



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 006153

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Dimitra Dubrow
Deceased:	Graziano Birgi
Date of birth:	01 October 1938
Date of death:	21 October 2024
Cause of death:	1a: Oesophageal perforation
Place of death:	Dandenong Hospital 135 David Street Dandenong Victoria 3175
Keywords:	In care, natural causes death

INTRODUCTION

1. On 21 October 2024, Graziano Birgi (**Graziano**) was 86 years old when he died at the Dandenong Hospital. He is survived by his niece.
2. Graziano was born in Italy and migrated to Australia at the age of 16.
3. Graziano's medical history included treatment resistant paranoid schizophrenia. He had resided in the Secure Extended Care Unit of Dandenong Hospital since June 2005.

THE CORONIAL INVESTIGATION

4. Graziano'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.
5. Graziano was a "person placed in custody or care" within the meaning of section 4 of the Act, as he was on an Inpatient Treatment Order under section 143 of the *Mental Health and Wellbeing Act 2022* (Vic) at the time of his death.
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. This finding draws on the totality of the coronial investigation into the death of Graziano Birgi including evidence provided to and obtained by the Court. 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

Circumstances in which the death occurred

9. Medical records from Monash Health outlined that in the week prior to his death, Graziano had poor oral intake of food and fluids and frequently declined nursing care. The records also indicated that Graziano had increasing frailty over the last 6 months, and palliative care discussions had taken place.
10. On 20 October 2024, Graziano had an unwitnessed fall during the afternoon. No head strike was observed, and he was noted to be alert and oriented post fall. He declined to be seen by a doctor. Nursing notes indicated that post-fall neurological examination and physical assessment was difficult as Graziano remained uncooperative. He was observed by staff throughout the afternoon and had dinner at 5pm.
11. At 7.30pm, Graziano had a further unwitnessed fall in his bedroom. He remained alert and oriented with no external injuries. He continued to refuse post-fall observations.
12. At 9.30pm, Graziano was observed to be in bed. Nursing notes indicated that he was dismissive of nursing intervention and gestured to staff to leave. He was observed to be asleep at 12.30am.
13. At 5.25pm, nursing staff noted that Graziano had shallow breathing. Physical observations were undertaken, and the on-call psychiatric registrar was informed. Subsequently, Graziano became unresponsive and was declared deceased at 5.55am.

Identity of the deceased

14. On 21 October 2024, Graziano Birgi, born 01 October 1938, was visually identified by Dr Grace Sodomaco.
15. Identity is not in dispute and requires no further investigation.

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.

Medical cause of death

16. Forensic Pathologist Dr Hans de Boer from the Victorian Institute of Forensic Medicine conducted an external examination on 23 October 2024 and provided a written report of his findings dated 26 November 2024.
17. The post-mortem CT scan revealed left pleural effusion and large right pleural fluid collection with abnormal appearing oesophagus. There was no skull fracture or intracranial haemorrhage. The aorta and pericardium appeared normal. The external examination was consistent with the reported circumstances.
18. Dr de Boer noted that the radiological findings were discussed with Consultant Radiologist Dr Chirs O'Donnell. The findings were deemed most suggestive of an oesophageal perforation due to disease. The specific underlying disease could not be determined. Possibilities included oesophageal malignancy, chronic ulceration and/or chronic inflammation.
19. Dr de Boer provided an opinion that the medical cause of death was *1(a) Oesophageal perforation*. Based on the available information, Dr de Boer was of the opinion that the death was due to natural causes.
20. I accept Dr de Boer'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 Graziano Birgi, born 01 October 1938;
 - b) the death occurred on 21 October 2024 at Dandenong Hospital, 135 David Street Dandenong Victoria 3175, from oesophageal perforation; and
 - c) the death occurred in the circumstances described above.
22. I note that section 52 of the Act requires that an inquest be held, except in circumstances where the death was due to natural causes. Having considered the evidence and the medical report from Dr de Boer, I am satisfied that Graziano died from natural causes, and I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into his death

I convey my sincere condolences to Graziano'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:

Senior Next of Kin

Dr Anand Panniraivan, Monash Health

Constable Matthew Morcon, Coronial Investigator

Signature:



Coroner Dimitra Dubrow

Date: 11 November 2025

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.
