

**FORM 37**

Rule 60(1)

**FINDING INTO DEATH WITH INQUEST**

*Section 67 of the Coroners Act 2008*

**Court reference:** 3063/09

**Inquest into the Death of FIONA MARY McBURNEY**

Delivered On:	24th February 2010
Delivered At:	Melbourne
Hearing Dates:	24th February 2010
Findings of:	HEATHER SPOONER
Representation:	N/A
Place of death/Suspected death:	Helen Schutt House, 1 Mountview Street Aspendale, Victoria 3195

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**FORM 37**

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**FINDING INTO DEATH WITH INQUEST**

*Section 67 of the Coroners Act 2008*

**Court reference:** 3063/09

In the Coroners Court of Victoria at Melbourne

**I HEATHER SPOONER**, Coroner

having investigated the death of:

**Details of deceased:**

Surname: **McBURNEY**

First name: **FIONA**

Address: 1 Mountview Street, Aspendale Victoria 3195

AND having held an inquest in relation to this death on 24th February 2010  
at Melbourne

find that the identity of the deceased was **FIONA MARY McBURNEY**  
and death occurred between the 21st and 22nd June, 2009  
at Helen Schutt House, 1 Mountview Street, Aspendale, Victoria 3195

from:

1a. **UNASCERTAINED**

in the following circumstances:

1. Ms McBurney was aged 37 at the time of her death. She resided at Helen Schutt House situate at 1 Mountview Street Aspendale. This was a permanent care facility that catered for adult residents with an intellectual disability. Ms McBurney had a past medical history that included Down's Syndrome, Secondary Intellectual Disability, Type 1 Diabetes Mellitus and Epilepsy. Her devoted family maintained regular and frequent contact.

2. A police investigation and mandatory Inquest by summary were conducted into the circumstances surrounding the death. It was apparent that Ms McBurney had been a resident at Helen Schutt House since about 1995. Her medical needs were attended to by her general practitioner, Dr Ferguson and a specialist consultant physician, Dr Lang.

3. In a statement from Dr Ferguson he indicated that his last consult was on 27th April 2009, for review of a fractured ankle:

‘...Consultations with Carer staff regarding Fiona occurred on a regular basis either when Fiona came for visits, when other residents of the facility attended for their own visits or via telephone. I have always found the Helen Schutt House staff to be caring, compassionate and conscientious over the years I have been dealing with them...’

4. According to a statement from Dr Lang:

‘...Her last consultation was on 19 May 2009. At that consultation I was informed that she had sustained a minor fracture of her left ankle and was ambulating with a boot. Her mobility was somewhat impaired. Her diabetes at the time was somewhat variable with blood glucose levels raging between 2mmol/L and 27mmol/L. She had not had any significant symptomatic hypoglycaemic episodes. At that consultation I rearranged her insulin doses so that she had less insulin overnight...’

5. On the evening she died, Ms McBurney was being cared for by Ms Drozdowski, a Residential Care Worker who was working the ‘sleepover shift’. Ms Drozdowski checked Ms McBurney’s blood glucose level and gave her a quarter vegemite sandwich before organising her medication and preparing her for bed at about 10.15pm. She heard nothing during the night but when she went to wake Ms McBurney a little after 7am the following morning it was apparent that she was deceased. Emergency Services were notified and attended.

6. Both Ms Drozdowski and another residential care worker, Ms Djokic indicated in their statements that Ms McBurney should have received a higher level of care, however, the House Supervisor, Ms Sellman stated:

‘I believe we were well on top of Ms McBurney’s issues in relation to her health.’

7. Mr McBurney told the Court that he appreciated the issue being raised but did not think his daughter was missing out in the care she received.

8. An autopsy was performed by Dr Bedford Specialist Pathologist at the Victorian Institute of Forensic Medicine. In his report he made the following comments:

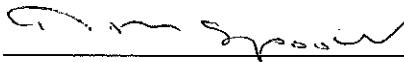
1. The deceased has Down’s Syndrome, a history of unstable diabetes and epilepsy.

2. She was found face down on her bed with no signs of significant injury. Toxicology was not contributory and unfortunately a glucose level was not able to be performed due to insufficient sample.

3. Death appears to be from natural causes with the most likely possibilities being an epileptic seizure or a hypoglycaemic episode (low blood sugar). No suspicious circumstances are identified. Due to the inability to definitely classify the cause of death the finding is therefore listed as 'Unascertained'.

9. It was apparent that Ms McBurney may have suffered a decline prior to her death and there was some difference in the evidence about her appropriate level of care, however, given that the cause of death remains unascertained it is difficult to know the degree to which this may have had any impact on her ultimate, unfortunate demise.

Signature:



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Heather Spooner

Coroner

Date: 24 February 2010