FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court Reference: 324/2008

Inquest into the Death of June Dianne Owen

Delivered On:	3 May 2011
Delivered At:	
Hearing Dates:	21 September 2009
Findings of:	Richard Pithouse
Representation:	Mr N. Murdoch – Stawell Regional Health Mr R. Willcox – Melinda Higgins
Place of death:	139 Cooper Street, Stawell VIC 3380
Counsel Assisting the Coroner	Senior Constable T. Cristiano

FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court Reference: 324/2008

In the Coroners Court of Victoria at Stawell

I Richard Pithouse, Coroner having investigated the death of:

Details of deceased:

Surname:	Owen
First name:	June Dianne
Address:	139 Cooper Street, Stawell VIC 3380

AND having held an inquest in relation to this death on 21 September 2009

at Stawell

find that the identity of the deceased was June Dianne Owen

and death occurred on 22 January 2008

at Stawell

from

1a Cardiomegaly and biventricular dilatation

in the following circumstances:

June Dianne Owen, the deceased, (date of death 22 January 2008) was sixty-three years of age at the time of her death. She resided at 139 Cooper Street, Stawell with her partner Desmond Murtagh.

Mrs Owen was a patient of the Stawell Medical Centre, and was a long term patient at that service under the care of Dr Cunningham. Dr Cunningham was called as a witness at the Inquest.

Dr Cunningham noted that the deceased's past medical history included;

- diabetes,
- panic attacks,
- anaemia due to iron deficiency,
- chronic cardiac failure,
- pulmonary hypotension,
- deep vein thrombosis,
- hysterectomy,
- incisional hernia
- right ventricular failure and
- suffering allergies to Augmentin and Morphine

Dr Cunningham had prescribed for the deceased, with which she was apparently compliant, the following medications;

- Avanza 30 milligrams,
- Cardizem 180 milligrams,
- Diamicron 30 milligrams,
- Imdur 60 milligrams,
- Lasix 40 milligrams,
- Metformin Hydrochloride 1000 milligrams,
- Monopril 20 milligrams,
- NEO-B12,
- Somac 40 milligrams,
- Wafarin 5 milligrams, 2 milligrams 1 milligrams and
- Xalatan eye drops.

Dr Cunningham gave evidence that it was his opinion that Mrs Owen was a patient who had an underlying disease, together with her signs and symptoms and that she was a person at

risk of sudden death. Dr Cunningham said that Mrs Owen had "...a very, very severely affected heart, so bad that she wasn't able to push blood effectively through her lungs."

The medication for Mrs Owen was ostensibly for management purposes, as there were limited treatment options for her underlying cardiac disease. Dr Cunningham gave evidence that patients at risk of sudden death were not admitted to hospital to manage that risk. He gave further evidence that even if the deceased were to be in hospital, it didn't necessarily mean that she would be saved in the event of cardiac arrest.

The deceased had been referred to a cardiologist at the Alfred Hospital for the assessment of possible treatment by way of a heart/lung transplant.

Mr Gregory Paul Hallam, paramedic from Rural Ambulance Victoria gave evidence that in the preceding 24 hours to her death, Mrs Owen had called and been attended to, or received advice from the Rural Ambulance Victoria on four occasions. Those occasions were;

1. 21 January 2008 at 14:28 at 49 Berg Street Stawell for a diabetic issue. There was some diffused abdominal pain, with a pain score of 1/10.
2. 21 January 2008 at 19:30 at 139 Cooper Street Stawell due to increasing abdominal pain. Conveyed to Stawell Hospital.
3. 21 January 2008 at an unknown time, the deceased contacted the Ambulance Service about a finger cut which would not stop bleeding. No attendance by the Ambulance Service.
4. 21 January 208 at 21:54 at 139 Cooper Streeet Stawell with increasing abdominal pain and distension to her back. Conveyed to Stawell Hospital.

The hospital patient records that were referred to in the course of the evidence given at the Inquest note that Mrs Owen attended the Stawell Hospital by ambulance at approximately 17:00 on 21 January 2008, rather than 19:00 as was the evidence of Mr Hallam. Mrs Owen confirmed that time when she gave her patient history upon her subsequent attendance at that hospital at approximately 22:15 on 21 January 2008.

On 21 January 2008 at approximately 17:00, Mrs Owen presented at the Stawell Hospital with abdominal pain. She was not seen by a doctor, but was seen by nursing staff. She was given 2 x panadeine forte tablets for pain relief. She was released and advised to attend her treating doctor for follow up if the pain persisted.

Melinda Helen Higgins, who was a registered nurse at the Stawell Hospital, gave evidence. Ms Higgins dealt with the deceased when she presented at the hospital at approximately 22:15 on January 21, 2008. The deceased upon presentation, according to the clinical notes of Ms Higgins and her evidence, was "... anxious and complaining of abdominal pain, right and left side radiating into back, right and left side. Nil nausea, pain commenced on Saturday, 20 evening for abdo pain...". Ms Higgins further noted that the deceased upon presentation was alert and orientated, with a pain score of 5/10. The deceased confirmed that she had last had pain relief at approximately 17:30 that day at the hospital. Ms Higgins physically examined Mrs Owen and made observations of her. She palpated the abdomen of Mrs Owen, but Mrs Owen could not distinguish where her pain was. Ms Higgins also noted that it was difficult to assess Mrs Owen due to her size.

Stawell Hospital is operated by Stawell Regional Health. Stawell Regional Health operates an unstaffed Emergency Department at all times. Qualified nursing staff are rostered to attend the Emergency area each shift and to attend patients when they present to the Department.

Stawell Regional Health does not employ any doctors as part of the hospital staff. Rather, there is a contractual arrangement with the Stawell Medical Centre which rosters a medical practitioner from that clinic to be on call to be responsible for responding to the Emergency Department of the hospital each day.

After Mrs Owen presented at the hospital at 22:15 on 21 January 2008, Ms Higgins contacted by phone the on-call doctor, Dr Briandha Jeremiah. In her evidence, Dr Jeremiah confirmed that she had been contacted by Ms Higgins at approximately 23:30 on 21 January 2008 in relation to Mrs Owen and was provided the presentation information about Mrs Owen. Dr Jeremiah conceded that Ms Higgins requested that she attend at the Emergency Department, but as Mrs Owens "...pain had disappeared completely during the day, (it) was reassuring (to her) ...as this suggested the cause (of the pain) was unlikely to

be an acute abdomen requiring immediate management ", she decided not to attend the Emergency Department and examine Mrs Owen.

Dr Jeremiah gave evidence she decided that as Mrs Owen had responded positively to the earlier pain relief that had been administered, it would be appropriate for there to be further pain relief prescribed. Dr Jeremiah prescribed Mrs Owen be given injections of pethidine (for pain) and Maxalon (for nausea which may result from the pethidine). The dosage was calculated by Dr Jeremiah on the height and weight of Mrs Owen and on the evidence was the appropriate dosage. At 23:45 Ms Higgins administered the medication.

There were conflicting accounts as to proposed management at the hospital of Mrs Owen after the pethidine was administered. Ms Higgins gave evidence that Dr Jeremiah's instructions were that Mrs Owen was to be released when she was pain free. Dr Jeremiah initially testified that her recollection was that her instructions were for Mrs Owen to be monitored for approximately 2 hours after the pethidine was administered. In cross examination , Dr Jeremiah conceded that she may not have given that instruction. It is common ground, however, that Mrs Owen was not to be admitted if she were pain free.

Mrs Owen was released from the hospital at 00:25 having been after being monitored for approximately 40 minutes and reporting that she was pain free. A taxi took her home. She travelled home alone. It appears that after arriving home some 5 minutes later, Mrs Owen entered her bedroom. She was observed shortly before by her partner Mr Murtagh to be breathing heavily. Mr Murtagh approximately 5 minutes later attended the bedroom and Mrs Owen was found to be deceased.

Senior Forensic Pathologist Dr Dodd at the Victorian Institue conducted an autopsy on the deceased on 25 January 2008 for Forensic Medicine. Dr Dodd observed the cause of death to be cardiomegaly and biventricular dilatation. Incidental findings in the course of the autopsy were;

1. Chronic obstructive airways disease
2. Meckel's diverticulum
3. Evolving cirrhosis
4. Myelolipoma of left adrenal gland

Of significance, Dr Dodd also noted that the toxicological analysis of body fluids was noncontributory to the death in this case. This opinion was not challenged in the course of the Inquest.

*COMMENTS:

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death (including any notification to the Director of Public Prosecutions under Section 69(2) of that Act):

1.

2.

3.

*RECOMMENDATIONS:

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

1.

2.

3.

Signature:

Date: 8 April 2011