IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 003438

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Brian Livingstone Clark
Date of birth:	12 May 1960
Date of death:	18 June 2025
Cause of death:	1a : UNASCERTAINED (NATURAL CAUSES)
Place of death:	23 Waterfern Street Fraser Rise Victoria 3336
Keywords:	In care; Natural Causes

INTRODUCTION

1. On 18 June 2025, Brian Livingstone Clark was 65 years old when he died of natural causes in care at 23 Waterfern Street, Fraser Rise, Victoria, 3336.

2. Brian was raised by his parents in NSW, and was one of four children. He met his future wife whilst at High School, where he also discovered his passion for design and music. He had two children with his first partner, and one child with his second.[1]

3. After a career in design and then running a cafe, Brian began to struggle with undiagnosed depression, and began driving a bus in an effort to keep up his mortgage payments.[2] He was eventually diagnosed in 2015, but then in reasonably quick succession also began suffering from gout, skin tags, diverticulitis and arachnoid cysts.[3]

4. In 2023, with his health continuing to decline, he began rotating living a few days each per week with his various siblings. His brother Graham became his legal guardian. Eventually, Brian started becoming confused and was diagnosed with early onset Alzheimer's Disease in May 2023, requiring full time care and supervision. Brian also had other blood and skin conditions and was hospitalised for stabilisation and then discharged to reside in care at a Specialist Disability Accommodation (**SDA**) located at the Waterfern St address.[4]

THE CORONIAL INVESTIGATION

5. Brian'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. 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.

6. Because Brian resided in an SDA dwelling at the time of his death, his passing was deemed to be 'in care'[5] and, as such, is subject to mandatory further investigation, pursuant to section 52(3A) of the Act.[6] These findings are the result of that investigation.

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[1] *Coronial Brief*, Statement of Carol Clark.
[2] *Ibid*.
[3] *Coronial Brief*, Report of Dr Richard Cai.
[4] *Coronial Brief*, Report of Dr Michael Oladiran.

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

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

9. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Brian'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.

10. In considering the issues associated with this finding, I have been mindful of Brian'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.

11. This finding draws on the totality of the coronial investigation into the death of Brian Livingstone Clark 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.[7]

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

Circumstances in which the death occurred

12. On 17 May 2025, Brian was taken by ambulance to sunshine hospital for breathing difficulties, then sent home later that day.[8]

[7] 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.

[8] *Coronial Brief*, Report of Dr Michael Oladiran.

13. On Monday, 16 June 2025, his Brian's sister Carol visited and notice that he was immobile, unable to talk and not eating.[9]

14. On 18 June 2025 at around 11:00 am, Brian's sister Jules then attended with her husband Graham, they notice Brian's shallow breathing and alerted staff.[10]

15. At 12:42 pm, carers contacted Ambulance Victoria in relation to a possible cardiac arrest. When paramedics arrived at 12:52 pm, the carers were conducting cardiopulmonary resuscitation on Brian but he appeared blue in colour and was not visibly breathing. Brian's paperwork indicated that he did not want medical intervention, and he was declared deceased.[11]

Identity of the deceased

16. On 19 June 2025, Brian Livingstone Clark, born 12 May 1960, was visually identified by his Brother in law, Graham Arthur Cole. Identity is not in dispute and requires no further investigation.

Medical cause of death

17. Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 23 June 2025 and provided a written report of his findings that same day.

18. The examination revealed Brian had most likely experienced a heart attack, or a pulmonary embolism, against a background of a chest infection, but there were no independent or traumatic causes of death, such that this death ought be best understood as the final stage of his accelerated but natural ageing process.

19. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or other common drugs or poisons, but did confirm the presence of prescribed medications in doses consistent with his medical history and caregiving plans.

20. Dr Burke provided an opinion that the medical cause of death was 1(a) UNASCERTAINED (NATURAL CAUSES), and I accept that opinion.

[9] *Coronial Brief*, Statement of Carol Clark.
[10] *Coronial Brief*, Statement of Graham Cole.
[11] *Coronial Brief*, Statement of Simon Bilston.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Brian Livingstone Clark, born 12 May 1960;

    b) the death occurred on 18 June 2025 at 23 Waterfern Street, Fraser Rise, Victoria, 3336, from 1(a) UNASCERTAINED (NATURAL CAUSES); and

    c) the death occurred in the circumstances described above.

22. Having considered all of the circumstances, I am satisfied that Brian's care was reasonable at appropriate at all material times.

I convey my sincere condolences to Brian's family for their loss.

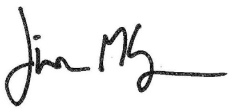
Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Daniel Clark, Senior Next of Kin

Senior Constable Roma Concepcion, Coronial Investigator

Signature:



Coroner Simon McGregor

Date: 12 November 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.