FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 3955/09

Inquest into the Death of RAYMOND GILES

Delivered On:	19th August 2010
Delivered At:	Melbourne
Hearing Dates:	19th August 2010
Findings of:	IAIN TRELOAR WEST
Representation:	N/A
Place of death:	Unit 6 Plenty Residential Services-Henderson Ct, Bundoora, Victoria 3083
SCAU:	Senior Constable Kelly Ramsey

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Court reference: 3955/09

In the Coroners Court of Victoria at Melbourne
I, IAIN TRELOAR WEST, Deputy State Coroner

having investigated the death of:

Details of deceased:

Surname: GILES
First name: RAYMOND
Address: Unit 6 Plenty Residential Services-Henderson Ct, Bundoora, Victoria 3083

AND having held an inquest in relation to this death on 19th August, 2010
at Melbourne
find that the identity of the deceased was RAYMOND GILES
and death occurred on the 14th August, 2009

at Unit 6 Plenty Residential Services - Henderson Ct, Bundoora, Victoria 3083

from

1a. PNEUMONIA IN A MAN WITH DOWN SYNDROME AND DEMENTIA
2. EPILEPSY

in the following circumstances:

1. Raymond Giles, aged 53 years, was in Department of Human Services care at the time of his death and resided at a residential unit in Bundoora, with five other male clients. His past medical history included Down Syndrome, hyperthyroidism, epilepsy and recurrent chest infections. In addition, he suffered from an incurable neurodegenerative condition which resulted in a progressive decline in his health in the twelve months preceding his death.

2. At approximately 6:15am on the 14th August 2010, the night shift supervisor observed that Mr Giles had developed a temperature which was treated and brought under control with paracetamol. During the course of monitoring Mr Giles, staff observed him having an epileptic fit and experiencing difficulties breathing, resulting in his doctor being contacted and ambulance attendance being requested. Ambulance officers arrived at approximately 9:00am and during their examination, Mr Giles went into cardiac arrest and could not be resuscitated.

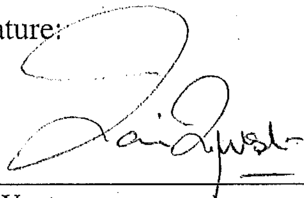
3. Despite a death certificate being issued, the death was reported to the coroner due to Mr Giles being "a person placed in care" at the time he died. No autopsy was performed out of respect for family wishes and because a reasonable cause of death could be determined by external examination and CT scan imaging. The imaging revealed marked consolidation of the

right lower lobe consistent with pneumonia and cerebral atrophy with marked ventricular dilatation.

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

1. On the evidence before me I am satisfied that Raymond Giles died of natural causes and that his 'in care' management was within ~~normal~~ parameters of reasonable health care practise.

Signature:



Iain West
Deputy State Coroner

19th August, 2010