IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 001764

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Judge John Cain
Deceased:	Vincenzo Mario Chiarello
Date of birth:	2 July 1965
Date of death:	2 April 2023
Cause of death:	1(a) Combined effects of Aspiration Pneumonia and Epilepsy (b) Cerebral Palsy
Place of death:	Royal Melbourne Hospital 300 Grattan Street Parkville

INTRODUCTION

1. On 6 May 2023, having commenced an investigation into the death of Mr Vincenzo Mario Chiarello (Mr Chiarello) I concluded that investigation and published findings that did not include findings in respect of the circumstances in which death occurred pursuant to section 67(2) of the Coroners Act 2008 (the Act). It has now come to my attention that Mr Chiarello's death was a death that is referred to in section 4(2)(c) of the Act as Mr Chiarello was immediately before death placed in care or custody. In those circumstances I am required by the Act to make findings with respect to the circumstances of Mr Chiarello's death and accordingly findings in respect of the circumstances of death are contained in this amended finding.

2. On 2 April 2023 Mr Chiarello was 57 years old when he died at Royal Melbourne Hospital 300 Grattan Street Parkville. At the time, Mr Chiarello lived in Specialist Disability Accommodation (SDA) located at 9 Corio Street Glenroy Victoria.. The National Disability Insurance Service (NDIS) had provided a Care Package for Mr Chiarello and the Care package included funding of his SDA accommodation at 9 Corio Street Glenroy.

3. The National Disability Insurance Agency (NDIA) had approved the most recent NDIS Care plan for Mr Chiarello and the plan was approved to commence from 12 May 2022.

4. In his NDIS plan Mr Chiarello stated:

   I live Scope supported accommodation. I have two brothers who visit me regularly.

   I attend Scope day programs 3 days a week and the other days I have 1:1 supports. On the weekends I sometimes see family members or go on an outing. I would love to be able to visit both my brothers. I barrack for Collingwood and enjoy going to musical events and watching AFL.

THE CORONIAL INVESTIGATION

5. Mr Chiarello'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.[1]

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 Mr Chiarello. 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.[2]

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

Identity of the deceased

9. On 6 April 2023, Vincenzo Mario Chiarello , born 2 July 1965, was visually identified by Nicola Chiarello, who signed a formal Statement of Identification to this effect.

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

Medical cause of death

11. Forensic Pathologist Dr Melanie Archer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on Mr Chiarello's body in the mortuary on 5 April 2023 and provided a written report of his findings dated 17 April 2023.

12. Dr Archer provided an opinion that the medical cause of death was.

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[1] 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.

[2] 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.

1 (a) Combined effects of aspiration pneumonia and epilepsy

(b) Cerebral Palsy

13. Dr Archer considered that Mr Chiarello's death was due to natural causes.

14. I accept Dr Archer's opinion.

Circumstances in which the death occurred.

15. Mr Chiarello was a 57 year-old man who lived in Specialist Disability Accomadaion at 9 Corio Street Glenroy. Mr Chiarello medical history included cerebral palsy, intellectual disability, epilepsy, and cellulitis (leg and ear).
16. He was admitted to Royal Melbourne Hospital on 12 March 2023 with a one-week history of increased lethargy and drowsiness. He was diagnosed with likely aspiration pneumonia and had seizure activity throughout the period of his admission. An EEG was performed and showed non convulsive status epilepticus.
17. Mr Chiarello was intubated, but was then extubated on 19 March 2023, and was palliated and died on 2 April 2023.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Vincenzo Mario Chiarello, born 2 July1965;

    b) the death occurred on 2 April 2023 at The Royal Melbourne Hospital 300 Grattan Street Parkville Victoria, ;

    the cause of Mr Chiarello's death was:

    1 (a) Combined effects of aspiration pneumonia and epilepsy

    (b) Cerebral Palsy and

    c) the death occurred in the circumstances described above.

19. The available evidence does not support a finding that there was any want of clinical management or care on the part of the SDA operator that caused or contributed to Mr Chiarello's death.

20. I note that Mr Chiarello's death was reportable by virtue of section 4(2)(c) of the Act because, immediately before her 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 Chiarello 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 Chiarello's death on the papers.

21. I convey my sincere condolences to Mr Chiarello's family and his carers and friends 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:

Nicola Chiarello, senior next of kin

Signature:

Judge John Cain
STATE CORONER
Date 30 November 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.