's swallowing and speech pathology history.
- What were Andrew's requirements with regard to mealtimes and feeding? Was the MMP appropriate for Andrew's needs?
- Did the MMP contain sufficient information and clarity for his support staff to follow? What education around MMPs to support staff would you consider necessary and appropriate?
- Where the meals provided to Andrew at Koonawarra House a) appropriate and b) in line with his MMP?
- Was chicken schnitzel an appropriate meal choice for Andrew in line with his MMP, and with consideration to the Soft & Bite Sized Food Guide?

Andrew's swallowing ability

41. A/Prof Phyland noted that there was minimal evidence in the available file notes that Andrew presented with pharyngeal stage dysphagia (disrupted physical swallowing ability). Ms Arthur reported from her swallow evaluation that his swallow reflex was intact although a cough was reported after sequential sips of liquid.

42. A/Prof Phyland noted that the general theme in the materials was that Andrew was reported to have eaten well, and on occasion had managed to safely ingest food that was not specifically given to him[13] without aspirating.

Appropriateness of the MMP

43. A/Prof Phyland considered that the MMP was appropriate based on Andrew's inferred cognitive profile, prior reported history of eating behaviours and performance on clinical evaluation, and she considered that guidance around his food and drink was appropriately and primarily based on his impulsivity with food quantities and the resulting risk of aspiration, rather than pharyngeal dysphagia. She noted that the recommendation for mildly thickened fluids was a conservative but appropriate initial recommendation though it was unclear if this was relaxed over time, but it would seem appropriate if it had been, in view of him having no reported difficulties with swallowing function.

Education around the MMP

44. A/Prof Phyland stated that the MMP was comprehensive and clear, and there was no obvious reason to suggest this was or was not followed. She did not consider that further education to support staff would have been necessary but noted that there appeared to have been no formal process or check system to ensure staff were specifically abreast of Andrew's requirements.

Appropriateness of meals provided at Koonawarra House

45. A/Prof Phyland was unable to glean from the file notes whether the meals served to Andrew were appropriate, as there was minimal to no reference to any diet modifications. However, it did appear that meals were supervised in line with the MMP. She noted that Andrew had been reported to enjoy eating foods that could be considered 'borderline' in terms of softness or texture (e.g. fries, calamari, burgers) and could have therefore posed a higher risk, but it was

[13] For example, when he 'grabbed' another resident's food and ate it.

unclear whether any modifications were made to those meals to comply with the MMP. He also managed to consume those foods without incident.

46. A/Prof Phyland considered that the provision of such foods was in keeping with the *National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018*, that requires care providers to follow the client's MMP whilst optimising the client's agency and quality of life in eating.

Appropriateness of the chicken schnitzel

47. A/Prof Phyland considered the chicken schnitzel to have been *a borderline but acceptable meal choice for Andrew.* She made this assessment having considered the nature of the foods he had previously consumed, his reported intact swallowing function, and the statement of Ms Sharma, who detailed the preparation of the schnitzel to be compliant with the Soft and Bite Sized Food Guide. It was unclear to A/Prof Phyland whether the schnitzel quantities per mouthful were appropriate and whether the meal was well supervised to prevent increased bolus sizes, in line with the MMP.

48. A/Prof Phyland summarised her opinion as follows:

- The main concern regarding Andrew's swallowing safety was related to cognitive and behavioural fluctuations with no strong signs of pharyngeal stage dysphagia.
- There was a considerable time interval between the speech pathology assessment and Andrew's demise with seemingly no swallowing or MMP review requested or undertaken.
- There were no reported incidents of aspiration over this time.
- Although progress note file entries do not provide sufficient detail to inform how rigorously the MMP was followed, there is evidence that reasonable attempts were made to give agency to Andrew in food choices, support his food-related quality of life and minimise risk.

LWB SERVICE IMPROVEMENTS

49. LWB advised the Court of several service improvements that had been made/implemented following Andrew's death.

50. In August 2022, LWB launched the 'My Meals My Way' program – a comprehensive mealtime management procedure to assist staff in making sure mealtimes are safe and enjoyable for residents. The program assists staff to support residents who have swallowing difficulties and to identify those who might be at risk.

51. LWB further undertook a comprehensive review of its internal policies and procedures relating to MMPs and implemented a suite of training programs for staff related to mealtime management. LWB provided the Court with copies of all relevant material, which I consider to be comprehensive and appropriate.

FINDINGS AND CONCLUSION

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

   a) the identity of the deceased was Andrew Phillip John Kursinskis, born 2 August 1964;

   b) the death occurred on 26 October 2021 at Monash Medical Centre, 246 Clayton Road, Clayton, Victoria, 3168;

   c) I accept and adopt the medical cause of death ascribed by Dr Judith Fronczek and I find that Andrew Phillip John Kursinskis, a man with multipole co-morbidities, died following food aspiration;

2. AND, I acknowledge the opinion of Associate Professor Phyland and accept that chicken schnitzel was a *borderline but acceptable* meal choice for Andrew Phillip John Kurskinskis. I consider that there could have been further education/training offered to care staff in relation to his mealtime management plan and requirements, but I do not find that the lack of same was causal or contributory to the death.

3. AND, I acknowledge that Life Without Barriers have taken significant steps to improve mealtime management for their residents. Consequently, I do not intend to make any recommendations in this matter.

4. AND FURTHER, I again note that had Andrew Phillip John Kursinskis' death occurred after the amendments to the *Coroners Regulations 2019* on 11 October 2022, his death would have been subject to a mandatory inquest, as he was an SDA resident residing in an SDA-enrolled dwelling at the time of his death.

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

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.

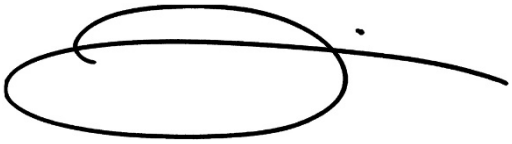
I direct that a copy of this finding be provided to the following:

Dawn Marshall, Senior Next of Kin

Barry Nilsson Lawyers on behalf of Life Without Barriers

Sergeant Kernal Brkic, Coronial Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 10 November 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.