IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 007187

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Leveasque Peterson
Deceased:	Dale William Cornish
Date of birth:	1 May 1945
Date of death:	5 October 2025
Cause of death:	1a : Complications of aspiration pneumonia in a man with intellectual impairment and other medical co-morbidities
Place of death:	Eastern Health Maroondah 1/15 Davey Drive Ringwood East Victoria 3135
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 5 October 2025, Dale William Cornish was 80 years old when died in hospital following several months of general functional decline and increased hospitalisations.

2. At the time of his death, Dale resided at a Specialist Disability Accommodation (**SDA**) dwelling in Croydon which was enrolled under the National Disability Insurance Scheme (**NDIS**). Dale received funded daily independent living support under the Disability Support for Older Australians Program, delivered and managed by Home@Scope Pty Ltd. Dale received assistance for most daily living activities including meal preparation, personal care, medication administration and continence care.

3. During Dale's childhood, he received diagnoses of an intellectual disability and severe visual impairment. He resided in care facilities from a young age during the 1970s, he was estranged from his family since around 2006. By the time of his death, Dale had an extensive medical history including double incontinence, high cholesterol, advanced dysphagia, legal blindness chronic constipation and recurrent lower-limb cellulitis and oedema. He also had a history of recurrent aspiration pneumonia.

4. In January 2025, Dale's general medical practitioner (**GP**) conducted his annual Comprehensive Health Assessment Program review and noted that Dale was experiencing age-related functional decline and adjusted his medication accordingly.

THE CORONIAL INVESTIGATION

5. Dale's death fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**) as he was a 'person placed in custody or care' within the meaning of the Act, as a person with disability who received funded daily independent living support and resided in an SDA enrolled dwelling immediately prior to his death.[1] This category of death is reportable to ensure independent scrutiny of the circumstances leading to death given the vulnerability of this cohort and the level of power and control exercised by those who care for them. The coroner is required to investigate the death, and publish their findings, even if the death has occurred as a result of natural causes.

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

[1] This class of person is prescribed as a 'person placed in custody or care' under the *Coroners Regulations 2019* (Vic), r 7(1)(d).

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.

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. This finding draws on the totality of the coronial investigation into the death of Dale William Cornish. 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

Circumstances in which the death occurred

9. On the morning of 16 March 2025, Dale appeared clammy and flushed, and had involuntary movements of his face, lip and right hand. Staff contacted emergency services and Dale was transported to hospital. Evidence indicates that Dale had sepsis due to his infected lower leg wounds. He was discharged on 24 March 2025 with antibiotics.

10. Between May and June, Dale underwent three further hospital admissions. On one occasion, he was admitted due to infected lower leg wounds, and he was twice admitted due to respiratory symptoms secondary to pneumonia. He maintained contact with his GP between admissions.

11. On 3 July 2026, three days after Dale was discharged from hospital due to presumed pneumonia, he attended his GP. His general condition appeared stable, and a chest examination was performed. The GP advised Dale to continue his course of antibiotics. Wound care advice for pressure wounds on his sacral region was also provided.

12. A week later, on 9 July 2025, staff noticed that Dale was not his normal self – he had laboured breathing and appeared disoriented. Staff completed regular observations and contacted

[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.

emergency services. Paramedics decided not to transfer him to hospital but recommended he attend his GP. During a GP consultation that afternoon, Dale's vital signs and oxygen saturation were stable, but he was still disoriented. Given Dale's multiple recent hospital admissions and altered mental state, the GP organised transfer to hospital.

13. Upon admission to hospital, Dale was initially treated with an empiric course of high-strength antibiotics. He became highly distressed by medical treatment such as drawing blood. Clinicians liaised with Dale's carers and GP and gathered a collateral history of his general functional decline and increased hospital admissions over the previous months. On 11 July 2025, it was decided to transition Dale to comfort-based care. This was decided in the context of Dale's continual refusal of medical treatment including blood tests, imaging, investigations and in the setting of concurrent physical decline with chronic risk of recurrent aspiration from feeding.

14. On the evening of 29 September 2025, Dale became drowsy and minimally responsive. A catheter was inserted and fluid therapy was commenced. Clinicians decided that if Dale deteriorated further, he would be placed on end of life care. This was put in place the following day and Dale passed away on 5 October 2025.

Identity of the deceased

15. On 15 October 2025, Dale William Cornish, born 1 May 1945, was visually identified by carer, Anne Howie.

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

Medical cause of death

17. Forensic Pathologist Dr Judith Fronczek of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 20 October 2025 and provided a written report of her findings dated 13 November 2025.

18. The post-mortem computed tomography (CT) scan showed no acute intracranial pathology, patchy bilateral enhanced lung markings, coronary artery calcifications and dilated bowel loops with coprostasis.

19. Dr Fronczek provided an opinion that the medical cause of death was 1(a) *Complications of aspiration pneumonia in a man with intellectual impairment and other medical co-morbidities*.

20. Dr Fronczek's provided an opinion that the cause of death was due to natural causes.

21. I accept Dr Fronczek's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Dale William Cornish, born 1 May 1945;

    b) the death occurred on 5 October 2025 at Eastern Health Maroondah 1/15 Davey Drive Ringwood East Victoria 3135 from *1a : Complications of aspiration pneumonia in a man with intellectual impairment and other medical co-morbidities*; and

    c) the death occurred in the circumstances described above.

23. The available evidence does not support a finding that there was any want of clinical management or care on the part of the disability service provider, or clinical staff at Eastern Health that caused or contributed to Dale's death.

24. Having considered all the available evidence, I find that Dale's death was from natural causes and that no further investigation is required. As such, I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into his death and to finalise the investigation of Dale's death in chambers.

I convey my sincere condolences to Dale's family, friends and carers for their loss.

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.

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

State Trustees

Scope@Home Pty Ltd

Senior Constable Benjamin Burch, Coronial Investigator

Signature:

Coroner Leveasque Peterson

Date: 14 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.