



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2025 002163

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Deceased:	David Evan Wild
Date of birth:	31 January 1964
Date of death:	20 April 2025
Cause of death:	1(a) Natural causes unascertained
Place of death:	15 Landrace Way, Clyde North, Victoria
Key words:	In care, dementia, unascertained cause of death, natural causes

INTRODUCTION

1. On 20 April 2025, David Evan Wild was 61 years old when he was found deceased at home. At the time, Mr Wild resided in specialist disability accommodation in Clyde North.
2. Mr Wild had worked as a storeman for Kmart in Brandon Park for about 40 years.
3. He welcomed two children in 1986 and 1989 respectively during his first marriage, which ended in 1990. In 2012, Mr Wild remarried to Vanessa Schilling, who had two children from a previous marriage. They later moved to Sandhurst.
4. According to Ms Schilling, Mr Wild did not have any significant medical issues when they commenced their relationship.

THE CORONIAL INVESTIGATION

5. Mr Wild's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008 (the Act)*. Generally, reportable deaths include deaths that are unexpected, unnatural or violent, or result from accident or injury. However, if a person satisfies the definition of a person placed in care immediately before death, the death is reportable even if it appears to have been from natural causes.¹
6. 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.
7. 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.
8. Mr Wild passed away on morning of 20 April 2025. However, his death was not reported to the coroner until 22 April 2025, by which time his body had been transferred to a funeral home and embalmed. Given he was 'in care' at the time of his death, his death was reportable.

¹ See the definition of "reportable death" in section 4 of the *Coroners Act 2008 (the Act)*, especially section 4(2)(c) and the definition of "person placed in custody or care" in section 3 of the Act.

9. The Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Mr Wild's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.
10. This finding draws on the totality of the coronial investigation into Mr Wild's death, 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

Identity of the deceased

11. On 24 April 2025, David Evan Wild, born 31 January 1964, was visually identified by his wife, Vanessa Wild, who signed a formal Statement of Identification to this effect.
12. Identity is not in dispute and requires no further investigation.

Medical cause of death

13. Forensic Pathologist, Dr Brian Beer, from the Victorian Institute of Forensic Medicine (VIFM), conducted an inspection on 29 April 2025 and provided a written report of his findings dated 16 May 2025.
14. The post-mortem examination was consistent with the reported circumstances.
15. Routine toxicological analysis of post/ante-mortem samples detected fluoxetine³ and its metabolite, and mirtazapine.⁴
16. Dr Beer provided an opinion that the medical cause of death was “*1(a) Natural causes unascertained*”.
17. I accept Dr Beer's opinion.

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.

³ Fluoxetine is indicated for major depression, obsessive compulsive disorder, and premenstrual dysphoric disorder.

⁴ Mirtazapine is indicated for the treatment of depression.

Circumstances in which the death occurred

18. In about 2019, Mr Wild's employer and his family observed symptoms of cognitive decline. This eventually led to a diagnosis of frontal temporal dementia in early 2020, when Mr Wild was aged 56 years.
19. Following his diagnosis, Mr Wild initially remained residing at home with Ms Schilling and her children. After several months, it became evident that Mr Wild required additional care that he could not receive at home. Mr Wild was subsequently admitted to Casey Hospital before being transferred to Kingston Hospital, where he stayed for about six months.
20. In about late 2020, Mr Wild moved to supported accommodation at 15 Landrace Way, Clyde North, where he resided with two other men. OnCall Group Australia (**OnCall**) provided disability services to Mr Wild, which included 24/7 support. Over the following years, Mr Wild's condition continued to decline; his mobility became increasingly limited and he also became incontinent, which led to frequent urinary tract infections. He eventually required a wheelchair when mobilising, hoists for transfers, and began having swallowing and choking issues due to dysphagia.
21. According to Dale Medcraft, Accommodations Services Manager at OnCall, Mr Wild had frequent hospital presentations for issues such as urinary tract infections, pneumonia, and falls-related injuries. He also received frequent medical support from his general practitioner, geriatrician, speech therapist, physical therapist, and occupational therapist.
22. In early 2024, Mr Wild admitted to hospital for a gallbladder infection. A mass was subsequently found below his gallbladder, but this was unable to be investigated further due to Mr Wild's poor health overall. His prognosis was guarded he was in hospital for over a week before his infection was adequately controlled.
23. Mr Wild's last hospital presentation was in April 2025 for aspiration pneumonia. Following a short admission, he was discharged on 14 April 2025 with antibiotics.
24. On 19 April 2025, staff members from OnCall provided assistance to Mr Wild as usual with no issues noted during the day. That evening, he was transferred to bed as usual and overnight staff member retired to bed at about 11.30pm.
25. At about 7.55am the following morning, 20 April 2025, an OnCall staff member attended Mr Wild's room to wake him. When she called out to Mr Wild, there was no response and she

realised that he was not breathing although he was still warm to her touch. Emergency services were contacted and staff administered cardiopulmonary resuscitation until paramedics arrived.

26. Ambulance Victoria paramedics arrived a short time later. Despite their efforts, Mr Wild was verified deceased at 8.20am.

FINDINGS AND CONCLUSION

27. Pursuant to section 67(1) of the Act I make the following findings:
- (a) the identity of the deceased was David Evan Wild, born 31 January 1964;
 - (b) the death occurred on 20 April 2025 at 15 Landrace Way, Clyde North, Victoria;
 - (c) the cause of Mr Wild's death was natural causes unascertained; and
 - (d) immediately before death, Mr Wild was a "*person placed in custody or care*" as defined in section 4 of the Act; and
 - (e) the death occurred in the circumstances described above.
28. Although the specific cause of Mr Wild's death remains unascertained, I accept Dr Beer's opinion that Mr Wild died from natural causes for the purposes of section 52(3A) of the Act.
29. There is nothing in the available material to suggest that there was any want of clinical management or care on the part of the staff of OnCall or others involved with Mr Wild that caused or contributed to his death.
30. I convey my sincere condolences to Mr Wild's family and friends for their loss.

PUBLICATION OF FINDING

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.

DISTRIBUTION OF FINDING

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

Vaness Wild, senior next of kin

OnCall Group Australia

Senior Constable Biley Webb, Victoria Police, Coronial Investigator

Signature:





Deputy State Coroner Paresa Antoniadis Spanos

Date: 13 April 2026

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.
