



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2025 008016

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Deceased:	Stewart Barclay
Date of birth:	19 March 1963
Date of death:	16 November 2025
Cause of death:	1(a) Alzheimer's disease
Place of death:	McCulloch House, Monash Health, 246 Clayton Road, Clayton, Victoria
Key words:	In care, Alzheimer's disease, dementia, natural causes

INTRODUCTION

1. On 16 November 2025, Stewart Barclay was 62 years old when he died at McCulloch House Inpatient Palliative Care Unit, Monash Health. At the time, Mr Barclay lived in in specialist disability accommodation in Dandenong. His wife, Ming Barclay, was his medical decision maker and lived at the family home in Mordialloc.
2. Mr Barclay was born in Cyprus, moving frequently as a child due to his father being a British Army officer. Mr Barclay received a Bachelor of Science in Scotland and settled in Australia, becoming a high school science teacher, eventually becoming head of a senior school.
3. Mr Barclay married his wife Ming in 1992 and they had two children – Aimee, born in 2000, and James, born in 2003.
4. In about 2010, Mr Barclay began developing behavioural issues that affected his work and family life. In November 2015 he received the medical diagnosis of early onset Alzheimer’s disease. Initially he remained physically fit, however exhibited confusion, erratic behaviour and increasing inability to carry out everyday tasks.
5. Mr Barclay entered full-time and National Disability Insurance Scheme (**NDIS**) funded care in 2018.

THE CORONIAL INVESTIGATION

6. Mr Barclay’s death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Generally, reportable deaths include deaths that are unexpected, unnatural or violent, or result from accident or injury. However, if a person satisfies the definition of a person placed in care immediately before death, the death is reportable even if it appears to have been from natural causes.^{1 2}
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

¹ See the definition of “*reportable death*” in section 4 of the *Coroners Act 2008* (**the Act**), especially section 4(2)(c) and the definition of “*person placed in custody or care*” in section 3 of the Act.

² Pursuant to section 52(2)(b) of the Act, a coroner must hold an inquest into a death if the death or cause of death occurred in Victoria and the deceased was, immediately before death, a person placed in custody or care. However, sub-section (3A) provides that a coroner is not required to hold an inquest if the coroner considers that the death was due to natural causes.

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. The Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Mr Barclays 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. This finding draws on the totality of the coronial investigation into Mr Barclay’s death, 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.³

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

Identity of the deceased

11. On 16 November 2025, Stewart Barclay, born 19 March 1963, was visually identified by his brother Bruce Barclay, who signed a formal Statement of Identification to this effect.
12. Identity is not in dispute and requires no further investigation.

Medical cause of death

13. Forensic Pathologist, Adjunct Associate Professor Hans de Boer, from the Victorian Institute of Forensic Medicine (VIFM), conducted an external examination on 19 November 2025 and provided a written report of his findings dated 27 November 2025.

³ 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.

14. The post-mortem CT (computed tomography) scan and external examination were consistent with the reported circumstances. The radiological findings included patchy posterior lung consolidation, suspicious for pneumonia. In addition, severe brain atrophy was noted.
15. Dr de Boer provided an opinion that the medical cause of death was “*1(a) Alzheimer’s disease*”. Dr de Boer was of the opinion that the death was due to natural causes.
16. I accept Dr de Boer’s opinion.

Circumstances in which the death occurred

17. Mr Barclay resided at a variety of supported disability accommodation facilities from 2018 until the time of his death in November 2025.
18. His dementia progressed such that he lost his ability to speak in 2023, eventually becoming completely dependent on carers for all his needs.
19. Toward the end of 2024, Mr Barclay moved to specialist disability accommodation in Dandenong operated by Acares Accommodation and Care Solutions.
20. Care services were provided by Arete Care. Mr Barclay received support 2:1 support for all activities of daily living and 1:1 care during the night for mobility, incontinence, and advanced dysphagia with high aspiration risk.
21. In September 2025, Mr Barclay had a brief hospital admission at Dandenong Hospital for aspiration pneumonia.
22. On 27 October 2025, Mr Barclay was admitted to Dandenong Hospital with a cough and fever and was treated with antibiotics for community acquired pneumonia. He was assessed as having a potential delirium and approaching end-of-life Alzheimer’s disease. His care was discussed with the Monash Health palliative care team and his wife who agreed with transitioning to comfort care. He was transferred back to his specialist disability accommodation on 30 October 2025.
23. Mr Barclay’s care needs continued to increase, and he eventually became unable to take any oral or sub-cutaneous medication. A multidisciplinary team meeting was held on 10 November 2025 and, in consultation with his wife, Mr Barclay was transferred to the Monash Health palliative care unit at McCulloch House. Formal end-of-life care was commenced on 12 November 2025.

24. Mr Barclay was kept comfortable until he passed away at 5.15pm on 16 November 2025.

FINDINGS AND CONCLUSION

25. Pursuant to section 67(1) of the Act I make the following findings:

- (a) the identity of the deceased was Stewart Barclay, born 19 March 1963;
- (b) the death occurred on 16 November 2025 at McCulloch House, Monash Health, 246 Clayton Rd, Clayton, Victoria;
- (c) the cause of Mr Barclay's death was Alzheimer's disease, which I consider to be a death from natural causes for the purposes of section 52(3A) of the Act; and
- (d) immediately before death, Mr Barclay was a "*person placed in custody or care*" as defined in section 4 of the Act;
- (e) the death occurred in the circumstances described above.

26. I convey my sincere condolences to Mr Barclay's family for their loss.

PUBLICATION OF FINDING

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

DISTRIBUTION OF FINDING

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

Ming Barclay, senior next of kin

Monash Health

First Constable, Thomas Hirst, Victoria Police, Coronial Investigator

Signature:



Deputy State Coroner Paresa Antoniadis Spanos

Date: 20 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.
