IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 005028

FINDING INTO DEATH WITH INQUEST

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

Inquest into the death of WENDY ELIZABETH PENNYCUICK

Delivered on:	24 June 2016
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street Southbank Victoria 3006
Hearing dates:	24 June 2016
Findings of:	Coroner Paresa Antoniadis SPANOS
Assisting the Coroner:	Sergeant Karen Connell, Police Coronial Support Unit.

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of WENDY ELIZABETH PENNYCUICK

and having held an inquest in relation to this death on 24 June 2016

in the Coroners Court of Victoria at Melbourne

find that the identity of the deceased was WENDY ELIZABETH PENNYCUICK

born on 15 June 1950

and that the death occurred on 3 October 2015

at Austin Hospital, Studley Road, Heidelberg, Victoria 3084

from:

I (a) ASPIRATION PNEUMONIA FOLLOWING EMERGENCY LAPAROTOMY FOR INCARCERATED UMBILICAL HERNIA

in the following circumstances:

1. Ms Pennycuick was a 65-year-old woman who had a medical history that included congenital blindness and mild to moderate intellectual disability. She was cared for at home by her parents until adolescence when she became difficult for them to manage. Thereafter, given the high level of care she required, Ms Pennycuick lived in group homes operated under the auspices of the Department of Health and Human Services [DHHS], initially at Kew Cottages and, after 2008, at a residence in Collins Street [Collins Street] in Kew.
2. Ms Pennycuick's family, particularly her parents, remained dedicated to her throughout their lives. Though her parents ultimately separated, each continued to visit their daughter and facilitate her visits to their homes. Ms Pennycuick's step-father visited her regularly after his wife's death in 1990 and her father visited her regularly until his death in 2011. She also participated in the Able Retirees Program five days each week.
3. Ms Pennycuick's medical needs were coordinated by her general practitioner, Dr Stephen Bennie of the East Kew Clinic. Her physical health had been relatively stable until about 2012 when a marked deterioration of health and mobility was noted. Ms Pennycuick was diagnosed with diabetes (2012) and epilepsy (2013), high cholesterol and osteoarthritis (2014), each of which was well-managed with medication. In addition, a range of care plans were developed incorporating specialist endocrinology, occupational therapy, physiotherapy, speech pathology and district nursing interventions, all administered at Collins Street where possible to minimize Ms Pennycuick's generalised anxiety disorder and particular anxiety about medical interventions.
4. In April 2015, an Aged Care Assessment was conducted at St Vincent's Hospital. Ms Pennycuick was assessed as requiring high level residential respite and permanent residential care. A subsequent assessment by the Aged Care Psychiatry Unit recommended that she be placed in a psycho-geriatric nursing home rather than one providing general nursing care.

5. In May 2015, Ms Pennycuick was diagnosed with a peri-umbilical hernia which appeared not to trouble her greatly. Nonetheless, she was referred to St Vincent's Hospital for outpatient assessment whereupon conservative management was recommended until the hernia became painful or could not be reduced. Dr Bennie considered this management plan appropriate given Ms Pennycuick's severe anxiety about a hospital admission and reluctance to co-operate with other treatment options.

6. On 30 September 2015, Ms Pennycuick was admitted to the Austin Hospital [the Austin] with high blood sugar levels, fever and vomiting. On examination, she was diagnosed with a strangulated umbilical hernia and underwent emergency surgery for small bowel resection and hernia repair that evening. The surgery was uncomplicated.

7. However, in recovery Ms Pennycuick vomited and was thought to have aspirated. She experienced decreased oxygen saturation and then faecal fluid passing through her naso-gastric tube. She was nursed in the Recovery High Dependency Unit overnight and her brother, Chris Pennycuick, informed of her clinical condition. Given Ms Pennycuick's deteriorating condition and prognosis, the decision was made that she was "not for resuscitation or intubation", but in accordance with her brother's wishes at that time, was to receive full ward management.

8. On the morning of 1 October 2015, Ms Pennycuick was transferred to the surgical ward and was noted to be very agitated. She was restrained to prevent her from interfering with her intravenous line and the high-flow nasal prongs delivering supplementary oxygen. She was reviewed several times by the Intensive Care team due to low oxygen saturations, agitation and poorly managed pain. She was not considered a good candidate for management by the Intensive Care or High Dependency Units.

9. The same day, Dr Adele Burgess, Head of the Austin's Colorectal Surgical Unit reviewed Ms Pennycuick in light of ongoing concerns about her agitation. Dr Burgess discussed Ms Pennycuick's condition with her brother who decided that no extreme measures should be undertaken given his sister's co-morbidities and deteriorating quality of life, but that comfort measures and antibiotics should be continued.

10. Ms Pennycuick was reviewed by endocrinology and acute pain specialists in the surgical ward. She continued to experience agitation and pain and continued her attempts to remove medical equipment. Ms Pennycuick's increased requirements for analgesia to address pain and agitation resulted in decreased oxygen saturations.

11. Ms Pennycuick's condition continued to deteriorate and she was assessed by palliative care specialists. In consultation with Chris Pennycuick, intravenous fluids and antibiotics were

discontinued early on the morning of 3 October 2015 when the focus of her care was confirmed as palliative. Ms Pennycuick died at 8.25am on 3 October 2015.

12. Apart from a jurisdictional nexus with the State of Victoria, reportable deaths are, generally, deaths that appeared to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury.[1] However, some deaths are reportable irrespective of the nature of the death, based on the status of the person immediately before death. Ms Pennycuick's death was reportable as she was a *person placed in custody or care*[2] of the Secretary to the DHHS. This is one of the ways in which the *Coroners Act* 2008 recognises that people in the control, care or custody of the State are vulnerable, and affords them the protection of the independent scrutiny and accountability of a coronial investigation.

13. Another protection is the requirement for mandatory inquests. While there is a discretionary power to hold an inquest in relation to any death a coroner is investigating,[3] this was a mandatory or statutorily prescribed inquest as Ms Pennycuick's was, immediately before death, a person placed in custody or care.[4]

14. This finding draws on the totality of the material the product of the coronial investigation of Ms Pennycuick's death, contained in the inquest brief compiled by First Constable Joseph McKeown of the Heidelberg Police Station. All this material, together with the inquest transcript, will remain on the coronial file. In writing this finding, I do not purport to summarise all evidence, but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity.

15. Ms Pennycuick's identity, and the date and place of her death were never at issue. I find, as a matter of formality, that Wendy Elizabeth Pennycuick, born on 15 June 1950, aged 65, late of 5 Collins Street, Kew, died at the Austin Hospital, Studley Road, Heidelberg, on 3 October 2015.

16. Nor was the medical cause of death contentious. No autopsy was performed but forensic pathologist Dr Yeliena Baber of the Victorian Institute of Forensic Medicine VIFM conducted an external examination of Ms Pennycuick's body, reviewed the police report of death, medical records and post-mortem computer-assisted tomography scans [PMCT], and provided a written report of her findings.

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[1] See section 4 of the Coroners Act 2008 [the Act] for the definition of "reportable death".

[2] See section 3 of the Act for the definition of a "person placed in custody or care".

[3] Section 52(1) of the Act provides that a coroner may hold an inquest into any death that the coroner is investigating.

[4] See section 52(2) and the definition of "person placed in custody or care" in section 3 of the Act. I note that since the insertion of subsection (3A) into section 52 of the Act in November 2014, coroners are no longer required to hold an inquest into the death of a person in custody or care immediately prior to death if the death was due to natural causes. Section 52(3B) outlines the circumstances in which a coroner may consider a death to be due to natural causes.

17. Dr Baber noted a fatty liver and bilateral increased lung markings on PMCT and observed that her external examination findings were consistent with Ms Pennycuick's clinical course.
18. Dr Baber advised that it would be reasonable to attribute Ms Pennycuick's death to *aspiration pneumonia following emergency laparotomy for incarcerated umbilical hernia* without the need for an autopsy.
19. In light of Dr Baber's advice, <u>I find that Ms Pennycuick died as a result of aspiration pneumonia following emergency laparotomy for incarcerated umbilical hernia.</u>
20. Based on the available evidence, I am satisfied that the health care provided to Ms Pennycuick by the medical and nursing staff at the Austin Hospital in the period preceding her death was appropriate and consistent with the care provided by the Victorian public health care system. Furthermore, the evidence does not support a finding that there was any want of clinical management or care on the part of Ms Penycuick's general practitioner or her DHHS carers at Collins Street, that caused or contributed to her death.

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

Mr Chris Pennycuick

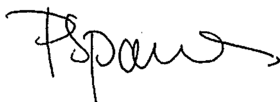
Pauline Chapman, Austin Health

Ms Katrina Hallal, House Manager, Department of Health Human Services, Disability Accommodation Services (East Division)

Dr Stephen Bennie, East Kew Clinic

First Constable Joseph McKeown, Heidelberg Police Station

Signature:



PARESA ANTONIADIS SPANOS
Coroner
Date: 24 June 2016