IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 002432

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Ian Robert Cameron
Date of birth:	2 December 1951
Date of death:	6 May 2025
Cause of death:	1a : COMPLICATIONS OF PYELONEPHRITIS AND HEPATOCELLULAR CARCINOMA IN A MAN WITH EPILEPSY
Place of death:	1 Glenora Street Chadstone Victoria 3148
Keywords:	In care death; SDA resident; Natural causes

INTRODUCTION

1. On 6 May 2025, Ian Robert Cameron was 73 years old when he died at home. At the time of his death, Ian lived in Specialist Disability Accommodation (**SDA**) 1 Glenora Street, Chadstone, Victoria, 3148.

2. Ian was the second child born to Margaret and Bob Cameron. Ian was born with number of significant disabilities including Motor Neuron Disease, Epilepsy and an Intellectual disability. These disabilities affected Ian's development. Ian lived with his parents until 1988 when his mother passed away and Ian was transferred into specialist disability accommodation run by the Department of Housing. In 2000, Ian was transferred to an SDA enrolled dwelling at 1 Glenora Street, Chadstone which was operated by Life without Barriers.

3. Ian was later diagnosed with Dysphagia and Osteoarthritis in addition to his pre-existing disabilities. These disabilities required Ian to be supported with daily living needs including personal care, showering, dressing, mobility and eating.

THE CORONIAL INVESTIGATION

4. 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. 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.

5. Because Ian was a Specialist Disability Accommodation (**SDA**) resident residing in an SDA enrolled dwelling[1] at the time of his death, his passing was determined to be 'in care' and, as such, is subject to a mandatory further investigation, pursuant to section 52(3A) of the Act. These findings are the result of that investigation.

6. 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.

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

7. 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.

8. Victoria Police assigned Senior Constable Nathan Beardsmore 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.

9. This finding draws on the totality of the coronial investigation into the death of Ian Robert Cameron 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.[2]

10. 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.

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

Circumstances in which the death occurred

11. In April 2025, Ian had acquired a chest infection but was improving over several weeks and did not have any reported breathing difficulties. Ian was susceptible to chest infections in the colder months.

12. On 6 May 2025, Ian was reported to be up early at 6:15 am and was vocal with his support worker from Life without Barriers, Mr Zheng Wu.[3] Mr Wu observed Ian to have a yellow substance on his face and Mr Wu, believed this to be potentially faeces. Mr Wu observed that the yellow substance appears to be on Ian's pillow and bed and accompanied Ian to the toilet to provide assistance.[4]

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[2] 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.

[3] *Coronial Brief*, Statements of Zheng Wu and Nigel Phillips.

[4] Ibid.

13. Whilst on the toilet, Mr Wu noted that Ian collapsed and Mr Wu rendered assistance and commenced cardiopulmonary resuscitation. Mr Wu contacted emergency services at around 6:30 am whilst performing ongoing resuscitation attempts.[5]

14. Ambulance paramedics arrived shortly after and also rendered assistance but were unable to revive Ian and he was pronounced deceased. Mr Wu noted that black material was protruding from Ian's mouth during resuscitation.[6]

Identity of the deceased

15. On 6 May 2025, Ian Robert Cameron, born 2 December 1951, was visually identified by their carer, Mr Zheng Wu.

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

Medical cause of death

17. Forensic Pathologist Dr Heinrich Bouwer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 7 May 2025 and provided a written report of his findings dated 29 August 2025.

18. The post-mortem examination revealed evidence of diffuse liver involvement by hepatocellular carcinoma, this was complicated by evidence of acute pyelonephritis, focal intra-abdominal pus collection and severe erosive gastritis. There was also evidence of dark fluid in the stomach which is likely from small mucosal erosions and erosive oesophagitis.

19. Dr Bouwer noted that erosive gastritis was likely caused by gastric acid reflex and was of the opinion that Ian's death was due to natural causes.

20. Toxicological analysis of post-mortem samples identified the presence of phenytoin (~3 mg/L) and trace amounts of paracetamol.

21. Dr Bouwer provided an opinion that the medical cause of death was 1(a) COMPLICATIONS OF PYELONEPHRITIS AND HEPATOCELLULAR CARCINOMA IN A MAN WITH EPILEPSY and I accept his opinion.

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[5] Ibid.
[6] Ibid.

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 Robert Cameron, born 2 December 1951;

    b) the death occurred on 6 May 2025 at 1 Glenora Street, Chadstone, Victoria, 3148, from 1(a) COMPLICATIONS OF PYELONEPHRITIS AND HEPATOCELLULAR CARCINOMA IN A MAN WITH EPILEPSY; and

    c) the death occurred in the circumstances described above.

23. Having considered all of the circumstances, I am satisfied that Ian's care was reasonable and appropriate at all material times. Ian's carers at Life without Barriers are noted to have been particularly supportive.

24. As Ian was residing in Specialist Disability Accommodation at the time of his passing, his death is considered to be 'in care' as defined by section 3 of the Act and subject to a mandatory inquest unless exceptions applied.[7] I am satisfied by the available evidence that Ian's death was due to natural causes and, pursuant to section 52(3A) of the Act, have therefore determined not to hold an inquest.

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

[7] Section 52(2) of the Act.

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.

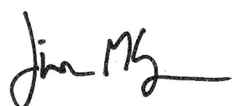
I direct that a copy of this finding be provided to the following:

Faye Deery, Senior Next of Kin

Scott Shelly, Barry Nilsson Lawyers

Senior Constable Nathan Beardsmore, Coronial Investigator

Signature:



Coroner Simon McGregor

Date: 25 March 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.