IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 000277

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paresa Antoniadis Spanos
Deceased:	Doriano Valenti
Date of birth:	2 September 1968
Date of death:	14 January 2023
Cause of death:	1(a) Respiratory failure in a man with cerebral palsy and Lennox-Gastaut syndrome
Place of death:	The Alfred Hospital, 55 Commercial Road, Melbourne, Victoria, 3004

INTRODUCTION

1. On 14 January 2023, Doriano Valenti was 54 years old when he died at the Alfred Hospital following a month-long admission. At the time, Mr Valenti lived in the disability living facility, Orange Grove, operated by Life Without Barriers in Balaclava, Victoria.

2. Mr Valenti was born in Footscray in 1968 to parents Mario and Delia Valenti. He had one older sister, Eleonora Luppino. According to his family, it was apparent from around 12 months of age that Mr Valenti had some form of intellectual disability. At this time, he did not show any signs of a physical disability and was otherwise an active and playful child.

3. Mr Valenti suffered a number of seizures from a young age. He was later diagnosed with cerebral palsy and Lennox-Gastaut syndrome, a severe form of epilepsy. Later in life he developed chronic mild pancytopenia[1] and became progressively frail.

4. Despite his limitations, Mr Valenti enjoyed a happy childhood with a loving family. He continued to live with his parents into adulthood and enjoyed walking, reading books, going to the beach and camping trips. Mr Valenti was highly social and is affectionately remembered by his sister as a "*happy, charming man who touched the lives of many*."[2]

5. In 2010, when Mr Valenti was 41 years old his parents became unable to look after him due to their own age and need for support. He moved out of the family home into supported care at Orange Grove in Balaclava. It took Mr Valenti some time to settle into his new environment but once he did, he settled well and considered Orange Grove his home. He lived there with three other residents with whom he developed close friendships.

6. Mr Valenti received daily support from carers at Orange Grove with personal hygiene and grooming, medication, and meal preparation. Four days a week he attended programs operated by Mecwacare such as arts and craft, music, and baking. Mr Valenti also enjoyed regular outings and frequent visits from his family.

7. In her statement included in the coronial brief, Mr Valenti's sister Ms Luppino expressed her appreciation for the care her brother received at Orange Grove which she described as a "*warm and loving environment*."[3]

[1] Pancytopenia is a medical condition in which there is significant reduction in the number of almost all blood cells.
[2] Statement of Eleonora Luppino, dated 15 May 2023.
[3] Ibid.

8. Mr Valenti's health gradually began to decline. In February 2022, Mr Valenti was admitted to The Alfred Hospital (**the Alfred**) with increased refractory seizures. He was reviewed by his neurologist and his dosage of his epilepsy medication, carbamazepine, was increased.

9. On 16 August 2022[4], Mr Valenti was admitted to the Alfred via ambulance following further functional decline and a cluster of seizures. Throughout this admission, Mr Valenti was comforted by visits from family and from his carers at Orange Grove before being discharged back to Orange Grove on 1 October 2022.

THE CORONIAL INVESTIGATION

1. Mr Valenti'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. 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.[5]

10. 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.

11. 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.

12. Victoria Police assigned Senior Constable Grace Adams to be the Coroner's Investigator for the investigation of Mr Valenti's death. The Coroner's 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.

[4] Dates for this presentation in the coronial brief differ. In an email dated 3 October 2022, Alfred Health confirmed that Mr Valenti presented via ambulance on 16/8/22.

[5] 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.

13. This finding draws on the totality of the coronial investigation into the death of Doriano Valenti 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.[6]

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

Identity of the deceased

14. On 14 January 2023, Doriano Valenti, born 2 September 1968, was visually identified by his sister, Eleonora Luppino, who signed a formal Statement of Identification to this effect.

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

Medical cause of death

16. Forensic Pathologist Dr Judith Fronczek, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination of Mr Valenti's body in the mortuary on 16 January 2023 and provided a written report of her findings dated 17 January 2023.

17. The post-mortem examination was consistent with Mr Valenti's history. A post-mortem computerised tomography (**CT**) scan showed hyperostosis frontalis interna,[7] an elevated right diaphragm, bilateral pleural effusions (fluid between the lung and chest wall), right lower lung consolidation, and kidney stones.

18. Dr Fronczek provided an opinion that the medical cause of death was *1 (a) respiratory failure in a man with cerebral palsy and Lennox-Gastaut syndrome.*

19. Dr Fronczek considered that Mr Valenti's death was due to natural causes.

20. I accept Dr Fronczek's opinion.

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[6] 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.

[7] Thickening of the inner side of the frontal bone of the skull.

Circumstances in which the death occurred

21. On 14 December 2022, Mr Valenti again presented to the Alfred via ambulance following a further general decline, including increased drowsiness, altered mentation, and increased difficulty with ambulating and toileting. A clinical exam was performed on his arrival which revealed general advanced frailty.

22. On 22 December 2022, Mr Valenti was admitted to the Intensive Care Unit (**ICU**) with hypotension, bradycardia, and ventricular stand still (absence of any ventricular activity for more than a few seconds). Due to his poor cardiac output, a permanent pacemaker was inserted on 24 December 2022. Mr Valenti was discharged from the ICU two days later to a general hospital ward.

23. Initially, Mr Valenti showed signs of improvement following his pacemaker procedure. He received physiotherapy, speech therapy, and occupational therapy with the view to transfer to the Caulfield Hospital rehabilitation ward. Unfortunately, Mr Valenti again declined and was again admitted to the ICU on two separate occasions[8] with hypothermia, respiratory failure, hypotension, and a fluctuating conscious state.

24. Mr Valenti's treating clinical team could not identify any reversible conditions, and determined that ongoing medical treatment would be of little benefit. Following discussions with family, on 14 January 2023, Mr Valenti was transferred to palliative care prioritising comfort care. Mr Valenti was in the company of his family and was kept comfortable in the until he passed away and was formally pronounced deceased at 7.50 pm on 14 January 2023.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Doriano Valenti, born 2 September 1968;

    b) the death occurred on 14 January 2023 at The Alfred Hospital, 55 Commercial Road, Melbourne, Victoria, 3004;

    c) the cause of Mr Valenti's death was respiratory failure in a man with cerebral palsy and Lennox-Gastaut syndrome; and

[8] Admissions on 7/1/23 to 12/1/23 and again on 13/1/23.

d) the death occurred in the circumstances described above.

26. The available evidence does not support a finding that there was any want of clinical management or care on the part of staff at Orange Grove or the Alfred Hospital that caused or contributed to Mr Valenti's death.

27. I note that Mr Valenti's death was reportable by virtue of section 4(2)(c) of the Act because, immediately before his death, he was a person placed in care. Section 52 of the Act requires an inquest to be held, except in circumstances where the death was due to natural causes. I am satisfied that Mr Valenti died from natural causes and that no further investigation is required. Accordingly, I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into his death and to finalise the investigation of Mr Valenti's death on the papers.

28. I convey my sincere condolences to Mr Valenti's family and his carers and friends at Orange Grove for their loss. It is palpably clear that Mr Valenti was a much-loved member of his family and resident at Orange Grove. The love and support he received enabled him to live a full and happy life. Mr Valenti is dearly missed by those around him.

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:

Eleonora Luppino, senior next of kin

Alfred Health

Orange Grove, Life Without Barriers

Senior Constable Grace Adams, Victoria Police, Coroner's Investigator

Signature:

Coroner Paresa Antoniadis Spanos

Date : 09 October 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.