IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 2091

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**ROSEMARY CARLIN, CORONER**
Deceased:	**MEDZIT JAKUPI**
Date of birth:	8 December 1947
Date of death:	9 June 2014
Cause of death:	Unascertained (natural causes)
Place of death:	52/65 South Gippsland Highway, Dandenong South, Victoria 3175

HER HONOUR:

Background

1. Mr Jakupi was born on 8 December 1947. He was 67 years old when he died on 9 June 2014 from unascertained natural causes. At the time of his death, Mr Jakupi lived alone in Shawlands Caravan Park in Dandenong South. He had six children and was semi-retired.

2. Mr Jakupi had a history of hypertension, hypercholesteromia, type 2 diabetes and he was a smoker. His former wife Ms Marion Jakupi (**Marion**) described him as healthy, however she also said he was generally ignorant about his health including the side effects of medications and dietary changes necessary to control his diabetes.

The coronial investigation

3. Mr Jakupi's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**).

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death and with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The law is clear that coroners establish facts; they do not cast blame, or determine criminal or civil liability[1].

5. Under the Act, coroners have another important function and that is, where possible, to contribute to the reduction in number of preventable deaths and the promotion of public health and safety by way of making comment or recommendations about any matter connected to the death under investigation.

6. Coroners are not obliged to investigate or make findings as to the circumstances surrounding unexpected natural causes deaths and usually do not do so. However, in this case I decided to investigate as an issue arose as to whether Mr Jakupi's death was preventable.

7. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation into Mr Jakupi's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses, and submitted a coronial brief of evidence. I also obtained

[1] In the coronial jurisdiction facts must be established on the balance of probabilities 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.

additional information from the Emergency Services Telecommunications Authority (**ESTA**), the City of Greater Dandenong and further statements from witnesses and emergency services personnel.

8. In writing this Finding, I have conducted a thorough forensic examination of the evidence.

Identity

9. Mr Jakupi was visually identified by his neighbour Mr Halil Bektas, on 9 June 2014. Identity was not in issue and required no further information.

Medical cause of death

10. On 10 June 2014, Dr Sarah Parsons, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an external examination of Mr Jakupi, reviewed a post mortem CT scan and medical records and referred to the Victoria Police Report of Death, Form 83. Dr Parsons completed a report dated 25 June 2014, in which she formulated the cause of death as unascertained (natural causes). I accept Dr Parsons' opinion as to the medical cause of death.

11. Dr Parsons commented that the post mortem CT scan showed bilateral effusions[2]. Dr Parsons stated that there was nothing to suggest that Mr Jakupi's death was due to anything other than natural causes, however without an autopsy[3] the exact cause of death could not be determined.

12. I asked Dr Parsons to provide a supplementary report on the likelihood of a different outcome had the ambulance paramedics been able to attend to Mr Jakupi more promptly. On 14 May 2015, Dr Parsons stated that without an exact cause of death she was unable to comment. She explained that if, for example, the cause of death was a pulmonary embolus[4] it is unlikely that the time would have made a difference, but if it was heart failure or another cardiac cause earlier treatment may have been effective.

13. Toxicological analysis of post mortem specimens taken from Mr Jakupi identified codeine and doxylamine[5].

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[2] An effusion is an abnormal amount of fluid around the lung.

[3] I originally ordered an autopsy, however after the family applied for a reconsideration of this decision on religious and cultural grounds I determined that an autopsy was not 'necessary and appropriate'.

[4] Pulimonary embolus is a blockage in one of the pulmonary arteries in the lungs

[5] Doxylamine is an antihistamine.

Circumstances in which the death occurred

14. On 8 June 2014, during a visit to Marion's home, Mr Jakupi mentioned that he was having trouble breathing.

15. At approximately 5.12am the next day, Mr Jakupi called emergency services stating that he was short of breath and having difficulty breathing. He gave his address as 65 South Gippsland Highway, Dandenong South.

16. An ambulance was dispatched at 5.14am and arrived at 65 South Gippsland Highway at 5.25am. Upon realising the address was a caravan park and they did not know the patient's site number, the ambulance paramedics asked the ESTA dispatcher to perform a call back. The dispatcher called Mr Jakupi six times but there was no answer. The dispatcher also called the listed number of the manager of the caravan park (three times), but again there was no answer. After driving slowly through the park, the paramedics could not locate Mr Japuki, and advised the dispatcher they would clear the scene and return to home base.

17. The dispatcher then requested police assistance in locating Mr Jakupi's site number and advised the paramedics to return to the caravan park and await police. The ambulance arrived for a second time at 5.40am and the paramedics again attempted to locate Mr Jakupi without success.

18. At 5.48am, the dispatcher advised the paramedics that Mr Jakupi lived at site 52[6]. However, because the caravan park was poorly lit, there was no obvious site plan and the sites were not clearly numbered, the paramedics still had difficulty in finding him. The number of Mr Jakupi's caravan was obscured by a truck and a parked car.

19. At 5.55am, the paramedics located Mr Jakupi. He was unresponsive and unconscious and they could not resuscitate him. He was declared deceased at 6.00am and police arrived shortly afterwards.

20. Having considered the evidence I am satisfied that further investigation is not required.

Findings

Pursuant to section 67(1) of the *Coroners Act 2008*, I make the following findings connected with the death:

21. I find that:

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[6] Police ascertained the site number from its LEAP database based on information from Telstra.

(a) the identity of the deceased was Medzit Jakupi, born 8 December 1947; and

(b) Mr Jakupi died on 9 June 2014, Victoria, from unascertained natural causes in the circumstances described above.

Comments

Pursuant to section 67(3) of the *Coroners Act 2008*, I make the following comments connected with the death:

1. Initial concerns were raised that the ambulance could not get through the caravan park boom gates. My investigation found that the ambulance was able to get through the boom gates and did not have difficulty entering the caravan park. The real problem was that no one knew that Mr Jakupi was living in a caravan park until the ambulance arrived and consequently his site number had not been ascertained.

2. The ESTA dispatcher did not know that the address given by Mr Jakupi was a caravan park because he did not say so and ESTA's computer system at the time did not reveal this fact. ESTA's computer system has now been changed to indicate the address is a caravan park.

3. The ESTA dispatcher followed ESTA protocol in the questions asked of Mr Jakupi. The protocol did not contain a follow up question as to the type of residence. If the operator had asked Mr Jakupi if he lived in a house or an apartment, it may have prompted him to give the operator the site number of his caravan.

4. The City of Greater Dandenong conducts annual inspections of all its registered caravan parks to ensure compliance with applicable regulations. Although the caravan park complied with its legal requirements by having its emergency contact numbers, which were mobile numbers, on the office door, they were not seen by the ambulance paramedics. Further, the listed number called by the ESTA dispatcher was for the landline in the office and was not heard by the caravan park manager.

5. Since Mr Jakupi's death, the caravan park now prominently displays its emergency contact numbers and a site plan at the entrance of the park (in addition to the office front door) so a similar event should not happen again. This is not a legal requirement, however is clearly desirable.

6. The circumstances of this case suggest that when conducting its annual inspections of caravan parks the City of Greater Dandenong should be careful to ensure that signage is sufficiently prominent as compliance with applicable regulations may not be enough.

7. Although a number of factors contributed to a delay in ambulance paramedics attending Mr Jakupi, given his precise cause of death is not known, I cannot be satisfied that earlier attendance would have prevented his death.

Recommendations

Pursuant to section 72(2) of the *Coroners Act 2008*, I make the following recommendation(s) connected with the death:

1. That ESTA protocols be amended to include an additional question after asking for the address such as 'What type of residence is that?' or 'Is that a house or a flat or something else?'

Pursuant to rule 64(3) of the Coroners Court Rules 2009, I order that this finding be published on the internet.

I convey my sincere condolences to Mr Jakupi's family.

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

Ms Marion Jakupi, Senior Next of Kin

Mr Colin Grant, Ambulance Victoria

Mr Mark Richards, Emergency Services Telecommunications Authority

Mr Jody Bosman Director City Planning City of Greater Dandenong

Senior Constable, Gae Pasmans Coroner's Investigator, Victoria Police

Signature:

ROSEMARY CARLIN
CORONER
Date: 5 July 2016