IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 000742

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 YIL 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 YIL, born in 1970;

   b) the death occurred on 7 February 2025 at Austin Hospital, 145 Studley Road, Heidelberg, Victoria, from complications of metastatic cholangiocarcinoma; and

   c) the death occurred in the circumstances described below.

2. YIL was 54 years old at the time of her death and resided in supported disability accommodation in Reservoir operated by Aruma.

3. Her medical history included Down syndrome, cognitive delay, hypoadrenalism, hyperlipidaemia, asthma, heart murmur, carpal tunnel surgery, morbid obesity, and metastatic cholangiocarcinoma.

4. YIL was described as sociable and friendly. Her favourite activities included colouring, doing word searches, rewriting books, and other community-based activities. She also enjoyed working as a packer at Endeavour (a sheltered workshop) in Thomastown.

5. YIL was first diagnosed with gallbladder and liver cancer toward the end of November 2022. She had surgery and commenced oral chemotherapy the following year. Despite this, the cancer progressed and in 2024, her treating clinician advised that her condition was

unsurvivable. YIL was thereafter transitioned to palliative care, continuing with chemotherapy.

6. In October 2024, two new tumours were found in her liver. Chemotherapy was stopped and she was kept comfortable with pain relief medications.

7. A final hospital admission in December 2024 for blocked bile ducts led to the cessation of all active cancer treatment.

Circumstances of death

8. YIL's health continued to decline in the weeks prior to her death. However, she continued enjoying her social activities.

9. In January 2025, YIL had to retire from her packing job. By this time, YIL was experiencing increasing fatigue, loss of appetite, confusion, incontinence, decreased mobility, and silent seizures. She began using a wheelchair and required full assistance with personal care.

10. On the night of 4 February 2025, YIL's sister, FPH, stayed at her residence and administered morphine via a butterfly needle to manage YIL's increasing pain.

11. On 5 February 2025, palliative care staff arranged for YIL to be transferred to the Austin Hospital for comfort-focused care. She was admitted to the palliative care unit with reduced oral intake, confusion, and pain.

12. Family members visited YIL on 5 and 6 February 2025 with YIL remaining cheerful, engaged, and responsive.

13. On 7 February 2025, YIL suffered a seizure and was administered midazolam, but her condition deteriorated rapidly. YIL passed away peacefully at 2.52pm that afternoon with family present.

Medical cause of death

14. Forensic Pathologist, Dr Gregory Young, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 10 February 2025 and provided a written report of his findings dated 11 February 2025.

15. The post-mortem examination revealed an irregularly contoured heterogeneous liver with calcification, renal calculi, and a chemotherapy port.

16. Dr Young provided an opinion that the medical cause of death was *"1(a) Complications of metastatic cholangiocarcinoma"* and the death was due to natural causes.

17. I accept Dr Young's opinion.

I convey my sincere condolences to YIL's family and friends for their loss.

Directions

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:

FPH, senior next of kin
Austin Health
Senior Constable Vahid Kamali, Victoria Police, Coroner's Investigator

Signature:

Coroner Sarah Gebert
Date: 11 December 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.