IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 005013

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Silvie Marion Burton
Date of birth:	1 May 1935
Date of death:	25 August 2024
Cause of death:	1a : ACUTE UPPER AIRWAY OBSTRUCTION BY FOOD BOLUS
Place of death:	827-829 Nepean Highway Mornington Victoria 3931
Keywords:	Food Bolus; Aged Care

INTRODUCTION

1. On 25 August 2024, Silvie Marion Burton was 89 years old when she died after choking on a food fed to her as part of her dinner meal plan as a resident at the Village Glen Mornington. At the time of her death, Silvie was a resident in the aged care facility, Village Glen Mornington, located at 827-829 Nepean Highway, Mornington, Victoria, 3931.

2. Silvie was admitted to the Village Glen Mornington in late 2023. Between March 2024 and August 2024, Silvie was assessed and treated for several reported falls following ongoing physical and cognitive decline. Silvie was referred to a geriatrician for cognitive assessment and was positively diagnosed with major neuro cognitive disorder (mix of suspected Alzheimer's dementia and Lewy Body type dementia).

3. Prior to her admission to Village Glen Mornington, Silvie had been a resident of Village Glen in Capel Sound for twenty years, during this time she was living independently and devoted her time to charity work for the George Vowell Foundation and Quota Club International.

4. Silvie's treating medical practitioner reported that Silvie had the following medical history including osteoarthritis, hypertension, hypercholesterolemia, hay fever, left neck femur fracture, glaucoma, trochanteric bursitis, Vitamin D deficiency, sigmoid hyperplastic polyps, osteoporosis, right neck femur fracture, left breast cancer, endometrial polyp, left fractured humerus, major neuro cognitive disorder (dementia), severe anxiety and depression, Charles Bonnet syndrome and reduced mobility.[1]

THE CORONIAL INVESTIGATION

5. Silvie'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.

6. 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.

[1] *Coronial Brief*, Statement of Dr Hardik Solanki.

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 Leading Senior Constable David Burton to be the Coronial Investigator for the investigation of Silvie'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.

9. This finding draws on the totality of the coronial investigation into the death of Silvie Marion Burton 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 o, probabilities.[2]

10. In considering the issues associated with this finding, I have been mindful of Silvie's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

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

Circumstances in which the death occurred

11. On 25 August 2024, at around 12.20 pm, Silvie was being fed her lunch time meal which consisted of roast turkey, potatoes and cranberry. Personal care attendant, Ms Rajwant Basra, was attending to Silvie and reported that she cut up the food into small pieces before feeding Silvie.[3] Silvie is sitting in a semi-angled (lower than upright) position on CCTV footage obtained by my investigator.[4]

12. Ms Basra reported that about three minutes into feeding Silvie, that Silvie started fluttering her eyes and Ms Basra offered her a drink which Silvie was reported to have responded with

[2] 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.

[3] *Coronial Brief*, Statement of Rajwant Basra.

[4] *Coronial Brief*, Exhibit 1 – CCTV footage obtained from Village Glen Mornington

"yes". CCTV footage evidences a 50 second window between Ms Basra leaving Silvie's bedside and returning with a liquid drink which is offered to Silvie.[5] CCTV footage shows Silvie visually uncomfortable and trying to gasp/clench her throat to remove something from her mouth whilst waiting on Ms Basra to return.[6]

13. Ms Basra reports that she tries to provide the liquid drink to Silvie and observed that she was having breathing problems.[7] Ms Basra requested assistance from colleagues, Mr Vardan Waliyla (Personal Care Assistant) and Ms Rajwinder Kaur (Enrolled Nurse).[8] CCTV footage shows Mr Waliyla and Ms Kaur attempt to assist Silvia sit upright by adjusting her chair and pat her back trying to dislodge any food bolus. Mr Waliyla is then observed to leave the area to locate Ms Tracey Reyes (Registered Nurse) for further assistance.[9]

14. CCTV footage shows that after 1 minute and 30 seconds, Ms Reyes returns with Mr Waliyla and assists Silvie with a combination of three or so back blows followed by a similar number of front thrusts (in a Heimlich manoeuvre fashion) from behind Silvie.[10] Ms Reye is observed to continue this for several minutes whilst Mr Waliyla obtains oxygen to attempt to assist Silvie with breathing.[11]

15. CCTV footage shows that after four minutes of back blows and front thrust combinations, Ms Reyes reaches for her mobile phone and appears to contact 000 emergency services for assistance.[12] Ms Reyes reports that emergency services reportedly arrived at 12:33 pm and Silvie was pronounced deceased at 12:40 pm.[13]

Identity of the deceased

16. On 25 August 2024, Silvie Marion Burton, born 1 May 1935, was visually identified by their carer, Gagandeep Mahel.

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

[5] Ibid.
[6] Ibid.
[7] *Coronial Brief*, Statement of Rajwant Basra.
[8] Ibid.
[9] *Coronial Brief*, Exhibit 1 – CCTV footage obtained from Village Glen Mornington
[10] Ibid.
[11] Ibid.
[12] Ibid.
[13] *Coronial Brief*, Statement of Tracey Reyes.

Medical cause of death

18. Senior Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 26 August 2024 and provided a written report of his findings dated 28 August 2024.

19. The post-mortem examination was consistent with the reported history.

20. Post-mortem CT scans evidenced metal in both hips and the left humerus, calcific coronary artery disease and foreign material in the upper airway, most likely representing food stuff.

21. Toxicological analysis of post-mortem samples identified the presence of citalopram (~0.1 mg/L) and no alcohol or other common drugs or poisons.

22. Dr Lynch provided an opinion that the medical cause of death was 1(a) acute upper airway obstruction by food bolus and I accept his opinion.

FURTHER INVESTIGATIONS

23. On 25 August 2024, the Ms Reyes completed an incident log of the fatal incident that occurred on 25 August 2024 and provided a copy of the incident log was provided to the Court indicating that:[14]

    a) She attended without delay and provided back blows and front thrusts (Heimlich manoeuvres) continuously.

    b) She contacted 000 emergency services at 12.30 pm and ambulance paramedics arrived at 12.33 pm and pronounced Silvie deceased at 12.40 pm.

    c) Silvie's treating general practitioner was updated about the fatal outcome and next of kin were updated and notified as well.

24. After reviewing all the available evidence, I find that there are several significant discrepancies in the CCTV footage obtained by my investigator and the reported time and actions taken to assist Silvie. It is apparent from the CCTV footage evidence that there were delays in contacting 000 emergency services and an inconsistent application of the recognised choking advice and approach to first aid adopted by Ms Reyes. St John Ambulance Victoria first aid fact sheet for Choking Adults or Children recommends that Triple Zero be

[14] *Coronial Brief*, Exhibit 4 – Incident Log Entry report by Tracey Reyes.

immediately contacted for ambulance assistance if coughing is unsuccessful in removing an object and that only then should 'five sharp blows' followed by 'five chest thrusts' be performed in rendering First Aid pending ambulance paramedic attendance.[15]

25. Of course, in a situation such as this, with multiple carers in attendance, the 000 contact could have been made simultaneously with the Heimlich Manoeuvre attempts.

FINDINGS AND CONCLUSION

26. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the Briginshaw gloss or explications.[16] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

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

    a) the identity of the deceased was Silvie Marion Burton, born 1 May 1935;

    b) the death occurred on 25 August 2024 at 827-829 Nepean Highway, Mornington, Victoria 3931, from 1(a) acute upper airway obstruction by food bolus; and

    c) the death occurred in the circumstances described above.

28. Having considered all of the evidence, I am satisfied that Silvie's care was not optimal in her final moments. I find several discrepancies in the statement and CCTV evidence collected in this investigation that identify potential missed opportunities to improve service responses to choking incidents.

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[15] St John Ambulance Victoria First Aid Factsheet – Choking in Adults and Children – Available online at: https://stjohn.org.au/assets/uploads/fact%20sheets/english/Fact%20sheets_choking%20adult.pdf

[16] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

29. Silvie had complex physical and disabilities that required assistance with daily life including assistance with cutting up her food in her meal plans. Silvie had a medical history including osteoarthritis, hypertension, hypercholesterolemia, hay fever, left neck femur fracture, glaucoma, trochanteric bursitis, Vitamin D deficiency, sigmoid hyperplastic polyps, osteoporosis, right neck femur fracture, left breast cancer, endometrial polyp, left fractured humerus, major neuro cognitive disorder (dementia), severe anxiety and depression, Charles Bonnet syndrome and reduced mobility.

30. In June 2022, researchers including Professor Bronwyn Hemsley published research following a review of coronial findings in Australia and Canada concerning death by choking or dysphagia.[17] The published research canvasses the issue of risk management of choking amongst vulnerable cohorts of individuals with significant cognitive, mental health conditions or dysphagia and confirms that "…*there is a lot that disability and aged care service provider organisations can do to help prevent this* [in reference choking risk management] *People with dysphagia have the right to expect proper support and safeguarding at mealtimes.*"[18]

31. Professor Hemsley further noted that, *"deaths from choking on food can be prevented with the appropriate access to health professionals, training of support staff in safe mealtime assistance, interventions to improve the texture and nutritional value of the food, and support staff providing enough supervision during mealtimes in support accommodation."*[19]

32. The risks of choking amongst individuals in aged care who suffer from dementia was identified as a systemic concern in the March 2021 findings of the Royal Commission in Aged Care Quality and Safety ("**Royal Commission**"). The Royal Commission's findings confirmed that "*as many as 70% of people in residential aged care could be living with dementia. We have been told that many nurses and general practitioners do not have a full understanding of the symptoms and needs of people living with dementia*."[20]

[17] McCarthy S, Hemsley B, Given F, Williams H, Balandin (2022) *Death by Choking or Dysphagia: A Review of Coronial Findings (Australia and Canada): A Picture of Preventable Death, Non-adherence to Written Recommendations, and Lack of Appropriate Supervision. J Law Med. 2022 Jun;29(2),* 400-405

[18] Ibid.

[19] Ibid.

[20] Royal Commission in Aged Care Quality and Safety (21 March 2021) *Final report – Executive Summary and Recommendations,* 127.

33. I received correspondence from the Village Glen CEO, Mr Marcus Thompson, advising me that the aged care business operating at 827-829 Nepean Highway, Mornington, Victoria, 3931 transferred ownership in December 2024 to Regis Aged Care.[21] Mr Thompson also took this opportunity to confirm that prior to the ownership transfer, Nursing staff at the facility did an annual first aid refresher course, and that first aid training was made mandatory for Personal Care Attendants.

34. Mr Thompson further confirmed that training to manage blocked airways and choking is a standard component of their practice and maintained as part of ongoing commitments to safety and wellbeing of aged residents. In light of the recent changes to ownership to Regis Aged Care, I have directed recommendations in this finding to be actioned by Regis Aged Care to ensure that previous organisational commitments continue to be implemented in their current settings.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

(i) That **Regis Mornington (Regis Aged Care)** ensure that all staff receive training and guidance to identify and appropriately respond to residents experiencing severe difficulty breathing due to a mild or severe obstruction of the airway due to a foreign body like a food bolus. This includes updating and/or developing appropriate choking hazard policies and procedures.

(ii) That **Regis Mornington (Regis Aged Care)** ensure that all relevant staff that require first aid training certification have up to date refresher training that including responding to a choking adult or child.

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

[21] Letter received by the Court from Marcus Thompson (CEO) – Village Glen Aged Care Residences dated 6 June 2025.

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:

Stephen Burton, Senior Next of Kin

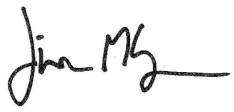
Damien Malone, Village Glen Aged Care (Capel Sound)

Alyson Sparkes, Regis Aged Care

Tracey Embrey, Aged Care Quality and Safety Commission

Leading Senior Constable David Burton, Coronial Investigator

Signature:



Coroner Simon McGregor

Date: 24 July 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.