IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 001013

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paul Lawrie
Deceased:	Christine Maree Giliberto
Date of birth:	21 October 1967
Date of death:	21 February 2025
Cause of death:	UROSEPSIS DUE TO AN OBSTRUCTING RENAL CALCULUS IN A WOMAN WITH MULTIPLE COMORBIDITIES
Place of death:	Sunshine Hospital 176 Furlong Road St Albans Victoria 3021
Keywords:	In care, supported disability accommodation, SDA, natural causes

INTRODUCTION

1. On 21 February 2025, Christine Maree Giliberto was 57 years old when she died at Sunshine Hospital. At the time of her death, Ms Giliberto lived in St Albans at a specialist disability accommodation, operated by HomeScope with support services provided by Scope (Aust) (**Scope**).

BACKGROUND

2. Christine ('Chrissy') Giliberto was born with hydrocephalus[1] and her brain size was significantly reduced. The day after her birth, her mother, Kathleen Giliberto, was told she was unlikely to live past her first year.

3. At three months of age, Ms Giliberto underwent two surgeries to place multiple shunts in order to drain excess cerebrospinal fluid. The shunts required elongating every few months, until Ms Giliberto was three years of age. At this point, the excess fluid was draining on its own, and no further shunts were required.

4. Ms Giliberto's medical history also included cerebral palsy, bilateral visual impairment, dysphagia, incontinence, and epilepsy. She was unable to walk or speak and had limited mobility on her right side.

5. Ms Giliberto was cared for by her family until she was approximately 12 years of age. At this time, a nurse informed her mother about Scope disability services. Ms Giliberto was subsequently enrolled in a day-program run by Scope. She was collected from home every weekday morning and returned each afternoon.

6. As Ms Giliberto grew older, it became increasingly difficult for her family to care for her at home. Physical handling of Ms Giliberto and using a hoist for transfers into her wheelchair required at least two people.

7. Ms Giliberto's family sought assistance from Scope, who initially placed her in a care home in Moreland. Kathleen Giliberto reported that for a few months this arrangement worked very well. However, after a change in staff, the quality of care declined, and Mrs Giliberto moved her daughter back to the family home.

[1] Hydrocephalus is the abnormal accumulation of cerebrospinal fluid in the ventricles deep in the brain.

8. When Ms Giliberto was 21 years of age, Scope placed her into supported disability accommodation (**SDA**) in St Albans. Ms Giliberto's parents visited her twice a week.

9. While at her SDA, Ms Giliberto visited the activity centre daily and enjoyed music therapy. Mrs Giliberto was consistently pleased with the care her daughter received at this SDA.

10. In 2023, Ms Giliberto was moved to a nearby SDA, operated by HomeScope. At her new home, Ms Giliberto was able to participate in additional activities – including going to church and excursions for lunch.

11. On 31 October 2024, Ms Giliberto was admitted to hospital following an unusual recovery from a seizure. She was found to have an obstructive calculus within the right distal ureter,[2] and discharged on 7 November 2024.

12. Throughout the later part of 2024 and early 2025, Ms Giliberto had several admissions to Western Health for stercoral colitis,[3] intractable seizures, and complications from an inoperable obstructed ureter. On 2 January 2025, Mrs Giliberto, in consultation with the medical team, decided upon conservative management and no surgical attempt in respect of the kidney stones. Ms Giliberto was then referred to Mercy Palliative Care for symptom management at her SDA.

THE CORONIAL INVESTIGATION

13. Ms Giliberto'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. Ms Giliberto was 'a person placed in custody or care' within the meaning of section 4 of the Act, as she was 'a prescribed class of person'[4] due to her status as an 'SDA resident residing in an SDA enrolled dwelling'.

14. 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

[2] A hardened deposit (stone) that blocks or impedes the lower segment of the ureters connecting the kidney to the bladder.
[3] Inflammation inside the colon due to faecal impaction.
[4] *Coroners Act 2008* (Vic) s 4(2)(j)(i).

purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

15. 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.

16. First Constable (FC) Jack Sides acted as the Coroner's Investigator for the investigation of Ms Giliberto's death. FC Sides conducted inquiries on my behalf and compiled a coronial brief of evidence.

17. This finding draws on the totality of the coronial investigation into the death of Christine Maree Giliberto 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.[5]

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

Circumstances in which the death occurred

18. On 9 February 2025, Ms Giliberto was admitted to Sunshine Hospital with respiratory distress. She was diagnosed with urosepsis,[6] and treated with intravenous antibiotics.

19. On 11 February 2025, Ms Giliberto had a seizure and her condition deteriorated despite active treatment. There were no available interventions for the uretic stone and consequently she had a minimal chance of recovery. Further infections and worsening sepsis were thought to be likely. Ms Giliberto's family supported an approach involving comfort care only and she was subsequently admitted to the palliative care unit.

20. Ms Giliberto's carers from Scope continued to visit her daily whilst she was in hospital to provide emotional and communication support.

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[5] 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.

[6] A type of sepsis caused by infections of the urinary tract.

21. At 3.13am on 21 February 2025, Ms Giliberto passed away.

Identity of the deceased

22. On 21 February 2025, Christine Maree Giliberto, born 21 October 1967, was visually identified by her sister, Juliana Giliberto.

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

Medical cause of death

24. Forensic Pathologist Dr Joanna Glengarry from the Victorian Institute of Forensic Medicine conducted an examination on 24 February 2025 and provided a written report of her findings dated 25 February 2025.

25. The post-mortem examination and CT scan revealed marked hydrocephalus and a ventricular-caval shunt, bibasil increase in lung markings, and renal calculi with uretic obstruction.

26. Dr Glengarry provided an opinion that the medical cause of death was *"1(a) Urosepsis due to an obstructing renal calculus in a woman with multiple comorbidities"*.

27. Dr Glengarry further stated that death was due to natural causes.

28. I accept Dr Glengarry's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Christine Maree Giliberto, born 21 October 1967;

    b) the death occurred on 21 February 2025 at Sunshine Hospital, 176 Furlong Road, St Albans, Victoria 3021, from urosepsis due to an obstructing renal calculus in a woman with multiple comorbidities; and

    c) the death occurred in the circumstances described above.

30. There is nothing to suggest that the care provided to Ms Giliberto at her SDA or at Sunshine Hospital was anything other than appropriate.

ACKNOWLEDGEMENTS

I extend my sincere condolences to Ms Giliberto's family and carers 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:

Kathleen Giliberto, Senior Next of Kin

Scope (Aust)

First Constable Jack Sides, Coronial Investigator

Signature:

Coroner Paul Lawrie

Date: 12 August 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.