



IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

**COR 2023 002611**

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

*Section 67 of the Coroners Act 2008*

Findings of:	Coroner Paul Lawrie
Deceased:	Rosemarie Paton
Date of birth:	19 May 1954
Date of death:	16 May 2023
Cause of death:	1(a) INTESTINAL PSEUDO-OBSTRUCTION IN A WOMAN WITH MULTIPLE SCLEROSIS
Place of death:	Multiple Sclerosis Care Facility, 4/303-311 Greensborough Road, Watsonia, Victoria, 3087
Keywords:	In care, natural causes

## INTRODUCTION

1. On 16 May 2023, Rosemarie Paton was 68 years old when she passed away at the Specialist Disability Accommodation where she resided – Multiple Sclerosis Care Facility, 4/303-311 Greensborough Road, Watsonia, Victoria, 3087. The facility is operated by MS Plus Ltd.
2. Ms Paton had suffered from multiple sclerosis for approximately 30 years and had relied on a wheelchair for 10 years. She also suffered from Type 1 diabetes mellitus.
3. Ms Paton had been bed bound for the last 12 months before her death and required 24 hour nursing care. Ms Paton’s sister was her Medical Power of Attorney and her family, including her two daughters, were active in her care.

## THE CORONIAL INVESTIGATION

4. Ms Paton’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. Ms Paton was a “person placed in custody or care” within the meaning of section 4 of the Act, as she was “a prescribed class of person”<sup>1</sup> due to her status as an “SDA<sup>2</sup> resident<sup>3</sup> residing in an SDA enrolled dwelling”.<sup>4</sup>
5. On 15 June 2023, I determined to discontinue the investigation pursuant to section 17(1) of the Act. I was at that time, and remain, satisfied that Ms Paton’s death was due to natural causes. I was also at that time, and remain, satisfied that there are no circumstances of concern in respect of the care or treatment provided to Ms Paton.
6. However, Ms Paton’s status as a person “in care” immediately before her death requires that I must hold an inquest into her death<sup>5</sup> unless I consider that the death was due to natural

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<sup>1</sup> Section 4(2)(j)(i) of the *Coroners Act 2008* (Vic) (‘the Act’).

<sup>2</sup> Specialist Disability Accommodation.

<sup>3</sup> An “SDA resident” includes a person who is an NDIS participant who is funded to reside in an SDA enrolled dwelling. See *Residential Tenancies Act 1997* – section 498B.

<sup>4</sup> *Coroners Regulations 2019* – regulation 7(1)(d)

<sup>5</sup> Section 52(2)(b) of the Act.

causes.<sup>6</sup> It also requires that I must, if possible, make a finding with respect to the circumstances in which the death occurred<sup>7</sup> and publish such finding.<sup>8</sup>

## **ORIGINAL FINDINGS SET ASIDE**

7. I am satisfied that it is appropriate to set aside the findings made by me on 15 June 2023 without re-opening the investigation. Accordingly, pursuant to section 77(2)(a) of the Act, I set aside those findings.

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

### **Circumstances in which the death occurred**

8. On 15 May 2023, Ms Paton became increasingly unwell with symptoms associated with intestinal pseudo-obstruction. She was assessed by a doctor and the decision was reached to provide comfort care rather than pursue active treatment.
9. Ms Paton continued to deteriorate overnight and passed away on the afternoon of 16 May 2023, surrounded by her family.

### **Identity of the deceased**

10. On 16 May 2023 Rosemarie Paton, born 19 May 1954, was visually identified by her sister, Beverlie de Jong.
11. Identity is not in dispute and requires no further investigation.

### **Medical cause of death**

12. Forensic Pathologist, Dr Ross Young from the Victorian Institute of Forensic Medicine, conducted an examination on 17 May 2023 and provided a written report of his findings dated 13 June 2023.
13. The post-mortem examination revealed features consistent with pseudo-obstruction. Dr Young noted that pseudo-obstruction occurs when the intestine is unable to contract and push food, stools, and air through the digestive tract. Resultant fluid and electrolyte shifts and increased abdominal pressure on the thoracic cavity via the diaphragm, may increase the risk

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<sup>6</sup> Section 52(3A) of the Act.

<sup>7</sup> Section 67 of the Act.

<sup>8</sup> Section 73(1B) of the Act.

of aspiration and/or cardiac arrhythmia, leading to death. Risk factors for the development of pseudo-obstruction include neuromuscular disorders (such as multiple sclerosis), and immobility.

14. Dr Young provided an opinion that the medical cause of death was 1 (a) **INTESTINAL PSEUDO-OBSTRUCTION IN A WOMAN WITH MULTIPLE SCLEROSIS**.

15. I accept Dr Young's opinion.

## **FINDINGS AND CONCLUSION**

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

- a) the identity of the deceased was Rosemarie Paton, born 19 May 1954;
- b) the death occurred on 16 May 2023 at Multiple Sclerosis Care Facility, 4/303-311 Greensborough Road, Watsonia, Victoria, 3087, from **INTESTINAL PSEUDO-OBSTRUCTION IN A WOMAN WITH MULTIPLE SCLEROSIS**; and
- c) the death occurred in the circumstances described above.

I convey my sincere condolences to Ms Paton's family and friends 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:

Cara Coombs, Senior Next of Kin

First Constable Hugh Nankivell, Coroner's Investigator

MS Plus Ltd

Signature:



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Coroner Paul Lawrie

Date : 22 August 2024

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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.

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