IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 2397

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the ***Coroners Act 2008***

I, PETER WHITE, Coroner having investigated the death of FLORA JUNE RASMUSSEN
without holding an inquest:
find that the identity of the deceased was FLORA JUNE RASMUSSEN
born on 7 June 1927
and the death occurred on 16 May 2015
at 83 Williams Road, Wangaratta, Victoria
from:

1 (a) CORONARY ARTERY DISEASE

Pursuant to section 67(1) of the *Coroners Act 2008* I make findings with respect to the following circumstances:

1. Flora June Rasmussen was an 87 year old lady who resided in a community residential unit for people with disabilities run by the Department of Health and Human Services (DHHS) in Wangaratta. Ms Rasmussen had a mild intellectual disability and in 1966, she went to live in a care facility. She lived in a range of accommodation facilities and moved to the Wangaratta facility in January 2012.
2. Ms Rasmussen was regularly taken to see her general practitioner at the Ovens Medical Clinic. She had a history of congestive cardiac failure and in the weeks leading up to her death, she was experiencing a deterioration in her health.
3. On the morning of 16 May 2015, Richard Kendall, the shift supervisor for the day shift, liaised with the outgoing night shift house supervisor and ascertained that it had been an uneventful night. At about 7.15am, Mr Kendall spoke to Ms Rasmussen. She said that she had a normal nights sleep. At approximately 8am, Ms Rasmussen went to have a shower. Mr Kendall checked on her while she was having a shower and again when she exited the shower and was getting dressed. A short time later, he checked on her again and found her lying on the floor and non responsive. He immediately called emergency services.

4. An ambulance unit and a MICA paramedic arrived a short time later. They attempted resuscitation however they were unable to revive Ms Rasmussen.

5. Ms Rasmussen's death was reported to the Coroners Court of Victoria by her general practitioner, Dr Patrick O'Connor. Senior Pathologist, Dr Michael Burke of the Victorian Institute of Forensic Medicine, performed a post mortem medical examination. Dr Burke's autopsy report noted that the examination showed coronary artery disease. There was no evidence of any injury that would have contributed or led to death. Dr Burke concluded that the cause of Ms Rasmussen's death was 1(a) coronary artery disease. I adopt Dr Burke's findings in relation to the medical cause of death.

6. As Ms Rasmussen resided in a DHHS residential facility, I caused the coroner's investigator to prepare a coronial brief of evidence. I have relied on the statements in that brief in this finding. I received a comprehensive statement from Dr O'Connor in relation to Ms Rasmussen's medical history and treatment. I also received a statement from Mr Kendall. I am satisfied that Ms Rasmussen received appropriate care while residing in the DHHS accommodation facility. I am also satisfied that her medical treatment was appropriate.

Pursuant to section 73(1B) of the Coroners Act 2008 I order that this finding be published on the website in accordance with the rules.

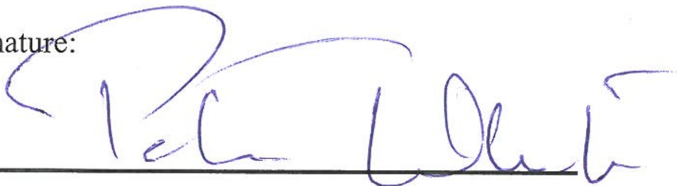
I direct that a copy of this finding be provided to the following:

Ms Rasmussen's family

Dr Patrick O'Connor

Leading Senior Constable Anthony Handley, coroner's investigator

Signature:



PETER WHITE
CORONER
Date: **16 October 2015**