IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2010 / 2173

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of:	**DAWN WIGG**
Delivered On:	1 May 2014
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne 3000
Hearing Dates:	1 May 2014
Findings of:	CAITLIN C ENGLISH, CORONER
Police Coronial Support Unit	Leading Senior Constable King Taylor

I, CAITLIN CREED ENGLISH, Coroner having investigated the death of DAWN WIGG

AND having held an inquest in relation to this death on 1 May 2014
At MELBOURNE
find that the identity of the deceased was DAWN WIGG
born on 18 November 1945
and the death occurred between 8 and 9 June 2010
at 22 O'Sullivan Road, Seymour 3660
from:

1 (a) ISCHAEMIC HEART DISEASE

in the following circumstances:

1. Dawn Wigg was 64 years of age when she died. At the time of her death she resided in Department of Human Services supported residential care at 22 O'Sullivan Road, Seymour where she had resided since 2008.

2. Due to Ms Wigg's 'in care' status, her death was reportable to the Coroner in accordance with s.11 of the Coroners Act 2008 (Vic). Subject to s.52 (2) of the Coroners Act 2008 (Vic) the Coroner must hold an inquest into a death if the deceased was, immediately before death, a person placed in custody or care.

3. Ms Wigg had a long history of institutional care since the age of nine due to an intellectual disability. Ms Wigg's medical history also included high cholesterol and diabetes.

4. Ms Wigg was treated by general practitioner Dr Carol Liow of the Goulburn River Group Practice in Seymour. Ms Wigg's mental health needs were monitored by consultant psychiatrist, Dr Francis Payne of the Kilmore Colonial Bank Specialist Centre in Kilmore.

5. Ms Wigg was treated for a psychiatric effective disorder with Haloperidol, a psycho-tropic medication often used for the management of psychotic symptoms associated with Schizophrenia, over a long period of time. In March 2008, Ms Wigg's medical practitioners had begun a plan to reduce the dose of Haloperiodol she was prescribed and this plan was ongoing at the time of her death.

Events prior to death

6. A police investigation was conducted into the circumstances of Ms Wigg's death.

7. On 20 April 2010, Ms Wigg was taken to the Northern Hospital Emergency Department following experiencing abdominal pain and vomiting. She was reviewed by the surgical team with respect to possible pancreatitis, but settled overnight. Following observation in hospital for two days following admission, no abnormal pathology was found and Ms Wigg was discharged back to her supported accommodation.

8. Approximately one week prior to Mr Wigg's death she was complaining of stomach aches and her disability support services officer Ann Allison took her to the Goulburn River Group Practice Clinic. Dr Liow diagnosed Ms Wigg with constipation and treated her with a laxative.

9. On 8 June 2010, Ms Wigg again developed abdominal pain, vomiting and diarrhoea and the general practitioner was requested to review her. At approximately 7pm, Dr Eliot Jarman examined Ms Wigg. On examination, he determined Ms Wigg was afebrile with a systolic blood pressure of 110. Dr Jarman noted that there were other residents at the supported accommodation with gastroenteritis and made a diagnosis of gastroenteritis The management consisted of intramuscular Stemetil.

10. At approximately 8.20pm on 8 June 2010, Ms Wigg was assisted into bed by Susan Spruyt, one of the disability support staff. This was the last time Ms Wigg was seen alive.

11. At approximately 8.20am on 9 June 2010 Ms Wigg was found deceased by Dianne Jehn, a disability support staffer working the morning shift.

Post Mortem Examination

12. A post mortem examination was performed by Dr Deepali Kamra, Pathology Registrar at the Victorian Institute of Forensic Medicine on 16 June 2010. Dr Kamra formulated the cause of death and made the following comments:

> *"Ischaemic heart disease is the generic definition for a group of closely related disorders resulting in myocardial ischaemia. Myocardial ischaemia is the imbalance between supply (perfusion) and demand of the heart for oxygen in blood. In the majority of cases this is due to coronary artery atherosclerosis. This lady had significant stenosis involving two of the coronary arteries and myocardial fibrosis consistent with ischaemic heart disease. Risk factors include increasing age, sex,*

hyperlipidaemia, hypertension, smoking and diabetes mellitus. The deceased had a history of diabetes mellitus and high cholesterol levels. The lungs showed interstitial granulomas. Granulomas can be seen in conditions such as sarcoidosis or infection. Infectious stains are negative. The most likely cause is sarcoidosis. Blood culture yielded growth of Clostridium butyricum. This is considered a contaminant. Toxicological analysis conducted on post mortem blood was non-contributory. There was no evidence of any injuries which may have caused or contributed to death."

Health and Medical Review

13. I directed the Coroners Prevention Unit, Health and Medical Investigations Team (HMIT)[1] to review the medical management of Ms Wigg leading up to her death.

14. The HMIT review found after considering "the medical records and based on Ms Wigg's presentation of abdominal pain and vomiting the medical management on the evening prior to her death appeared appropriate. There was no suggestion of a cardiac condition during the general practitioners examination of Ms Wigg the previous evening."

[1] The role of the Health and Medical Investigation Team (HMIT) is to assist the Coroner's investigation into the nature and extent of deaths which occurred during the provision of healthcare, and identify potential system factors in healthcare related deaths. HMIT personnel comprise of practising Physicians and Clinical Research Nurses who draw on their medical, nursing and research experiences, skills and knowledge to independently evaluate clinical evidence for the investigation of reportable healthcare deaths and to assist in identifying remediable factors that may assist in prevention and risk management in health services settings.

Findings

I find that unfortunately Dawn Wigg died from ischaemic heart disease. Medical management of Ms Wigg was appropriate in the circumstances.

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

Mr John Williams

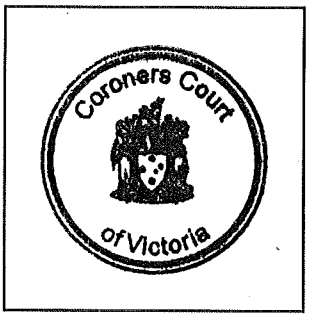
Constable Paul Tobin, Investigating Member, Victoria Police

Shane Beaumont, Department of Human Services

Carolyn Tremellen, Manager, Residential Client Services, Department of Human Services - Goulburn

Dr Eliot Jarman and Carol Liow, Goulburn River Practice Group

Signature:



CAITLIN ENGLISH
CORONER
Date: 1 May 2014