IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 004669

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 Mark Wesley Tyson and without holding an inquest, make the following findings pursuant to section 67(1) of the *Coroners Act 2008* (**the Act**):

   a) the identity of the deceased was Mark Wesley Tyson, born 11 November 1963;

   b) the death occurred on 10 August 2025 at Stawell Regional Health, 27-29 Sloane Street, Stawell, Victoria from complications of cerebral palsy; and

   c) the death occurred in the circumstances described below.

2. Mark was 61 years old when he died in hospital following a functional decline in health. At the time of his death, he resided in specialist disability accommodation in Stawell, managed by Possability Lifestyle Solutions (**Possability**).

3. Mark was born with cerebral palsy, resulting in several complications including an intellectual disability and epilepsy (which was well-managed by medication). Due to his cerebral palsy, he was prone to pneumonia which often required hospitalisation. Throughout his life, Mark was non-verbal and non-ambulant. He used a wheelchair and relied on carers to mobilise. Mark also experienced difficulty eating and would often refuse food and drink. During the last several years of his life, he consumed a modified diet of pureed foods and thickened fluids.

4. Mark resided at Possability from 8 July 1998. He required constant assistance and was entirely dependent on staff for all aspects of personal care and daily living.

5. Mark's carers described him as a "*pleasant man*" who often smiled and laughed when interacting with other people. Mark enjoyed various outings with his carers, such as going to concerts and feeding ducks at the local park. He also enjoyed sitting outside in the sun, listening to music, and watching television.

6. On 11 August 2023, Mark's mother, Lorraine Payne, made an advanced care plan to guide medical treatment decisions made on his behalf. The plan specified that, in the event of deterioration beyond any hope of an acceptable outcome, Mark should not receive life prolonging treatment and should instead "*be kept comfortable and pain free*". It listed cardiopulmonary resuscitation (**CPR**), intubation, nasogastric tube insertion and percutaneous endoscopic gastrostomy as treatments Mark would not want to receive.

Circumstances of death

7. At 9.30am on 26 July 2025, Mark presented to Stawell Regional Health, accompanied by his carer, with dehydration after refusing food and drink for a prolonged period. He was treated with intravenous therapy and discharged from emergency at 11.45am with advice to follow up with his general practitioner within a week.

8. At 7.43am on 29 July 2025, Mark presented to hospital again after his carer noticed further deterioration. Hospital records listed his presenting complaint as malnourishment and noted he was not for nasogastric tube insertion or percutaneous endoscopic gastrostomy. He was sent home at about 8.29am with advice to get blood tests in the community and see his general practitioner for follow up and consideration of palliating.

9. On 31 July 2025, Stawell Medical Centre received Mark's blood test results and advised that he immediately present to hospital. Mark was admitted to Stawell Regional Health at 4.40pm with malnourishment and hypernatremia. Clinicians formed the view that there were signs and symptoms indicating that the end of life was imminent. Following discussions with Lorraine, Mark was commenced an end-of-life care pathway and comfort measures.

10. Over the coming days, Mark's carers visited him frequently. At 8.22am on 10 August 2025, he passed away comfortably in the presence of a carer.

Medical cause of death

11. Forensic Pathologist, Dr Brian Beer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 12 August 2025 and provided a written report of his findings dated 21 August 2025.

12. The findings of the post-mortem examination were consistent with the history.

13. Dr Beer provided an opinion that the medical cause of death was *"1(a) Complications of cerebral palsy*".

14. Dr Beer also expressed an opinion that the death was due to natural causes.

15. I accept Dr Beer's opinion on these matters.

Coroners Prevention Unit review

16. As part of my investigation, I obtained advice from the Coroners Prevention Unit[1] (**CPU**) regarding the medical care Mark received prior to his death.

17. Upon reviewing the available medical records, the CPU noted that Mark lost interest in food and drink, leading to renal impairment, and he was unlikely to regain interest. With this knowledge, a shared decision was made to palliate. The CPU explained this was consistent with Mark's family's prior decisions (as documented in his advanced care plan).

18. The CPU concluded that the medical care Mark received was reasonable.

19. I accept the CPU's conclusion.

Having considered all of the circumstances, I am satisfied that Mark's death was due to natural causes, and an inquest is therefore not required pursuant to section 52(3A) of the Act.

I convey my sincere condolences to his family for their loss.

[1] The Coroners Prevention Unit was established in 2008 to strengthen the prevention role of the coroner. The unit assists the coroner with research in matters related to public health and safety, and the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health, and mental health.

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:

Lorraine Payne, senior next of kin

Wesley Tyson, senior next of kin

Senior Constable Wayne Dibben, Victoria Police, Coroner's Investigator

Signature:

Coroner Sarah Gebert

Date: 06 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.