IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 003024

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

** Amended pursuant to section 76 of the Coroners Act 2008 on 19 May 2025*

Findings of:	Coroner Simon McGregor
Deceased:	Alexander Petricca
Date of birth:	23 September 1994
Date of death:	31 May 2024
Cause of death:	1a : RESPIRATORY SEPSIS IN A MAN WITH CEREBRAL PALSY AND EPILEPSY
Place of death:	Austin Hospital 145 Studley Road Heidelberg Victoria 3084
Keywords:	Death in care; disability; natural causes

* The finding was amended on 19 May 2025 to correct references to the date of death and information reflected in paragraphs 1, 2, 3, 5, 25(b) and 26.

INTRODUCTION

1. On 31 May 2024, Alexander Petricca was 29 years old when he died of natural causes whilst being palliated in the Austin Health Palliative Care Unit. At the time of his death, Alexander lived at 108 Vincent Drive, South Morang, Victoria, 3752 (**Vincent Drive**) which was a Specialist Disability Accommodation (**SDA**) facility managed by Scope Australia Pty Limited.

2. Alexander was born premature at 27 weeks with his twin sibling at Monash Medical Centre. Alexander's twin passed away 16 days after birth.

3. Alexander was provided with oxygen during his three month stay at Monash Medical Centre. At two and a half months old, Alexander accidentally pulled his oxygen supply out of his nose causing complications which led to the development of cerebral palsy, quadriplegia with severe spasticity, developmental delay and Autism.[1]

4. Upon release from hospital, Alexander lived with his mother until January 2023. Alexander was placed in an assisted living facility two times during 2023 but both placements only lasted a few weeks due to inadequate resourcing to handle his high needs.[2] Alexander continued living at home with his mother in Strathmore with support workers visiting three times per week.[3]

5. In August 2023, Alexander had spent some time at St Vincent's Hospital due to very low oxygen saturation levels. Alexander's treating doctors informed his mother that Alexander had aspiration pneumonia and that now that it had happened, he would most likely continue to deteriorate.[4]

6. In November 2023, Alexander was eventually placed in Vincent Drive which was managed by Scope Australia. Alexander was reported to be well taken care of in this new facility and staff were very supportive.[5]

[1] *Coronial Brief*, Statement of Lisa Petricca.
[2] Ibid.
[3] Ibid.
[4] *Coronial Brief*, Statement of Lisa Petricca;
[5] Ibid; Statement of Lisa Evans (Scope).

THE CORONIAL INVESTIGATION

7. Alexander'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.

8. In this instance, Alexander was a '*person placed in custody or care'* pursuant to the definition in section 4 of the Act, as he was '*a prescribed person or person belonging to a prescribed class of person*' due to his status as an '*SDA resident residing in an SDA enrolled dwelling.'*[6]

9. 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.

10. 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.

11. Victoria Police assigned Senior Constable Alex Boulton to be the Coronial Investigator for the investigation of Alexander's death. The Coronial 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.

12. This finding draws on the totality of the coronial investigation into the death of Alexander Petricca 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.[7]

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[6] Pursuant to Reg 7(1)(d) of the Coroners Regulations 2019, a "prescribed person or a prescribed class of person" includes a person in Victoria who is an "SDA resident residing in an SDA enrolled dwelling", as defined in Reg 5.

[7] 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

13. In considering the issues associated with this finding, I have been mindful of Alexander's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

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

Circumstances in which the death occurred

14. On 17 March 2024, Alexander was observed to have difficulty breathing during a family visit and was taken to St Vincent's Hospital for treatment. Alexander was admitted and received antibiotics and oxygen until his discharge on 19 March 2024.[8]

15. Between 2 April 2024 and 9 April 2024, Alexander was transported to St Vincent's Hospital after reporting to have low oxygen saturation levels and vomiting. Alexander was treated with antibiotics and oxygen before being discharged back to Vincent Drive.[9]

16. Between 18 April 2024 and 13 May 2024, Alexander was transported to Austin Hospital when staff at Vincent Drive became concerned about his breathing. Alexander was treated for fluid build up in his left lung and a Do Not Resuscitate (**DNR**) plan was discussed between treating medical practitioners and his family.[10]

17. On 17 May 2024, Vincent Drive staff observed Alexander to have difficulty breathing and a low oxygen saturation. Alexander was transported to Austin Hospital and treated for breathing issues, a urinary tract infection and acute sepsis.[11] Alexander was subsequently transferred to the Austin Health Palliative Care unit where it was suggested that he receive continuous oxygen, suction and palliative care support. Alexander's health however continued to decline as it was likely that he had experienced an aspiration event. Alexander's prognosis was discussed with his family and the focus was placed on comfort care given the likelihood of a terminal event.[12]

18. On 31 May 2024, Alexander passed away whilst his family had remained bedside throughout his admission to Austin Hospital.[13]

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evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[8] *Coronial Brief*, Statement of Lisa Petricca; Statement of Lisa Evans (Scope).
[9] Ibid.
[10] *Coronial Brief*, Statement of Tegan Howard (Austin Health); Statement of Lisa Evans (Scope).
[11] *Coronial Brief*, Statement of Tegan Howard (Austin Health); Statement of Dr Emilia Greculescu.
[12] *Coronial Brief*, Statement of Tegan Howard (Austin Health).
[13] Ibid.

Identity of the deceased

19. On 31 May 2024, Alexander Petricca, born 23 September 1994, was visually identified by their mother, Lisa Petricca.

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

Medical cause of death

21. Forensic Pathologist Dr Joanna Glengarry from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 3 June 2024 and provided a written report of her findings dated 3 June 2024.

22. The post-mortem examination revealed no evidence of any injuries that could have caused or contributed to Alexander's death.

23. The post-mortem computed tomography (**CT**) scan showed no skull fracture or acute skeletal fractures. There was evidence of complex skeletal deformities with remote spinal surgery. There was bibasilar consolidation, the right lung more so than the left, in keeping with pneumonia.

24. On the basis of the information made available to Dr Glengarry, she formed the opinion that the death was due to natural causes and confirmed the medical cause of death as 1(a) respiratory sepsis in a man with cerebral palsy and epilepsy. I accept Dr Glengarry's opinion.

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 Alexander Petricca, born 23 September 1994;

    b) the death occurred on 31 May 2024 at Austin Hospital, 145 Studley Road, Heidelberg, Victoria, 3084, from 1(a) respiratory sepsis in a man with cerebral palsy and epilepsy; and

    c) the death occurred in the circumstances described above.

26. As Alexander was residing in Specialist Disability Accommodation at the time of his passing, his death is considered to be 'in care' as defined by section 3 of the Act and subject to a mandatory inquest unless exceptions applied.[14] I am satisfied by the available evidence that Alexander's death was due to natural causes and, pursuant to section 52(3A) of the Act, have therefore determined not to hold an inquest.

27. I am further satisfied that his care was reasonable and appropriate.

I convey my sincere condolences to Alexander'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:

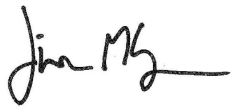
Tommaso Petricca, Senior Next of Kin

Lisa Petricca, Senior Next of Kin

Naomi Baquing, Scope Australia

Senior Constable Alex Boulton, Coronial Investigator

Signature:



Coroner Simon McGregor

Date: 20 May 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

[14] Section 52(2) of the Act.

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.