IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 006182

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paul Lawrie
Deceased:	Pennelope Shandelle Wilding
Date of birth:	6 April 1974
Date of death:	26 October 2022
Cause of death:	1(a) Aspiration pneumonia in the setting of percutaneous endoscopic gastrotomy (PEG) feeding in a woman with cerebral palsy and dysphagia
Place of death:	Frankston Hospital, 2 Hastings Road, Frankston, Victoria, 3199
Keywords:	In care, disability, aspiration pneumonia, cerebral palsy, dysphagia, natural causes

INTRODUCTION

1. On 26 October 2022, Pennelope Wilding was 48 years old when she died at Frankston Hospital. From two years of age Ms Wilding resided at Crofton House, specialist disability accommodation in Frankston, Victoria.

2. At the age of four months, Ms Wilding suffered an allergic reaction to her second triple antigen vaccination. This resulted in her becoming epileptic and quadriplegic and throughout her life she suffered cerebral palsy, epilepsy, asthma, and depression. She was wheelchair bound and completely dependent on her carers at Crofton House for all her daily activities.

3. In 2020, due to ongoing difficulties with swallowing, Ms Wilding was fitted with a percutaneous endoscopic gastrotomy (**PEG**) tube to aid in the administration of medications and fluids. In July 2022, she was admitted to hospital for pneumonia secondary to a COVID-19 infection, and again in September 2022 for pneumonia.

THE CORONIAL INVESTIGATION

4. Ms Wilding'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 be due to natural causes.

5. Since 2019, funding for disability services in Victoria has shifted from the Department of Families, Fairness and Housing to the National Disability Insurance Scheme. This change meant that the definition of a 'person placed in custody or care' in section 3(1) of the Act, which included 'a person under the control, care or custody of the Secretary to the Department of Human Services or the Secretary to the Department of Health', was no longer sufficient to capture the group of vulnerable persons in receipt of disability services.

6. The *Coroner's Regulations 2019* were amended on 11 October 2022 to create a new category of persons considered to be 'in care' pursuant to regulation 7, namely a 'person in Victoria who is in an SDA[1] resident residing in an SDA enrolled dwelling'. Accordingly, Ms Wilding was a person 'in care' for the purposes of the Act at the time of her death.

[1] Specialist Disability Accommodation

7. 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.

8. 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.

9. Victoria Police assigned Senior Constable Andrew Barnes to be the Coroner's Investigator for the investigation of Ms Wilding's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as Ms Wilding's mother and general practitioner, the forensic pathologist, and investigating officers – and submitted a coronial brief of evidence.

10. This finding draws on the totality of the coronial investigation into the death of Ms Wilding including evidence contained in the coronial brief. 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.[2]

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

Circumstances in which the death occurred

11. On 13 October 2022, Ms Wilding was admitted to Frankston Hospital with abnormal breathing and low oxygen levels, believed to be the result of aspiration pneumonia. She suffered several complications which included difficulty breathing, vomiting episodes and multiple medical emergency team (**MET**) calls for tachypnoea (rapid breathing).

12. Ms Wilding's PEG site developed a purulent discharge, and her abdomen became distended. She was initially treated with oral antibiotics, later upgraded to intravenous antibiotics.

[2] 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.

13. Ms Wilding's condition continued to deteriorate, and she did not respond to intravenous antibiotics. After a conversation between clinicians and Ms Wilding's family, a decision was made to palliate Ms Wilding. She received palliative care and passed away on 26 October 2022.

Identity of the deceased

14. On 28 October 2022, Ms Wilding, born 6 April 1974, was visually identified by her friend, Antoinette Bevear.

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

Medical cause of death

16. Forensic Pathologist, Dr Joanne Ho, from the Victorian Institute of Forensic Medicine, conducted an external examination on 31 October 2022 and provided a written report of her findings dated 9 November 2022.

17. The post-mortem examination showed a PEG tube within the left abdomen with mild overlying purulent discharge. The post-mortem CT scan showed dilated lateral ventricles, thoraco-lumbosacral fixation, and a right foot deformity. Dr Ho also noted whiteout of the right lung, a full bladder, and subcutaneous emphysema along the left thigh.

18. Toxicological analysis was not indicated and therefore was not performed.

19. Dr Ho provided an opinion that the death was due to natural causes and the medical cause of death was '1 (a) Aspiration pneumonia in the setting of percutaneous endoscopic gastrotomy (PEG) feeding in a woman with cerebral palsy and dysphagia'.

20. I accept Dr Ho's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Pennelope Shandelle Wilding, born 6 April 1974;

    b) the death occurred on 26 October 2022 at Peninsula Health, 2 Hastings Road, Frankston, Victoria, from '1(a) aspiration pneumonia in the setting of percutaneous endoscopic gastrotomy (PEG) feeding in a woman with cerebral palsy and dysphagia'; and

c) the death occurred in the circumstances described above.

22. I am satisfied Ms Wilding's death was due to natural causes.

23. I am also satisfied that the care and medical treatment provided to Ms Wilding was appropriate.

I convey my sincere condolences to Ms Wilding's family and her carers for their loss.

Pursuant to section 73(1B) of the A

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

Michael and Sue De Carteret Wilding, Senior Next of Kin

Senior Constable Andrew Barnes, Coroner's Investigator

Signature:

Coroner Paul Lawrie

Date : 11 December 2023

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.