IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 001265

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Ian William McCulloch
Date of birth:	15 September 1960
Date of death:	3 March 2024
Cause of death:	1a : UNASCERTAINED (NATURAL CAUSES) IN A MAN WITH ADVANCED MYOTONIC DYSTROPHY
Place of death:	Life Without Barriers 34 Douglas Street Ashwood Victoria 3147
Keywords:	Death in care; Disability; Natural causes

INTRODUCTION

1. On 3 March 2024, Ian William McCulloch was 63 years old when he passed from natural causes. At the time of his death, Ian lived at Life Without Barriers 34 Douglas Street, Ashwood, Victoria, 3147 with his carers.

2. Ian had two siblings, and was raised by his mother, initially in Mount Beauty, before he was educated at Kingswood College in Box Hill. After repeating year 8, he left school at the year 10 level.[1]

3. He worked for almost 20 years with Australian Paper Mills before he was made redundant eventually receiving a Commonwealth rehabilitation services disability pension. Despite the pension he supplemented his income delivering pamphlets in his neighbourhood where he was well known and well liked.

4. He lived at home with his mother until 2020 when he had a fall and his mother could no longer pick him back up. At this point he moved into the Life Without Barriers facility in Douglas St Ashford, where he was very happy and well looked after despite his mounting mobility issues resulting from Myotonic Dystrophy.[2]

5. Ian was diagnosed with dysphagia in 2016 and implemented safe swallowing strategies. He survived one cardiac event requiring hospitalisation in 2018, before his health deteriorated rapidly in the final year of his life.[3]

THE CORONIAL INVESTIGATION

6. Ian'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.

7. The death of a person in care or custody is a mandatory report to the coroner, even if the death appears to have been from natural causes. In Ian's case, he was a Specialist Disability Accommodation resident residing in an SDA enrolled dwelling at the time of his death, so his

[1] Statement of Margaret McCulloch, *Coronial Brief.*
[2] Ibid.
[3] Statement of Nigel Phillips, *Coronial Brief.*

passing was determined to be 'in care'[4] and, as such, is subject to a mandatory inquest, pursuant to section 52(2) of the Act.[5]

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. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Ian'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 the death of Ian William McCulloch 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.[6]

12. In considering the issues associated with this finding, I have been mindful of Ian's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

---

[5] See Regulation 7(1)(d) of the *Coroners Regulations 2019*.

[6] 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.

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

Circumstances in which the death occurred

13. On the evening of 2 March 2024, Ian was watching TV in his room and had been assisted to change and get ready for bed. At 11:05, staff turned off his television for him. At 11:07 PM and 11:09 pm being called out four staff assistants who were at that time attending to another client. [7]

14. At 11:11 pm, carer Betsy Kameri entered his room and found him in a kneeling position with his head down on the bed. He was breathing but unresponsive so she called 000 immediately and followed the call takers directions to roll him onto his back and commence cardiopulmonary resuscitation.[8]

15. Ambulance and Fire Rescue Victoria arrived and took over, whilst the facility notified Ian's mother. The paramedics declared Ian deceased at 12:15 am on 3 March 2024.[9]

Identity of the deceased

16. On 3 March 2024, Ian William McCulloch, born 15 September 1960, was visually identified by his carer, Ms. Betsy Kamarei.

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

Medical cause of death

18. Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 6 March 2024 and provided a written report of his findings dated 12 March 2024.

19. The examination revealed a pattern of muscle wastage consistent with his advanced dystrophic diagnosis and medical history. No other independent causes of death nor any indicia of maltreatment were apparent. His CT scan confirmed that he had arterial calcification, which is a known risk for people with his diagnosis.

[7] Statement of Nigel Phillips, *Coronial Brief.*
[8] Ibid.
[9] Patient Care Records, Exhibits 6 & 7, *Coronial Brief.*

20. Toxicological analysis of post-mortem samples identified the presence of therapeutic doses of Amiodarone, Desethylamiodarone, Apixaban, Salicylic Acid and Lignocaine, but did not identify the presence of any alcohol or other common drugs or poisons.

21. Dr Burke provided an opinion that the medical cause of death was 1(a) UNASCERTAINED (NATURAL CAUSES) IN A MAN WITH ADVANCED MYOTONIC DYSTROPHY, and I accept his opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Ian William McCulloch, born 15 September 1960;

    b) the death occurred on 3 March 2024 at Life Without Barriers, 34 Douglas Street, Ashwood, Victoria, 3147, from 1(a) UNASCERTAINED (NATURAL CAUSES) IN A MAN WITH ADVANCED MYOTONIC DYSTROPHY; and

    c) the death occurred in the circumstances described above.

23. Having considered all of the circumstances, I am satisfied that Ian's death was by natural causes, and that his care was reasonable and appropriate.

I convey my sincere condolences to Ian's family 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.

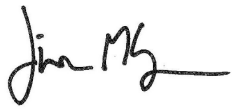
I direct that a copy of this finding be provided to the following:

Margaret McCulloch, Senior Next of Kin

Life Without Barriers (C/- Scott Shelly, Barry Nilsson Lawyers)

First Constable Morten Windfeld-Lund, Coronial Investigator

Signature:



Coroner Simon McGregor

Date: 13 June 2025

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.