IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2025 006312

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Deceased:	David Ian Maskell
Date of birth:	27 February 1960
Date of death:	31 August 2025
Cause of death:	1(a) Aspiration pneumonia
Place of death:	23 Pioneer Road, Grovedale, Victoria
Key words:	Person placed in custody or care, aspiration pneumonia

INTRODUCTION

1. On 31 August 2025, David Ian Maskell was 65 years old when he passed away at home due to natural causes. At the time, Mr Maskell lived in Grovedale in Specialist Disability Accommodation (**SDA**) with three other residents.

2. Mr Maskell had resided in the SDA on Pioneer Road in Grovedale since about 2005 and received supported independent living services from Scope (Aust) Limited (**Scope**) for meal preparation, personal care, medication administration, continence management, and behaviour support.

3. According to Scope, Ms Maskell's medical history included intellectual disability, autism spectrum disorder, psychotic disorder, chronic anxiety disorder, obsessive compulsive disorder, bilateral vision impairment, congestive heart failure, torturous colon, and chronic constipation.

4. He received support from multiple clinicians and allied service practitioners including his general practitioner, cardiologist, psychiatrist, speech pathologist, behaviour support practitioner, and physiotherapist.

5. Mr Maskell was non-verbal and expressed himself through facial movements, body language, gestures, single words, and grunting sounds. Mr Maskell's mobility and balance deteriorated significantly after he was diagnosed with congestive heart failure and hospitalised in 2021. He was noted to be extremely unsteady on his feet and required two staff members to assist with walking and all transfers. Multiple trials of wheelchair use were unsuccessful, as Mr Maskell repeatedly tried to stand and get out of the wheelchair while it was moving, making it unsafe. At home, Mr Maskell was able to walk short distances with support from staff.

6. Mr Maskell enjoyed engaging in activities which included using sensory gadgets, going for a drive, walks in nature, picnics, and listening to music.

THE CORONIAL INVESTIGATION

7. Mr Maskell's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Generally, reportable deaths include deaths that are unexpected, unnatural or violent, or result from accident or injury. However, if a person

satisfies the definition of a person placed in care immediately before death, the death is reportable even if it appears to have been from natural causes.[1]

8. 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.

9. 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.

10. The Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Mr Maskell'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.

11. This finding draws on the totality of the coronial investigation into Mr Maskell's death, 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.[2]

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

Identity of the deceased

12. On 31 August 2025, David Ian Maskell, born 27 February 1960, was visually identified by a support worker, Timothy Fryer, who signed a formal Statement of Identification to this effect.

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

[1] See the definition of "reportable death" in section 4 of the *Coroners Act 2008* (**the Act**), especially section 4(2)(c) and the definition of "person placed in custody or care" in section 3 of the Act.
[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.

Medical cause of death

14. Forensic Pathologist, Adjunct Associate Professor Hans de Boer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 5 September 2025 and provided a written report of his findings dated 25 November 2025.

15. The post-mortem examination revealed bilateral acute bronchopneumonia with findings indicative of the aspiration of gastric contents. Dr de Boer noted that aspiration acutely limits lung function and incites a severe inflammatory response, which can rapidly progress into metabolic and physiological derangement and result in death.

16. He explained further that aspiration is a challenging diagnosis post-mortem, since cardiopulmonary resuscitation (**CPR**) can also cause aspiration. However, based on the marked vital response in the lungs, the aspiration in Mr Maskell's case is much more likely to have preceded CPR.

17. Dr de Boer noted that the cause of the aspiration was not entirely clear. The bowels were distended, and Mr Maskell's history of longstanding bowel issues was noted, which would have carried a risk of vomiting. There was no bowel transition point, ischaemia, volvulus or peritonitis. Possibly, the bowel distention had a functional cause that was not visible with the naked eye.

18. In addition, examination demonstrated a marked increase of heart weight (cardiac hypertrophy), based on the post-mortem findings likely due to stenosis of the aortic valve, possibly with a contribution of hypertension. Dr de Boer explained that cardiac hypertrophy alters the functional and electroconductive properties of the heart, and this can cause cardiac failure and/or fatal cardiac arrythmias. According to the medical records, Ms Maskell was known to have cardiac failure.

19. As such, Dr de Boer noted that it cannot be entirely excluded that the aspiration was preceded by a cardiac event. The examination findings and death can however be entirely explained by aspiration without such prior cardiac event.

20. The right ventricle of the heart showed marked fatty infiltration and in the posterior wall of the left ventricle was mild interstitial fibrosis with a single focus of inflammation without myocyte changes. In absence of inflammation, fibrosis, or degeneration of myocytes in the right ventricle, an underlying genetic cardiomyopathy (arrhythmogenic cardiomyopathy) was not deemed likely.

21. There was no evidence of other substantial natural disease or substantial trauma.

22. Routine toxicological analysis of post-mortem samples detected diazepam[3] and nordiazepam, clomipramine,[4] olanzapine,[5] valproic acid,[6] amiodarone,[7] frusemide,[8] paracetamol,[9] and lignocaine.[10]

23. Dr de Boer noted that toxicological analysis detected low/normal levels of various medications, some of which were likely administered during CPR. The effects of the substances were not relevant for the cause of death.

24. Dr de Boer provided an opinion that the medical cause of death was *"1(a) Aspiration pneumonia"*, which he described as a death from natural causes.

25. I accept Dr de Boer's opinion.

Circumstances in which the death occurred

26. On 30 August 2025, Mr Maskell's support workers contacted the Victorian Virtual Emergency Department (**VVED**) due to concerns that he had not had a bowel movement for six or seven days. According to Scope, the VVED doctor advised Scope staff to proceed with prescribed 'as needed' medication and extra water and to follow up with his general practitioner the next day if Mr Maskell had not had a bowel motion.

27. According to Dr Loren Sher, Program Director the VVED, minor faecal leakage was noted at assessment. There was no nausea or vomiting, and Mr Maskell appeared clinically well, with no acute distress or other systemic concerns. Mr Maskell's condition had been discussed with his general practitioner, who had advised he should seek further medical advice if the constipation persisted for six to seven days, however he was unable to see this general practitioner that day due to weekend closure.

28. Dr Sher noted that Mr Maskell's presentation was consistent with constipation on a background of chronic constipation and intellectual disability, with no evidence of acute

[3] Diazepam is indicated for anxiety, muscle relaxation and seizures. Nordiazepam, temazepam, and oxazepam are metabolites. Adverse effects of diazepam include confusion, incoordination, physical dependence, sedation, and seizures in withdrawal. Overdose can cause ataxia, drowsiness, and muscular weakness.
[4] Clomipramine (chlorimipramine) is indicated for major depression, panic disorder, neuropathic pain and enuresis.
[5] Olanzapine is an antipsychotic drug.
[6] Valproic acid is indicated for epilepsy, and as an adjunct in mania and schizophrenia where other therapy is inadequate.
[7] Amiodarone is indicated for severe tachyarrhythmias.
[8] Frusemide is used to treat oedema and mild to moderate hypertension.
[9] Paracetamol is an analgesic drug.
[10] Lignocaine (lidocaine) is a local anaesthetic and antiarrhythmic drug.

medical illness. Staff were advised to continue the bowel-management plan, specifically taking two scoops of Osmolax (laxative powder) with lunch and again at 6.00pm. Staff were also instructed to reassess later that evening if Mr Maskell's bowels had still not opened. Red-flag symptoms such as chest pain, difficulty breathing and vomiting that would require earlier medical review, transfer to the Emergency Department, or calling emergency services were also discussed.

29. Overnight, support workers observed Mr Maskell was vocalising loudly. It was common for him to do this, and he was typically able to indicate if he was in pain and gesture towards a particular part of his body. In this instance, when staff asked if he was in pain, he indicated he was not in pain.

30. At about midnight, Mr Maskell was observed d to be looking around and reaching for things that were not there. He later appeared distressed but eventually settled and slept from 5.00am to 9.00am.

31. When Ms Maskell awoke on the morning of 31 August 2025, he appeared to be in good spirits and later had a large bowel motion. Later in the day, Mr Maskell was taken to Colac where he had a walk. When he returned home, he had KFC for lunch and went to bed.

32. At about 5.55pm, a support worker checked on Mr Maskell and observed him to be unresponsive and gurgling. He was repositioned into a seated position at which time he vomited and his lips turned blue. Staff moved him to the floor where he vomited again and became unresponsive. Staff began administering CPR and contacted emergency services.

33. Ambulance Victoria paramedics arrived a short time later and provided treatment. Sadly, Mr Maskell could not be revived and his death was verified at 6.55pm.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was David Ian Maskell, born 27 February 1960;

    (b) the death occurred on 31 August 2025 at 23 Pioneer Road, Grovedale, Victoria;

    (c) the cause of Mr Maskell's death was aspiration pneumonia; and

    (d) immediately before death, Mr Maskell was a *"person placed in custody or care"* as defined in section 4 of the Act;

(e) the cause of Mr Maskell's death was aspiration pneumonia which I consider to be a death from natural causes for the purposes of section 52(3A) of the Act; and

(f) the death occurred in the circumstances described above.

35. I convey my sincere condolences to Mr Maskell's family and community for their loss.

PUBLICATION OF FINDING

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.

DISTRIBUTION OF FINDING

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

Colin McLellan, senior next of kin
Senior Constable James Blackney, Victoria Police, Coronial Investigator

Signature:





Deputy State Coroner Paresa Antoniadis Spanos

Date: 20 November 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.