IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 004396

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge Liberty Sanger, State Coroner
Deceased:	Susan Gayle McFarlane
Date of birth:	1 December 1960
Date of death:	29 July 2025
Cause of death:	1a: Hepatocellular carcinoma Contributing factor 2: Cirrhosis
Place of death:	3 McCole Street Sale Victoria 3850
Keywords:	In care, natural causes

INTRODUCTION

1. On 29 July 2025, Susan Gayle McFarlane was 64 years old when she died at 3 McCole Street, Sale.

2. At the time of her death, Susan was a National Disability Insurance Scheme (**NDIS**) participant. She received funding to reside in a Specialist Disability Accommodation (**SDA**) enrolled dwelling[1] provided by Aruma Disability Services (**Aruma**) located in Sale. Susan received daily independent living support at her home.

3. Susan was described as a passionate reader who also loved horses and animals of all kinds.

4. Susan's medical history included subarachnoid haemorrhage, asthma, anxiety disorder, depression, epilepsy, Type 2 diabetes mellitus, hypertension, non-alcoholic fatty liver disease (**NAFLD**) cirrhosis, chronic obstructive pulmonary disease, recurrent urinary tract infection (**UTI**) and a previous stroke.

5. Susan's conditions were managed by her general practitioner (**GP**) at Inglis Medical Centre under a Chronic Disease Management Plan as well as by specialists, including a gastroenterologist.

6. Susan was also supported by her daughter, Micah Battley, who visited her regularly.

7. Susan's health had been deteriorating since early 2024, requiring presentations to the Emergency Department (**ED**). During those presentations, she was diagnosed with a portal vein thrombosis. An abdominal ultrasound conducted on 21 March 2024 showed sonographic features of liver cirrhosis.

THE CORONIAL INVESTIGATION

8. Susan's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**), as she was a '*person in care or custody*', being a person

[1] SDA enrolled dwelling is defined under the *Residential Tenancies Act 1997* (Vic). The definition, as applicable at the time of Susan's death, is a permanent dwelling that provides long-term accommodation for one or more SDA residents, that is enrolled as an SDA dwelling under relevant NDIS (Specialist Disability Accommodation) Rules in force at the relevant time. An SDA resident means a person who is a NDIS participant funded to reside in an SDA enrolled dwelling, or who receives continuity of supports under the Commonwealth Continuity of Support Program in respect of specialist disability services for older people (from 1 July 2021, the Disability Support for Older Australians program). The definition of SDA resident was amended on 1 July 2024 pursuant to the *Disability and Social Services Regulation Amendment Act 2023* to extend to include persons who are residing, or propose to reside, in an SDA dwelling under an SDA residency agreement or residential rental agreement.

in Victoria who was an '*SDA resident residing in an SDA enrolled dwelling'* immediately prior to her death.

9. 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.

10. 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.

11. State Coroner, Judge John Cain (as his Honour then was) originally held carriage of this matter, prior to this retirement in August 2025. I assumed carriage of this investigation on 1 September 2025.

12. This finding draws on the totality of the coronial investigation into the death of Susan Gayle McFarlane, including information obtained from her health records, the Aruma resident file and the National Disability Insurance Agency (**NDIA**). 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]

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

Identity of the deceased

13. On 29 July 2025, Susan Gayle McFarlane, born 1 December 1960, was visually identified by her daughter, Micah Battley.

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

Medical cause of death

[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.

15. Forensic Pathologist Associate Professor (**A/Prof**) Sarah Parsons from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 31 July 2025. A/Prof Parsons provided a written report of her findings dated 5 August 2025.

16. The post-mortem CT scan revealed findings including a remote craniectomy, irregular outline of the liver, increased lung markings and pleural effusions.

17. Toxicological analysis was not indicated and was therefore not undertaken.

18. A/Prof Parsons provided an opinion that the medical cause of death was *1a: Hepatocellular carcinoma,* with *cirrhosis* as a contributing factor.

19. A/Prof Parsons also provided an opinion that the death was due to natural causes.

20. I accept A/Prof Parsons' opinion as to the medical cause of death.

Circumstances in which the death occurred

21. On 8 June 2025, Susan was transported by ambulance to Sale Hospital in the context of worsening symptoms related to liver disease, including jaundice and fever. Later that day, she was transferred to St Vincent's Hospital Melbourne (**SVHM**), where she was admitted for investigation and specialist care.

22. During her admission at SVHM, further investigation confirmed hepatocellular carcinoma. Following a multidisciplinary team meeting, her treating clinicians considered her prognosis poor and recommended supportive and palliative care, rather than active treatment.

23. On 17 June 2025, a family meeting was held involving Susan, her family and her treating team. Susan and her family decided that her ongoing care would be transferred to palliative care and expressed a preference to receive palliative care in the community.

24. On 19 June 2025, Aruma completed a community palliative care referral to Central Gippsland Health (**CGH**).

25. On 20 June 2025, Susan was discharged from SVHM and transferred to Sale Hospital for discharge planning. She was discharged later that same day to her residence for symptom management, with input from her GP and the CGH Palliative Care team pending finalisation of her palliative care plan.

26. On 24 June 2025, Susan was transported to by ambulance to Sale Hospital ED due to a marked functional decline. She was diagnosed with a UTI and treated with antibiotics, and a blocked bile duct was identified. She was discharged home the same day with a plan to undergo endoscopic retrograde cholangiopancreatography.

27. On 26 June 2025, Susan's palliative care plan was finalised by the CGH Palliative Care team. Plan. An Advance Care Directive was also completed in consultation with Susan and her GP. It provided that her care would prioritise comfort measures only.

28. Susan's condition continued to deteriorate over the following weeks.

29. Susan passed away on the morning of 29 July 2025.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Susan Gayle McFarlane, born 1 December 1960;

    b) the death occurred on 29 July 2025 at 3 McCole Street, Sale, Victoria, 3850 from hepatocellular carcinoma with cirrhosis as a contributing condition; and

    c) the death occurred in the circumstances described above.

31. The available evidence does not support a finding that there was any want of clinical management or care on the part of the disability service provider, the GP at Inglis Medical Centre, or the clinicians of the Palliative Care team at Central Gippsland Health that caused or contributed to Susan's death.

32. Having considered all the available evidence, I find that Susan's death was from natural causes and that no further investigation is required. As such, I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into her death and to finalise the investigation of Susan's death in chambers.

I convey my sincere condolences to Susan's family, friends and carers 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:

Micah Battley, Senior Next of Kin

Aruma Disability Services

First Constable Immanuel Hay, Coronial Investigator

Signature:

Judge Liberty Sanger, State Coroner

Date: 22 July 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.