FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 1358/11

Inquest into the Death of LEANNE FIONA MACKENZIE

Delivered On:	22 September 2011
Delivered At:	Melbourne
Hearing Dates:	22 September 2011
Findings of:	Coroner Kim M W Parkinson
Place of death:	Northern Hospital
PSCU:	Leading Senior Constable King Taylor

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In the Coroners Court of Victoria at Melbourne
I, KIM PARKINSON, Coroner

having investigated the death of:

Details of deceased:

Surname: MACKENZIE
First name: LEANNE
Address: 240 Saxton Drive, Moe, Victoria 3825

AND having held an inquest in relation to this death on 22 September 2011
at Melbourne

and that the identity of the deceased was LEANNE FIONA MACKENZIE
and death occurred on 14th April, 2011

at Northern Hospital, 185 Cooper Street, Epping, Victoria 3076

from
1a. ABDOMINAL SEPSIS IN A WOMAN WITH CORONARY ARTERY DISEASE
1b. POST REPAIR SMALL BOWEL PERFORATION
1c. REPAIR INCARCERATED INCISIONAL HERNIA

In the following circumstances:

1. Ms Leanne Fiona Mackenzie was born on 28 June 1962 and she was 48 years of age at the time of her death. Ms Mackenzie was intellectually disabled and a recipient of disability residential services provided by the Department of Human Services pursuant to the Disability Act 2006. She was under the care of the Department of Human Services and resided at Department of Human Services premises located at 240 Saxon Drive, Moe.

2. Ms Mackenzie was a person in care as defined by s3(d) of the **Coroners Act 2008** ("the Act") and accordingly her death was reportable pursuant to s5(c) of that Act. An inquest into her death is mandatory pursuant to s52(2)(b) of the Act. This inquest has proceeded by summary of the circumstances.

3. Ms Mackenzie had a medical history of Prader-Willi Syndrome, lymphoedema, sleep apnoea, psoriasis, amenorrhoea, anxiety, agitation and hypertension.

4. On 3 April 2011, she underwent a laparotomy for incarcerated incisional hernia at the Latrobe Regional Hospital. There was no evidence of ischaemic gut and the hernia was repaired, however her post operative progress was poor.

5. On 4 April 2011, she was transferred to the Northern Hospital for possible peritonitis and bleeding. Despite intensive medical intervention, Ms Mackenzie died on 14 April, 2011.

6. An autopsy conducted by Dr Michael Burke, Senior Forensic Pathologist of the Victorian Institute of Forensic Medicine. Dr Burke reported that the cause of death was:

1(a) Abdominal Sepsis in a woman with Coronary Artery Disease;
1(b) Post-repair small bowel perforation;
1(c) Repair incarcerated incisional hernia.

7. Having considered the available evidence I am satisfied that the medical care and management provided to Ms Mackenzie was reasonable and appropriate in the circumstances. There were no suspicious circumstances relating to her death.

8. I find that Ms Leanne Fiona Mackenzie died on 14 April 2011 and that the cause of her death was abdominal sepsis in a woman with coronary artery disease, post-repair of a small bowel perforation in the context of the repair of an incarcerated incisional hernia.

Signature:

Kim M W Parkinson
Coroner

22nd September, 2011