IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 4554

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paul Lawrie
Deceased:	Christopher Mark Tognon
Date of birth:	6 October 1982
Date of death:	5 August 2025
Cause of death:	ASPIRATION PNEUMONIA COMPLICATING PANCREATITIS
Place of death:	Wimmera Base Hospital 83 Baillie Street, Horsham Victoria 3400
Keywords:	In care, natural causes

INTRODUCTION

1. On 5 August 2025, Christopher Mark Tognon was 42 years old when he passed away at Wimmera Base Hospital, 83 Bailie Street, Horsham, Victoria, following a brief period of acute illness. At the time of his death, Mr Tognon resided at the Clifton Avenue Community Residential Unit in Stawell, a Specialist Disability Accommodation (**SDA**) dwelling enrolled under the National Disability Insurance Scheme (**NDIS**) and operated by Possability Group.[1]

2. Mr Tognon was born with significant neurological deficit resulting in intellectual disability, cerebral palsy, spastic quadriplegia, blindness and epilepsy. He could not walk or weight bear and required full assistance for all activities of daily living. He was dependant on a Percutaneous Endoscopic Gastronomy (PEG) tube for nutrition and fluids.

3. Mr Tognon was cared for by his father until 2014, when he moved into the Clifton Avenue Community Residential Unit.

THE CORONIAL INVESTIGATION

1. Mr Tognon'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. The death of a person in care is a mandatory report to the coroner, even if the death appears to have been from natural causes. Mr Tognan was a "person placed in custody or care" within the meaning of section 4 of the Act, as he was a "prescribed class of person"[2] due to his status as an "SDA resident residing in an SDA enrolled dwelling".

2. Senior Constable Cirak from the Ararat Police Station was assigned as the Coronial Investigator for the investigation of Mr Tognon's death. Senior Constable Cirak conducted inquiries on my behalf and compiled a coronial brief of evidence.

3. This finding draws on the totality of the coronial investigation into the death of Mr Tognon 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.[3]

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[1] ABN 58 638 044 327

[2] Section 4(2)(j)(i), *Coroners Act 2008* (Vic).

[3] 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

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

Circumstances in which the death occurred

4. On 3 August 2025, Mr Tognon fell ill with a high temperature and a cough, and he was conveyed by ambulance to the Stawell Hospital, arriving at 3.50pm. The clinical impression was that Mr Tognon was suffering from pancreatitis and early stage pneumonia. He returned to the residential unit at 5.55pm under close observation from staff.

5. By the late evening of 3 August 2025, Mr Tongon's symptoms had worsened and he had begun vomiting. He was taken to the Horsham Hospital.

6. By the early hours of 4 August 2025, Mr Tognon's temperature had dropped, and he was hypotensive and comatose. Efforts to stabilise his blood pressure had only a limited effect.

7. After a discussion between clinicians and Mr Tognon's family it was decided that the best course was comfort care only, and this commenced at 11:00am on 4 August 2025.

8. Mr Tognon passed away at the Horsham Hospital at 12.35am on 5 August 2025.

Identity of the deceased

9. Christopher Mark Tognon, born 6 October 1982, was visually identified by his father, John Tognan. Identity is not in dispute and requires no further investigation.

Medical cause of death

10. Forensic Pathologist Dr Daniel Hussey from the Victorian Institute of Forensic Medicine conducted an examination on 7 August 2025 and provided a written report of his findings dated 18 August 2025.

11. The post-mortem CT scan showed features of pancreatitis and pneumonia involving both lungs. There were no signs of any injuries that could have caused or contributed to the death.

evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

12. Dr Hussey provided an opinion that the medical cause of death was 1(a) ASPIRATION PNEUMONIA COMPLICATING PANCREATITIS, and that the death was due to natural causes.

13. I accept Dr Hussey's opinion.

Further investigation

14. As part of the investigation, I sought an opinion from Dr George Douros of the Coroners Prevention Unit Health and Medical Investigations Team concerning the question of antibiotic coverage upon Mr Tognon's presentation at Stawell Hospital on 3 August 2025. Dr Douros advised that aspiration pneumonia involving gastric contents is likely to result in a chemical pneumonitis rather than a bacterial infection. Consequently, antibiotics are not necessarily indicated immediately, and it is appropriate that the pneumonia and pancreatitis were treated symptomatically. Also, Mr Tognon's deterioration was likely due to recurrent aspiration from vomiting despite it being initially responsive the antiemetics prescribed.

15. I accept Dr Douros' opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Christopher Mark Tognon, born 6 October 1982;

    b) the death occurred on 5 August 2025 at Wimmera Base Hospital, 83 Bailie Street, Horsham, Victoria, from ASPIRATION PNEUMONIA COMPLCATING PANCREATITIS; AND

    c) the death occurred in the circumstances described above.

17. There is nothing to suggest that the medical care provided to Mr Tognon was anything other than appropriate.

ACKNOWLEDGEMENTS

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

I thank the Coronial Investigator and those assisting for their work in this investigation.

DIRECTIONS

1. 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.

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

   John Tognon & Gail Tognon, Senior Next of Kin

   Possability Group

   Wimmera Health Care Group

   Senior Constable Zvonko Cirak, Coronial Investigator

Signature:

Coroner Paul Lawrie

Date: 15 July 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.