FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 4805/08

Inquest into the Death of MARGARET ELIZABETH ANNE JONES

Delivered On:	17th June, 2011
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street, MELBOURNE 3000
Hearing Dates:	6th June, 2011
Findings of:	Coroner Paresa Antoniadis SPANOS
Representation:	Sergeant David DIMSEY, Police Coronial Support Unit, to assist the Coroner

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In the Coroners Court of Victoria at Melbourne

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of:

Details of deceased:

Surname:	JONES
First name:	MARGARET
Address:	242 Jetty Road, Rosebud, Victoria 3939

AND having held an inquest in relation to this death on 6th June, 2011

at Melbourne

find that the identity of the deceased was, MARGARET ELIZABETH ANNE JONES, also known as MARGARET JONES, born on the 7th September, 1946

and that death occurred on the 24th October, 2008

at 242 Jetty Road, Rosebud, Victoria 3939

from: 1(a) ISCHAEMIC HEART DISEASE
1(b) DIABETES
2 SMITH-MAGENIS SYNDROME WITH INTELLECTUAL DISABILITY

in the following circumstances:

1. Ms Jones was a 62 year old woman who had resided in the above community residential unit managed by the Department of Human Service (DHS) for four years preceding her death. Ms Jones had a past medical history which included Smith-Magenis syndrome, an intellectual disability, scoliosis, diabetes, chronic ear infections and cardiomegaly. She had lived in various care facilities since the death of her father and primary carer in 1983.

2. Ms Jones' brother Brian and his wife Allison took a great interest in her well-being and she stayed with them at their house in Rye every second weekend. According to her carers, Ms Jones was a wonderful person with a great personality but she was also complex and it could be difficult to understand her needs at times. In the six weeks preceding her death, Ms Jones was unwell with constant bouts of flu-like symptoms.

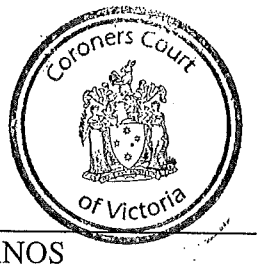
3. On 23 October 2008, Ms Jones was taken to her regular general practitioner Dr Mandar Gokhale from the South Coast Medical Centre as her carers thought she may have the flu. Dr Gokhale was unable to take her blood pressure as Ms Jones was hitting out, but managed to check her pulse and listen to her chest. He found her vital signs acceptable and made no changes to her regular medications. Ms Jones returned home for dinner and her usual evening routine.

4. According to the overnight carer, Mr Tony Francis, Ms Jones went to sleep quickly once she was in bed at about 10:00pm. When he walked past her room at 2:00am on 24 October 2008, he heard a gurgling sound and went in to investigate. He found her pulseless and called "000" who instructed him to perform cardiopulmonary resuscitation (CPR) until ambulance officers arrived a short time thereafter. They continued CPR but could not revive Ms Jones.

5. Dr Gokhale provided a Medical Certificate of Cause of Death (death certificate) in which he attributed Ms Jones' death to *ischaemic heart disease secondary to diabetes* and noting *Smith-Magenis syndrome with intellectual disability* under part 2, that is as significant conditions not directly related to the cause or mechanism of death. Senior Forensic Pathologist Dr Noel Woodford from the Victorian Institute of Forensic Medicine (VIFM) conducted an external examination, reviewed the medical records and the death certificate and advised that cause of death as provided on the death certificate is reasonable.

6. As Ms Jones was a person placed in care immediately before she died,[1] her death was reportable to the coroner, irrespective of the cause of death, and an inquest is mandated as part of the coronial investigation into her death.[2] In this respect, the *Coroners Act 2008,* recognises the vulnerability of those in the care of the State by ensuring that there is always a level of coronial scrutiny of the care they received, at least insofar as it may have caused or contributed to the death. Based on the totality of the material before me, I find no evidence of any want of care on the part of the staff of DHS, which may have caused or contributed to her death.

Signature:



PARESA ANTONIADIS SPANOS
CORONER
Date: 17th June, 2011

1 See definition of "person placed in custody or care" in section 3 of the *Coroners Act 2008* which includes, relevantly, - *"a person who is under the control, care or custody of the Secretary to the Department of Human Services."*

2 Section 52(2)(b) of the Act.