



IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

**COR 2024 005848**

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

*Section 67 of the Coroners Act 2008*

Findings of:	Coroner Paul Lawrie
Deceased:	Giovanni John Miceli
Date of birth:	17 March 1971
Date of death:	4 October 2024
Cause of death:	1a: SEPSIS 1b: ASPIRATION PNEUMONIA
Place of death:	Austin Hospital 145 Studley Road, Heidelberg Victoria 3084
Keywords:	In care, Specialist Disability Accommodation, SDA, natural causes

## INTRODUCTION

1. On 4 October 2024, Giovanni John Miceli was 53 years old when he died at the Austin Hospital. At the time of his death, Mr Miceli lived at a specialist disability accommodation (SDA) in Preston, run by Agapi Care.

## THE CORONIAL INVESTIGATION

2. Mr Miceli'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 have been from natural causes. Mr Miceli was a 'person placed in custody or care' within the meaning of section 4 of the Act, as he was 'a prescribed class of person'<sup>1</sup> due to his status as an 'SDA'<sup>2</sup> resident residing in an SDA enrolled dwelling'.
3. 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.
4. 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.
5. Victoria Police assigned First Constable (FC) Tess Stevens to be the Coronial Investigator for the investigation of Mr Miceli's death. The Coronial Investigator conducted inquiries on my behalf and compiled a coronial brief of evidence.
6. This finding draws on the totality of the coronial investigation into the death of Mr Miceli including evidence contained in the coronial brief. Whilst I have reviewed all the material, I

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<sup>1</sup> *Coroners Act 2008* (Vic) s 4(2)(j)(i).

<sup>2</sup> Specialist Disability Accommodation.

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.<sup>3</sup>

## **BACKGROUND**

7. Mr Miceli was born with cerebral palsy and lived with an intellectual disability. He was unable to talk, but he understood both English and Italian and would communicate with his family through eye contact and nods. Mr Miceli's medical history also included recurrent chest infections, chronic constipation, and a swallowing disorder.
8. Due to his disability, Mr Miceli was unable to attend mainstream school and instead went to a school for disabled children. Eventually, the school was unable to meet Mr Miceli's needs and he attended Scope's day services.
9. In 2019, Mr Miceli's parents were no longer able to care for him, and he moved to Agapi Care in Preston. Mr Miceli enjoyed living at Agapi Care and he was frequently taken out for activities in the community although he was confined to a wheelchair. He also enjoyed regular visits with his family. Mr Miceli was dependent on care staff for all activities of daily living, mobility assistance, and transfer assistance, amongst other things.
10. Throughout his life Mr Miceli was very prone to chest infections which occasionally developed into pneumonia. Approximately three weeks prior to his final admission to hospital, he was taken to hospital with a chest infection and placed on an increased course of antibiotics.

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

### **Circumstances in which the death occurred**

11. On 29 September 2024, at 7.00am, Agapi Care staff attempted to wake Mr Miceli as part of his usual morning routine, however he was observed to be breathing in an unusual manner, and he had a fever.
12. Staff contacted emergency services and Mr Miceli was transported by ambulance to the Austin Hospital (**the Austin**). Upon arrival at the Austin, Mr Miceli was observed to hypotensive and hypoxic. He also had reduced consciousness and fever.

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<sup>3</sup> 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. Mr Miceli was assessed as having sepsis (of either chest or gastrointestinal origin) and an acute kidney injury. Despite treatment with antibiotics and fluid, which was the ceiling of care, Mr Miceli's condition did not improve. Hospital staff had discussions with Mr Miceli's family about his prognosis and a decision was made to commence end of life care. He was transferred to the palliative care unit on 2 October 2024. Mr Miceli passed away on 4 October 2024 at 6.57pm.

### **Identity of the deceased**

14. On 4 October 2024, Giovanni John Miceli, born 17 March 1971, was visually identified by his sister, Franca Leone.
15. Identity is not in dispute and requires no further investigation.

### **Medical cause of death**

16. Forensic Pathologist Dr Brian Beer from the Victorian Institute of Forensic Medicine conducted an examination on 7 October 2024 and provided a written report of his findings dated 11 October 2024.
17. The post-mortem examination and CT scan revealed right lower lobe pneumonia.
18. Dr Beer provided an opinion that the death was due to natural causes and the medical cause of death was "*I(a) Sepsis*" secondary to "*I(b) Aspiration pneumonia*".
19. I accept Dr Beer's opinion.

### **FINDINGS AND CONCLUSION**

20. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
  - a) the identity of the deceased was Giovanni John Miceli, born 17 March 1971;
  - b) the death occurred on 4 October 2024 at Austin Hospital, 145 Studley Road, Heidelberg, Victoria 3084, from sepsis secondary to aspiration pneumonia; and
  - c) the death occurred in the circumstances described above.

21. There is nothing to suggest that the care Mr Miceli received at Agapi Care and the Austin Hospital was anything other than appropriate.

## ACKNOWLEDGEMENTS

I convey my sincere condolences to Mr Miceli's family for their loss.

I thank the Coroner's Investigator and those assisting for their work in this investigation

## DIRECTIONS

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:

Alfredo & Vita Miceli, Senior Next of Kin

Austin Health

First Constable Tess Stevens, Coronial Investigator

Signature:



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**CORONER PAUL LAWRIE**



Date: 14 April 2026

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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.

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