IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 005460

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Jacqui Hawkins
Deceased:	Gela Anne Vigor-Newitt
Date of birth:	13 March 1948
Date of death:	4 October 2020
Cause of death:	1(a) Pneumonia 1(b) Chronic obstructive airway disease
Place of death:	St Vincent's Hospital, 41 Victoria Parade, Fitzroy, Victoria, 3065

INTRODUCTION

1. On 4 October 2020, Gela Anne Vigor-Newitt was 72 years old when she passed away in hospital. At the time of her death, Ms Vigor-Newitt was serving a term of imprisonment at the Dame Phyllis Frost Centre. She was planned for release on 15 October 2020.

THE CORONIAL INVESTIGATION

2. Ms Vigor-Newitt's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury. The death of a person in care or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes.

3. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

4. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

5. This finding draws on the totality of the coronial investigation into the death of Ms Vigor-Newitt. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

6. Ms Vigor-Newitt entered custody at the Dame Phyllis Frost Centre (**DPFC**) on 16 December 2019. Her medical history included congestive cardiac failure, poly

[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

rheumatica, obesity, pulmonary emboli, deep vein thrombosis and a major depressive disorder. Ms Vigor-Newitt experienced chronic pain and mobility issues, and required multiple medications and ongoing assessments and reviews. She underwent several medical and allied health assessments to determine her care plans.

7. Ms Vigor-Newitt was hospitalised from 20 to 28 July 2020. She had increasing shortness of breath and chest pain. Whilst in hospital she was diagnosed with hiatus hernia and haematuria.

8. Ms Vigor-Newitt was transported to hospital again on 19 August 2020 after a fall preceded by chest pain. She returned to DPFC later that day after her chest pain resolved and tests confirmed she had not sustained any injury from the fall. Ms Vigor-Newitt was placed in 'protective quarantine' for 14 days per Corrections Victoria Covid-19 protocol. Due to her ongoing care needs, she undertook quarantine in her usual cell accommodation.

9. On 27 September 2020, during a review with a registered psychiatric nurse (**RPN**), the RPN became concerned about Ms Vigor-Newitt's physical presentation and breathing difficulties. Ms Vigor-Newitt told the RPN she had been advised to go to hospital two days prior, but refused because she would have to quarantine for a further 14 days on return. The RPN referred Ms Vigor-Newitt to the health centre. She was reviewed by a registered nurse (**RN**) and her vital signs were normal, except for an elevated pulse rate (115bpm). She appeared pale and was having difficulty breathing. Ms Vigor-Newitt was advised she should be transferred to hospital for further investigations, but refused. She agreed to stay in the medical centre for monitoring that day. By the afternoon, her vital signs were in normal range and she had no visible breathing distress.

10. On 28 September 2020, Ms Vigor-Newitt was seen by health staff in the morning and the evening for her medications and no health issues or concerns were noted.

11. On 29 September 2020, Ms Vigor-Newitt's personal care attendant noticed she was short of breath and she was taken to the health centre. On assessment, her vital signs were within normal limits, but it was noted she had used her inhaler medications (salbutamol nebuliser) four times that morning. She was coughing and short of breath. She was subsequently reviewed by a medical officer who recommended transfer to hospital for further assessment of her exacerbation of shortness of breath.

12. Ms Vigor-Newitt was admitted to St Vincent's Hospital. She returned a negative Covid-19 swab and was treated for community acquired pneumonia and subsequent exacerbation of her congestive cardiac failure and chronic respiratory disease.

13. At about 6.20am on 30 September 2020, Ms Vigor-Newitt was found unresponsive by nursing staff. She was in cardiac arrest. After significant resuscitation efforts, Ms Vigor-Newitt was resuscitated, intubated and placed in the Intensive Care Unit (**ICU**) for ongoing care.

14. On 4 October 2020, Ms Vigor-Newitt was extubated, which she did not tolerate well. Her condition deteriorated and her treatment was reorientated towards comfort measures. She passed away at 1.33pm, surrounded by family.

Identity of the deceased

15. On 4 October 2020, Gela Anne Vigor-Newitt, born 13 March 1948, was visually identified by her son, Robert Neil Vigor.

16. Identity is not in dispute and requires no further investigation.

Medical cause of death

17. Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 5 October 2020 and provided a written report of his findings dated 15 October 2020.

18. Dr Bedford noted that Ms Vigor-Newitt had a well-recognised history of chronic obstructive airway disease and a diagnosis of community acquired pneumonia, from which she passed away. On the information available to him, Dr Bedford was of the opinion that Ms Vigor-Newitt's death was due to natural causes.

19. Dr Bedford provided an opinion that the medical cause of death was 1 (a) *Pneumonia* 1 (b) *Chronic obstructive airway disease.*

FINDINGS AND CONCLUSION

20. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Gela Anne Vigor-Newitt, born 13 March 1948;

b) the death occurred on 4 October 2020 at St Vincents Hospital, 41 Victoria Parade, Fitzroy, Victoria, 3065, from pneumonia as a consequence of chronic obstructive airway disease; and

c) the death occurred in the circumstances described above.

21. Having considered all of the evidence, I am satisfied that Ms Vigor-Newitt was provided with appropriate medical care and management whilst incarcerated.

I convey my sincere condolences to Ms Vigor-Newitt's family for their loss.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Robert Vigor, Senior Next of Kin

Justice Assurance and Review Office

Signature:

JACQUI HAWKINS

CORONER

Date: 20 July 2021

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.