IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 003441

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Susan June Mahoney
Date of birth:	2 February 1951
Date of death:	19 June 2025
Cause of death:	1a : ACUTE RENAL FAILURE COMPLICATING DECREASED ORAL INTAKE IN THE SETTING OF ANGELMAN SYNDROME
Place of death:	McCulloch House - Monash Medical Centre 246 Clayton Road Clayton Victoria 3168
Keywords:	SDA resident; In care death

INTRODUCTION

1. On 19 June 2025, Susan June Mahoney was 74 years old when she died at Monash Medical Centre in Clayton. At the time of her death, Susan lived in Specialist Disability Accommodation (**SDA**) operated by Scope Australia at 1 James Street, Noble Park, Victoria, 3174.

2. Susan was born the eldest of four siblings and was raised in the Bentleigh area of Victoria with her family until 1957. Susan had an intellectual disability since an early age and was formally diagnosed with Angelman Syndrome at the age of 30. Susan was non-verbal, wheelchair bound and fully dependent on others for daily living activities.

3. Susan's family arranged for her to receive care at specialist accommodation facilities in Kew, Seaford and Noble Park. Susan received Supported Independent Living (**SIL**) services from Scope Australia since 2008.

THE CORONIAL INVESTIGATION

4. 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**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

5. Because Susan 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.

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

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

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

8. Victoria Police assigned Sergeant Toby Williams to be the Coronial Investigator for the investigation of Susan'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 Susan June Mahoney 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 Susan'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, Scope support staff began to observe that Susan's oral intake was reducing significantly from her regular intake. Susan was starting to spit out mouthfuls of food and fluids and also refusing to drink water.

12. On 2 May 2025, Susan saw her regular General Practitioner (GP), Dr Audrey Chandrapala about observed swallowing difficulties and refusal of food and fluids. Dr Chandrapala prescribed antibiotics for seven days and to return if there was no improvement.

13. On 9 May 2025, Susan returned to see Dr Chandrapala reporting a continuation of her symptoms and was referred to attend Dandenong Hospital. Within 24 hours of her admission, Susan demonstrated tolerating oral intake once again with no nausea, vomiting or any other

[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.

symptoms suggestive of a reversible gastrointestinal pathology. Susan was seen by a speech pathologist who cleared her to return to her level 4 pureed diet.

14. Susan was reported to continue to tolerate small amounts of oral intake and was discharged back to the care of Dr Chandrapala on 12 May 2025. Dr Chandrapala had discussions around the progression of Susan's Angelman syndrome with her brother, John Mahoney, indicating reduced oral intake may be a progression of her underlying condition.

15. On 25 May 2025, Susan re-presented to Dandenong Hospital with reduced oral intake concerns. Hospital staff had difficulty maintaining IV access as Susan repeatedly succeeded in pulling out their cannulas. There were discussions with her brother John about significant complications from the cannulas being repeatedly pulled out as well as from re-cannulation, and that IV fluids were not a sustainable nor an appropriate long term management plan. A family meeting was held on 27 May 2025 to explain the situation, lack of reversible causes for Susan's reduced oral intake and significant risks with ongoing re-cannulation attempts. The decision was made for supportive treatment with encouragement of oral intake as much as possible and close observation.

16. Susan demonstrated some improvement in small amounts of oral intake and a further family meeting was held on 30 May 2025, detailing that this reduction in oral intake was likely due to progressive neurocognitive impairment related to her Angelman syndrome and that further invasive investigation would be futile in terms of management. A consensus was reached to discharge Susan, after ruling out reversible causes with the non-invasive investigations and a demonstration of her ability to tolerate small amounts of oral intake, acknowledging that the amount of oral intake was significantly less than the daily requirement. John understood that the likelihood of Susan's condition worsening was high and that her progressively reducing oral intake would be ongoing, however he was pleased that there had been some increase in her oral intake on discharge. Susan's medical team also spoke directly to Dr Chandrapala, to communicate the likely worsening of her overall clinical state due to irreversible and progressively worsening oral intake.

17. On 16 June 2025, Susan re-presented to Dandenong Hospital with very poor oral intake and hypotension. She appeared uncomfortable and soon after admission, she was transitioned to a palliative care management plan after discussion with John, as her oral intake was steadily worsening and irreversible.

18. The palliative care team reviewed her on 17 June 2025 and accepted her for transfer to a palliative care ward. Susan was commenced on a syringe driver of palliative medications to manage her restlessness and agitation while awaiting a palliative care bed. Susan was reported to have passed away at 1:53 pm on 19 June 2025.

Identity of the deceased

19. On 19 June 2025, Susan June Mahoney, born 2 February 1951, was visually identified by their brother, John Henry Mahoney.

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

Medical cause of death

21. Forensic Pathologist Dr Hans de Boer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 23 June 2025 and provided a written report of his findings dated 24 June 2025.

22. The post-mortem examination and CT scan results were consistent with the reported circumstances and there was no evidence of substantial injury. Dr de Boer formed the opinion that the death was ultimately due to natural causes, namely due to complications of the deceased's Angelman syndrome.

23. Dr de Boer provided an opinion that the medical cause of death was 1(a) ACUTE RENAL FAILURE COMPLICATING DECREASED ORAL INTAKE IN THE SETTING OF ANGELMAN SYNDROME and I accept his opinion.

FINDINGS AND CONCLUSION

24. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[3] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

[3] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular

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

    a) the identity of the deceased was Susan June Mahoney, born 2 February 1951;

    b) the death occurred on 19 June 2025 at McCulloch House - Monash Medical Centre, 246 Clayton Road, Clayton, Victoria, 3168, from 1(a) ACUTE RENAL FAILURE COMPLICATING DECREASED ORAL INTAKE IN THE SETTING OF ANGELMAN SYNDROME; and

    c) the death occurred in the circumstances described above.

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

27. As Susan was residing in Specialist Disability Accommodation at the time of her passing, her death is considered to be 'in care' as defined by section 3 of the Act and subject to a mandatory inquest unless exceptions applied.[4] I am satisfied by the available evidence that Susan'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 Susan's family for their loss.

finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

[4] 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.

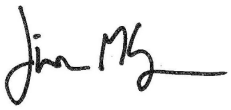
I direct that a copy of this finding be provided to the following:

John Mahoney, Senior Next of Kin

Naomi Baquing, Scope Australia

Sergeant Toby Williams, Coronial Investigator

Signature:



Coroner Simon McGregor

Date: 03 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.