IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2026 001003

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

1. I, Coroner Sarah Gebert, having investigated the death of Graham Peter Edwards and without holding an inquest, make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

   a) the identity of the deceased was Graham Peter Edwards, born 2 December 1957;

   b) the death occurred on 20 February 2026 at Ballarat Base Hospital, 1 Drummond Street, North Ballarat, Victoria from respiratory failure secondary to acute exacerbation of chronic obstructive pulmonary disease and heart failure; and

   c) the death occurred in the circumstances described below.

2. Graham was 68 years old at the time of his death and resided in supported independent living in Ballarat, where he received 24-hour support.

3. Graham suffered chronic pain throughout his life due to a hunting accident he sustained in his youth. His medical history also included chronic obstructive pulmonary disease, hypertension, heart failure with reduced ejection fraction, hepatitis C, clozapine induced myocarditis, chronic pain, asthma, and alcoholism. He had a long history of major mental illness, including delusional disorder and depression, and was subject to a community mental health treatment order.

4. In the months leading up to his death, Graham's medical condition deteriorated. He became increasingly immobile and short of breath.

Circumstances of death

5. In the early hours of 19 February 2026, Graham was admitted to the emergency department at Ballarat Base Hospital. He was treated for infective exacerbation of chronic obstructive pulmonary disease with acute on chronic respiratory failure and exacerbation of heart failure with fluid overload and acute kidney injury. He received high flow oxygen and non-invasive ventilation with bilevel positive airway pressure; however, he continued to deteriorate.

6. At about 1.24pm, following discussions with his family, Graham was transitioned to comfort care measures.

7. At about 11.05am on 20 February 2026, Graham died with his family by his side.

Medical cause of death

8. Forensic Pathologist, Dr Michael Burke, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 23 February 2026 and provided a written report of his findings dated 26 February 2026.

9. The post-mortem examination was consistent with reported circumstances.

10. Dr Burke provided an opinion that the medical cause of death was *"1(a) Respiratory failure"* secondary to *"1(b) Acute exacerbation of chronic obstructive pulmonary disease and heart failure"* due to natural causes.

11. I accept Dr Burke's opinion.

I convey my sincere condolences to Graham's family and friends 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:

Chrystal Hall, senior next of kin

Constable Jye Hoskin, Victoria Police, Coroner's Investigator

Signature:





Coroner Sarah Gebert

Date: 22 October 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.