IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 007263

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the Death of Kenneth James Saunders

Delivered On:	15 September 2026
Delivered At:	Southbank, Victoria
Hearing Dates:	15 September 2026
Findings of:	Coroner Paul Lawrie
Representation:	No Appearances
Counsel Assisting the Coroner	Bemani Abeysinghe, Coroner's Solicitor
Keywords	In care, Specialist Disability Accommodation, SDA

1. I, Coroner Paul Lawrie, having investigated the death of Kenneth James Saunders, and having held an inquest in relation to this death on 15 September 2026 at Southbank, Victoria, I find that:

   a. The identity of the deceased was Kenneth James Saunders born on 28 August 1969.

   b. The death occurred on 12 October 2025 at Bendigo Health, 100 Barnard Street, Bendigo, Victoria 3550.

   c. The cause of death was**:**

      1(a) : ASPIRATION PNEUMONIA
      1(b) : HYPOXIC ISCHAEMIC BRAIN INJURY
      1(c) : POST REMOTE HEROIN OVERDOSE

2. I find, under section 67(1)(c) of the *Coroners Act 2008* (Vic) that the death occurred in the following circumstances:

INTRODUCTION AND PERSONAL BACKGROUND

3. On 12 October 2025, Kenneth James Saunders was 56 years old when he died at the Bendigo Hospital in Victoria. Mr Saunders is survived by her mother, Pauline Cornwill.

4. In 1998, when he was 28 years old, Mr Saunders sustained a severe hypoxic brain injury following a drug overdose. This resulted in him being non-verbal and quadriplegic requiring full time care. He was fitted with a percutaneous endoscopic gastrostomy (PEG) tube for feeding, a suprapubic catheter and a baclofen pump.[1] He communicated with finger and

[1] A baclofen pump is a device that delivers baclofen, a muscle relaxant medicine, to the fluid in the spinal canal. It manages severe spasticity arising from various brain and spinal cord conditions.

eyebrow movements. Mr Saunders had a complex medical history with multiple comorbidities.[2]

5. At the time of his death, Mr Saunders resided in Bendigo, Victoria at a Specialist Disability Accommodation (**SDA**) dwelling enrolled under the National Disability Insurance Scheme (**NDIS**) where he received full time care. The SDA was operated by Homes Victoria.[3] He had resided there since 2001.[4] Mr Saunders received Supported Independent Living (**SIL**) assistance through Scope (Aust) Ltd (**Scope**).

6. In the last five years of his life, Mr Saunders had suffered a progressive decline in his health including recurrent chest infections requiring multiple hospital admissions.

CORONIAL INVESTIGATION

7. 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.

8. 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

[2] Mr Saunders' medical history included osteoarthritis, hypertension, Hepatitis C, liver cirrhosis, spasticity, recurrent urinary tract infections, diskitis at the T11/T12, neuropathic pain, osteoporosis, thiamine deficiency and recurrent chest infections.
[3] Homes Victoria sits within the Victorian Department of Families, Fairness and Housing, a registered NDIS provider.
[4] Mr Saunders resided in Clarendon Nursing Home in Maryborough, Victoria between 1997 and 2001.

comments or recommendations in appropriate cases about any matter connected to the death under investigation.

9. Pursuant to section 4(2)(c) of the *Coroners Act 2008* (Vic) (**the Act**), the death of a person who immediately before their death was 'a person placed in custody or care', falls within the definition of a reportable death. A person in Victoria who is an SDA resident[5] residing in an SDA enrolled dwelling'[6] is a person 'in care' within the meaning of the Act.[7] The death of a person in care is a mandatory report to the Coroner, regardless of the apparent cause of death.

10. I am satisfied that Mr Saunders was an SDA resident residing in an SDA enrolled dwelling, and therefore he was a person 'in care' for the purposes of the Act. Accordingly, pursuant to section 52(2)(b) of the Act, an inquest is mandatory where the apparent cause of death is not wholly attributable to natural causes.

11. I determined that the inquest should proceed in a summary manner as the evidence may be regarded as complete and uncontentious, and it is appropriate for the evidence to be admitted in a summary form without the need to examine witnesses. The inquest took place on 15 September 2026.

12. First Constable (FC) Jesse Simpson and Senior Constable (SC) Benjamin Smythe of Victoria Police acted as Coronial Investigators for the investigation of Mr Saunders' death. FC Smythe conducted inquiries on my behalf and submitted a coronial brief of evidence.

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[5] 'SDA resident' means a person with a disability – (a) who receives, or is eligible to receive, funded daily independent living support; and (b) who is residing, or proposes to reside, in an SDA dwelling under an SDA residency agreement or residential rental agreement, *Residential Tenancies Act 1997* – s.3(1).
[6] *Residential Tenancies Act 1997* – s.3(1) (definition of 'SDA enrolled dwelling').
[7] *Coroners Regulations 2019* – r.7(1)(d)

13. This finding draws on the totality of the coronial investigation into the death of Kenneth James Saunders including the 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.[8]

IDENTITY OF THE DECEASED

14. On 14 October 2025, Kenneth James Saunders, born 28 August 1969, was visually identified by his mother, Pauline Cornwill.

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

MEDICAL CAUSE OF DEATH

16. Forensic pathologist, Dr Michael Burke from the Victorian Institute of Forensic Medicine conducted an external examination on 15 October 2025 and provided a written report of findings dated 23 October 2025.

17. The post-mortem computed tomography scan revealed increased lung markings and wasted skeletal muscles. No acute changes in the head were found.

18. Dr Burke provided an opinion that the medical cause of death was, '1(a) Aspiration pneumonia secondary to 1(b) Hypoxic ischaemic brain injury due to 1(c) Post remote heroin overdose'.

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[8] 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.

19. I accept Dr Burke's opinion.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

20. On 4 October 2025, Mr Saunders was admitted to the Bendigo Hospital in a reduced conscious state, thought to be secondary to an aspiration pneumonia and a possible urinary tract infection.

21. He was treated with intravenous antibiotics, initially with meropenem, which was subsequently de-escalated to cefepime following a review by the infectious diseases team. As a result, Mr Saunders' condition improved to a level near his baseline. He was then continued with oral augmentin.

22. On the evening of 10 October 2025, Mr Saunders' condition declined with a reduction in his Glasgow Coma Scale score. He was suffering from hypotension as well as hypoxia. His treating clinicians considered that this was secondary to another aspiration event and Mr Saunders was treated with intravenous antibiotics. Despite the efforts of his treating team, Mr Saunders continued to deteriorate.

23. Following consultation with Mr Saunders' family, he was transitioned to comfort care and he passed away at 7:52pm on 12 October 2025.

24. Mr Saunders' mother, Pauline Cornwill provided a written statement dated 6 March 2026 in which she stated that she had no concerns, and she was very happy with the care received by her son at the SDA.

CONCLUSION

25. I am satisfied that the care and support Mr Saunders received at the SDA and through his SIL provider was appropriate. I reach the same conclusion regarding the medical care provided to Mr Saunders by Bendigo Health.

ACKNOWLEDGEMENTS

26. I extend my sincere condolences to Mr Saunders' family for their loss.

27. I thank the Coronial Investigators and those assisting for their work in the investigation.

DIRECTIONS

28. Pursuant to section 73(1) of the Act, I direct that this finding be published on the Coroners Court website in accordance with the Rules.

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

    Pauline Cornwill, Senior Next of Kin

    Bendigo Health

    Homes Victoria, Department of Families, Fairness and Housing

    Scope (Aust) Ltd

    National Disability Insurance Agency

    First Constable Jesse Simpson, Coronial Investigator

    Senior Constable Benjamin Smythe, Coronial Investigator

Signature:

Coroner Paul Lawrie

Date: 15 September 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 inquest. 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.