IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 003577

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge John Cain, State Coroner
Deceased:	Leonardo Antonio Biancofiore
Date of birth:	16 November 1957
Date of death:	10 July 2019
Cause of death:	1(a) NECK INJURIES IN THE SETTING OF A DOG ATTACK
Place of death:	10 Ancona Drive, Mill Park, Victoria, 3082

BACKGROUND

1. Leonardo Antonio Biancofiore (**Leo**) was 61 years old at the time of his death on 10 July 2019. Leo was born on 16 November 1957 in Italy and immigrated to Australia when he was six years old and married his wife, Donata in 1983. They had one son together, named Mark.

2. At the age of 27, Leo was diagnosed with a medical condition called Syringomyelia which is a neurological condition of the spine. The condition is painful, and Leo took prescription medication to relieve the pain. He walked with the assistance of forearm crutches and had four-wheel walking trolley to assist him around the home. Leo also used a motorised scooter for getting around the local neighborhood.

3. Due to his medical condition, Leo had been forced to retire from fulltime work at the age of 40. Until that time, Leo worked as a Boilermaker and ran a trash and treasure business with a friend at Whittlesea and Thomastown Markets.

4. On 10 July 2019, Leo was attacked by his American Staffordshire Terrier named 'Junior' at his home at 10 Ancona Drive, Mill Park. Leo suffered significant injuries as a result of the attack. Donata also suffered serious but non-life-threatening injuries as she tried to assist Leo.

THE CORONIAL INVESTIGATION

5. Leo'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.

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. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Leonardo's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, and investigating officers – and submitted a coronial brief of evidence on 16 October 2019.

9. This finding draws on the totality of the coronial investigation into the death of Leonardo Antonio Biancofiore 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.[1]

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

Identity of the deceased, pursuant to section 67(1)(a) of the Act

10. On 11 July 2019, Leonardo Antonio Biancofiore, born 16 November 1957, was visually identified by his brother, Dominic Biancofiore.

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

Medical cause of death, pursuant to section 67(1)(b) of the Act

12. Specialist Forensic Pathologist, Dr Victoria Francis from the Victorian Institute of Forensic Medicine, conducted an autopsy on the 11 July 2019 and provided a written report of her findings dated 16 January 2020

13. The post-mortem examination revealed significant injuries with associated tissue loss to the lower face and neck, which included complete transection of the carotid artery and some of the left jugular vein was missing. There were also multiple injuries to the chest and both upper arms. The findings are consistent with injuries being inflicted in a dog attack.

14. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or any commons drugs or poisons.

15. Dr Francis provided an opinion that the medical cause of death was:

    1 (a) NECK INJURIES IN THE SETTING OF A DOG ATTACK.

[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.

16. I accept Dr Francis's opinion as to the cause of death.

Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act

17. In or around May 2011, Leo and Donata's son, Mark and his wife Danielle purchased an American Staffordshire Terrier which they named Junior.[2] At the time they purchased Junior, Mark and Danielle already owned a 3-year-old English Staffordshire named Angel.

18. In November 2011, six months after purchasing Junior, Mark and Danielle moved in with Leo and Donata into their house in Mill Park. Mark and Danielle separated in July 2012, and Danielle moved out of the Mill Park residence taking Angel with her.[3]

19. In 2013, Mark and Danielle reconciled and built a house together in 2016.[4] When they moved into the new house, they took both dogs with them. However, the two dogs were incompatible and could not co-exist in the same house. It was decided that Junior would stay with Leo and Donata.[5] Junior had been living with Leo and Donata for approximately eight years prior to the attack and was considered by Donata to be their dog.

20. Junior was described by Donata as very affectionate dog and always wanting to be close to her and Leo. However, Danielle described Junior as being '*very dog aggressive*' and he was not able to attend obedience school because of his behavioural issues.[6] Junior was prescribed medication to '*calm him down'*[7], but the medication was not continued. Mark stated that Junior was always '*very cuddly'* and described him as a placid dog.[8] However, Mark acknowledged that Junior was aggressive towards other dogs including Angel.

21. In the days before the attack, Junior had urinated inside the house which was unusual. Donata had spoken to Mark about this, and he had planned to take Junior to the Vet for a checkup.[9] Donata also reported that on 8 July 2019 (two days before the attack), Junior became quite agitated in response to the noise of bricks falling in the backyard.[10]

22. On the 10 July 2019, Donata was in the study and responded to Leo calling for help because he had fallen down and required assistance. Donata found Leo lying face down on the floor,

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[2] Coronial brief (**CB**), pg 20.
[3] CB. pg 21.
[4] CB, pg 22.
[5] Ibid.
[6] CB, pg 29.
[7] CB, pg 29.
[8] As above, at 2.
[9] CB, pg 15.
[10] Ibid.

near the kitchen island bench. Donata stated that Junior was '*pulling the back of Leo's hair*'.[11] Donata tried to move Junior outside, however, Junior continued to bite at the back of Leo's neck and '*the bites were getting more and more aggressive*'.[12]

23. Donata subsequently decided to move Leo outside and keep Junior inside. She was unable to contain Junior in the house and the attacks became more severe with Junior biting Leo's face and neck. Donata moved a chair over Leo to offer some protection and used one of his crutches to keep Junior away. These attempts to keep Junior away from Leo were unsuccessful.[13]

24. While Donata was attempting to protect Leo, Junior attacked Donata, biting her face, arms and head. Donata reported that she started screaming which alerted the neighbours who tried to distract Junior to allow Leo and Donata to escape.

25. The neighbours who heard Donata's screams, called emergency services, and a number of calls were logged with Emergency Services Telecommunications Authority (**ESTA**). The incident required the dispatch of Ambulance Victoria and Police resources which coincided with a severe weather event affecting parts of Victoria. Due to the demands placed upon the emergency call service by the severe weather warning, there were some delays in ESTA answering the emergency calls that were made to report the dog attack.

26. Between 6:20pm and 6:30pm, Police received a priority one job for a dog attack at Ancona Drive, Mill Park.[14] When the Police officers arrived on scene, they used OC spray and discharged their firearms in an attempt to stop the attack. All four Police officers who responded to the call were involved in the response, and eventually Junior was contained inside the house. Once the scene was made safe, Ambulance Victoria officers attended to Leo and Donata.

27. Donata was subsequently taken to the hospital for treatment.[15] Leo was declared deceased at the scene.

28. A Council Ranger attended the scene and Junior was removed and taken to a local veterinary clinic where he was euthanized.

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[11] CB, pg 15.
[12] CB, pg 16.
[13] Ibid.
[14] CB, g 71.
[15] See statement of First Constable Thomas Shakespeare (CB, pgs 59 – 62)

29. A postmortem was conducted by Veterinary Pathologist, Andrew Stent to ascertain whether there were any underlying factors that may have contributed to the attack. No lesions were identified to explain sudden aggression and the brain was described as grossly and histologically unremarkable. The autopsy did not provide any explanation or any insight into why the attack occurred.[16]

FURTHER INVESTIGATIONS

Investigation by Inspector General for Emergency Management

30. The Inspector General for Emergency Management (**IGEM**) was established on 1 July 2014 by the *Emergency Management Act 2013 (Vic)* as an independent statutory authority to:

    - provide assurance to the government and the community in respect of emergency management arrangements in Victoria; and
    - foster continuous improvement in emergency management in Victoria.[17]

31. IGEM undertakes independent reviews, evaluations and assessments of Victoria's emergency management arrangements, as well as the sector's performance and capabilities.

32. On 26 November 2019, Mr Tony Pearce, Inspector General wrote to the then Acting State Coroner Caitlin English advising that he had been requested by the Minister for Police and Emergency Services (**the Minister**) to investigate this incident.

33. The IGEM investigation was undertaken with the approval of the Minister pursuant to section 64(1)(c) of the *Emergency Management Act 2013 (Vic)*. This was also supported by the then-Minister for Health and Minister for Ambulance Services. The IGEM report was delivered to the Minister for Police and Emergency Services in April 2021. The IGEM report was embargoed and marked confidential, not for distribution or public release.

34. The Coroners Court was provided with a confidential copy of the IGEM report and on 20 December 2021, IGEM advised that the Inspector-General supported the use of the IGEM report and material in these Findings.

[16] CB, pgs 112 – 115.
[17] IGEM report, dated April 2021, pg 9.

35. The IGEM investigation focused on ESTA's management of the emergency call taking and dispatch procedures, as well as Ambulance Victoria's referral service triage process, in relation to the multiple triple zero (000) calls that were received in relation to the incident.

36. During the course of its investigation, IGEM identified several performance issues in the management of emergency communications for this incident and opportunities for improvement. The identified performance issues were:

- emergency call answer delays;
- incorrect ambulance event type selection;
- poor information transfer and understanding between ambulance and police communications;
- no clinical referral to AV communications/clinical officers at the ESTA centre;
- missed opportunity to upgrade ambulance event type and priority;
- lack of procedural clarity about ringing back callers to obtain information;
- ESTA telephone advice and requests of emergency callers; and
- delay in dispatch of ambulance.

37. The IGEM did not find a single cause of the identified performance issues. Instead, it identified a sequence of interconnected causal factors, which contributed to the overall issues with management of emergency call-taking and dispatch.[18] The root causes of these performance issues were identified as, but not limited to:

- the misalignment of Ambulance Victoria and ESTA operating procedures and lack of tracking; and

- lack of tracking of call-taking and dispatch performance trends for individuals, cohorts and centres and therefore targeted remediation activities.[19]

38. The IGEM report also makes a number of observations which are not identified as directly affecting ESTA's management of emergency call-taking and dispatch in this case, but there is potential for this to occur in the future. It also recognises that the Ambulance Victoria referral system is intended to reduce the demand on emergency ambulance resources. However, it is paramount that Ambulance Victoria manages its communications system and the risks associated with incorrect classifications

[18] IGEM report, dated April 2021, pg 12.
[19] IGEM report, dated April 2021, pg 10.

39. The IGEM made four (4) recommendations[20]:

Recommendation 1

The Inspector-General for Emergency Management recommends that the Emergency Services Telecommunications Authority work with Ambulance Victoria (AV) to ensure call-takers are confident and supported when notifying Clinicians if they have any concerns regarding the appropriateness of an event type's priority. This may include the development of a targeted training package that highlights the purpose of the AV Clinician as a safety net, the need to activate the Clinician function in Computer-aided Dispatch, and real-world examples of its appropriate use.

Recommendation 2

The Inspector-General for Emergency Management recommends that the Emergency Services Telecommunications Authority (ESTA) updates its call-taker and dispatch training manuals to address in more detail scene safety management (including for call-backs).

This should include guidance on what call-takers or dispatchers may reasonably instruct callers to do. For example, if emergency services personnel are already on scene at an emergency, then callers should be instructed to follow the directions of such personnel. If a caller is reticent or scared or refusing to follow the instructions of a call-taker then they should cease further encouragement of the caller to do something about which they are not comfortable, regardless of whether the instruction may place them in any danger.

In updating the manual in this way, ESTA should reinforce the importance of call takers and dispatchers not doing further harm nor putting at further risk any person on scene. Further harm or risk cannot be justified by the need to fulfil a call-taking or dispatch workflow, including obtaining further information about an emergency.

Recommendation 3

The Inspector-General for Emergency Management recommends that Ambulance Victoria review its Communications Standard Operating Procedures (CSOPs) for emergency dispatch to fully align with its current call-taking and dispatch expectations. This should at a minimum address issues identified in this investigation including:

[20] IGEM report, dated April 2021, pgs 14 – 19.

- *make a clear requirement for ESTA dispatchers to – at a minimum – read all Computer-aided Dispatch (CAD) Event Remarks on events before placing them on hold to ensure that the event details align with the event type and priority assigned at primary triage*

- *the specific requirements for making call-backs after ESTA processes calls from third- and fourth-party callers*

- *develop and document a process to ensure that other agencies are aware that Ambulance Victoria may not be responding to REFCOMM 'J' events regardless of whether ESTA call-takers may or may not transfer the initial caller to a referral service triage practitioner.*

- *requirements around asking callers to do something that they do not wish to do or may place them or others in danger*

- *dispatch expectations for all event priorities and the integrated referral services, to address the conflicting requirements on the emergency ambulance dispatcher to attempt to dispatch all events but then override or ignore this and place Priority 3 events on hold for 30-minutes*

- *to detail how an ESTA dispatcher should bring to the attention of a Duty Manager a field request for additional ambulance resources at an existing CAD event. To assist Ambulance Victoria - in addition to the other emergency services organisations (ESOs) to whom ESTA provides emergency telecommunications services - in this respect, it may be useful for these organisations and ESTA to share and discuss their unique CSOPs and how these integrate with ESTA's Standard Operating Procedures. In this way, all ESOs may receive a benefit from learning how the others draft, consult upon, and operationalise communications policies and procedures, and may share ideas and brainstorm solutions to mitigate risk*

Recommendation 4

The Inspector-General for Emergency Management recommends that Ambulance Victoria and Emergency Services Telecommunications Authority clarify the process that Ambulance Victoria dispatchers must follow so that they consistently read event remarks to identify and action any dispatch related flags or anomalies that may require notification of the Ambulance Victoria Clinician or Duty Manager/Communications Support Paramedic. Also,

that ESTA update its Standard Operating Procedures (SOPs) to implement any changes from Ambulance Victoria Communications Standard Operating Procedures revisions associated with Recommendation 3 and to address the gaps between the workflows described in its training manual and what is not currently a requirement of SOPs including:

- *the requirement for ESTA dispatchers to at least review the event details of any event before a dispatcher places it on hold to ensure that the event type and priority matches the event remarks*
- *the requirement to insert a comment to indicate "Ambulance Victoria still assessing" its response to Priority 3 events*
- *the expectations of call-takers making call-backs to a first- or second-party caller after initially receiving the request for assistance from a third-party caller or fourth-party caller.*

40. Being mindful of section 7 of the Act which makes it clear that I should 'avoid unnecessary duplication of inquiries and investigations' and having reviewed the IGEM report, I am satisfied that no further investigation of the circumstances surrounding the death of Mr Bianofiore is required.

41. The focus of my investigation then turned to what steps had been taken to implement the recommendations in the IGEM report. While IGEM have the responsibility to monitor the implementation of any recommendations it makes, the Court contacted ESTA and Ambulance Victoria to understand the steps taken by each agency to adopt and implement the recommendations.

42. ESTA and Ambulance Victoria were asked to respond to two questions:

- whether ESTA and Ambulance Victoria accept the recommendations in the IGEM report; and
- whether ESTA and Ambulance Victoria have adopted or intend to adopt the recommendations in the IGEM report and if so, provide an update in respect of the progress of implementing these recommendations.

43. ESTA and Ambulance Victoria provided the Court with letters in response.

ESTA

44. In accordance with the *Emergency Services Telecommunications Authority Act 2004 (Vic)*, ESTA provides 24-hour emergency call taking and dispatching services for police, fire, ambulance and the state emergency service. Ambulance Victoria has a different agreement with ESTA than other emergency management agencies, whereby, ESTA employees dispatch events, with Ambulance Victoria has overall ultimate responsibility for the governance of its own dispatch performance.

45. IGEM provided ESTA with a confidential copy of the IGEM report by email on 27 July 2021. ESTA has advised that due to an administrative error, the IGEM report was not read by an appropriate ESTA employee until late November 2021. This, together with the resultant pressure from the COVID-19 pandemic, ESTA has been delayed in considering the IGEM report and the relevant recommendations.[21]

46. ESTA has advised that it accepts recommendations 1, 2 and 4 in the IGEM report.

47. With respect of recommendation 1, ESTA has advised that it has been implemented from ESTA's perspective with the relevant materials being provided to the IGEM.

48. With respect to recommendation 2, ESTA has advised that the implementation of this recommendation will be finalised within the next six months.

49. Further, ESTA has made contact with the Acting Chief Executive of Emergency Management Victoria to advise on its willingness to participate in an inception meeting with the relevant agencies, to discuss the implementation of recommendation 4 (as well as recommendation 3). A date for the inception meeting is yet to be set.

Ambulance Victoria

50. In July 2021, Ambulance Victoria received a confidential copy of the IGEM report. On 16 September 2021, Ambulance Victoria advised IGEM that it accepts and intends to adopt recommendations 1, 3 and 4.[22]

51. Ambulance Victoria has advised that it had intended for the IGEM recommendations to be implemented by 30 June 2022. Due to the current pressures on Ambulance Victoria, as a

[21] Letter from ESTA to Coroners Court of Victoria, dated 28 February 2022.
[22] Letter from Ambulance Victoria to Coroners Court, dated 28 February 2022, pg 1.

result of the COVID-19 pandemic there has been a delay in implementing the recommendations.

52. The letter from Ambulance Victoria sets out in some detail the steps that will be taken to implement and address each of the recommendations made by IGEM.

53. I have summarised the work being done by Ambulance Victoria to implement the recommendations below[23]:

- Recommendation 1 - Ambulance Victoria is working with ESTA's 'Learning and Development Team' to develop training material for their call taking and dispatch staff. The development and implementation of these packages will recommence once service delivery returns to a manageable level.

- Recommendation 3 - In October 2021, ESTA advised that they have commenced a review of training material, to ensure that it is up to date with current practice and procedures, including recent changes to operational processes implemented as part of a COVID-19 response. Once completed, Ambulance Victoria will undertake workshops with ESTA to finalise the documents, including Ambulance Victoria CSOPs. Ambulance Victoria will also include all further changes and clarifications as recommended by IGEM.

- Recommendation 4 – Ambulance Victoria has engaged with ESTA to clarify the process outlined in this recommendation. All additional changes (included those identified in recommendation 3), will be incorporated into a consolidated training package and revised SOPs.

54. I am satisfied that the steps outlined by Ambulance Victoria will adequately address the recommendations and issues identified in the IGEM report, around ESTA emergency call taking and dispatch arrangements, albeit there has been a delay in the implementation of the recommendations. The initial steps taken appear to be appropriate, including cooperation between the ESTA and Ambulance Victoria and ongoing reviews of standard operating procedures and training material.

[23] Letter from Ambulance Victoria to Coroners Court, dated 28 February 2022, pg 2.

FINDINGS AND CONCLUSION

55. Pursuant to section 67(1) of the Act, I make the following findings:

    a) the identity of the deceased was Leonardo Antonio Biancofiore, born 16 November 1957;

    b) the death occurred on 10 July 2019 at 10 Ancona Drive, Mill Park, Victoria, 3082, from NECK INJURIES IN THE SETTING OF A DOG ATTACK; and

    c) the death occurred in the circumstances described above.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

56. IGEM have completed a comprehensive review of the issues arising from the ESTA emergency call and dispatch arrangements on 10 July 2019. I am satisfied that IGEM will take the necessary steps to support Ambulance Victoria and ESTA in adopting and implementing the recommendations in the IGEM report. I support the IGEM recommendations and that they will improve the call and dispatch service provided by ESTA. In supporting these recommendations, I note and agree with the IGEM's observation in their report that '*it is highly unlikely that any issues with the management of this event would have changed the outcome for Leo Biancofiore*'.[24]

57. From the IGEM report, it is clear that there were performance issues with the systems and processes in place for emergency call taking and dispatching.

58. Having regard to the information provided by ESTA and Ambulance Victoria, I am satisfied that they are taking steps to improve the systems and process, as well as support and adequately train their staff.

59. To reduce the likelihood of the issues associated with this incident reoccurring, I support the comments made in the IGEM report, that ESTA and Ambulance Victoria '*maintain their commitment to continuous improvement and the implementation of recommendations'*.[25]

[24] IGEM report, dated April 2021, pg 10.
[25] IGEM report, dated April 2021, pg 13.

I convey my sincere condolences to Leonardo'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:

Donata Biancofiore, Senior Next of Kin

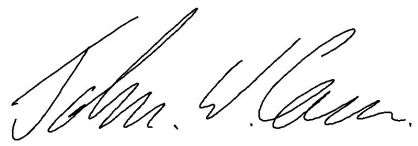
Mark Biancofiore, Son

ESTA

Ambulance Victoria

Senior Constable Sam Robertson, Coroner's Investigator

Signature:



JUDGE JOHN CAIN
STATE CORONER
Date: 27 April 2022

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.