



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 007400

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of: Coroner Simon McGregor

Deceased: Saba Pietropaolo

Date of birth: 10 February 1934

Date of death: 22 December 2024

Cause of death: 1a : CHOKING

Place of death: CraigCare Berwick
25 Parkhill Drive
Berwick Victoria 3806

Keywords: Aged care death; Choking

INTRODUCTION

1. On 22 December 2024, Saba Pietropaolo was 90 years old when she died at CraigCare (Berwick). At the time of her death, Saba lived at CraigCare (Berwick), 25 Parkhill Drive, Berwick, Victoria, 3806.
2. Saba was born in Italy and migrated to Australia in 1962. Saba lived in Cranbourne West and did odd jobs in factories and farms. In the early 1970s, Saba and her partner had a car accident which involved significant injuries to her hips and caused her ongoing pain.
3. Saba moved into CraigCare (Berwick) in 2024 and was bedridden with pain in her hips and legs. Saba's treating General Practitioner confirmed that Saba had atrial fibrillation, left shoulder pain, bilateral osteoarthritis in her hips, hypertension, sub-clinical hyperthyroidism, gastric ulcers and diverticulitis.¹ Saba was reviewed by a speech pathologist on 15 November 2024 and recommended to consume thick fluids only.²

THE CORONIAL INVESTIGATION

4. Saba'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.
5. 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.
6. 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.
7. Victoria Police assigned First Constable Jack Van Brummelen to be the Coronal Investigator for the investigation of Saba's death. The Coronal Investigator conducted inquiries on my

¹ *Coronial Brief*, Statement of Dr Samira Weerakoon.

² *Ibid.*

behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

8. This finding draws on the totality of the coronial investigation into the death of Saba Pietropaolo 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.³
9. In considering the issues associated with this finding, I have been mindful of Saba’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

10. On 22 December 2024, at approximately 10:00 am, Mario Peters, Mario’s partner Kylie Hampson and Nick Pietropaolo attended CraigCare (Berwick) to visit Saba. During the visit, Saba requested to drink some coffee and Nick made enquiries with staff to allow Saba to have some coffee. Staff noted that a consent waiver needed to be signed as restrictions were noted on her client file that she was not to drink thin fluids. The consent form, “Dignity of Risk”, was signed later by Nick Pietropaolo after the fatal incident.
11. I received conflicting accounts of the events that transpired when Saba consumed the coffee but confirm that Saba reportedly went silent after sipping the coffee and was observed not to be breathing. Saba’s sons rushed to contact staff and ambulance paramedics arrived shortly after but Saba was pronounced deceased at 12:15 pm.⁴

Identity of the deceased

12. On 22 December 2024, Saba Pietropaolo, born 10 February 1934, was visually identified by her daughter in law, Kylie Hampson.

³ 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.

⁴ *Coronial Brief*, Statements of Nick Pietropaolo, Mario Peters and Arshpreet Kaur Chahal.

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

Medical cause of death

14. Forensic Pathologist Dr Gregory Young from the Victorian Institute of Forensic Medicine (VIFM) conducted an external examination on 23 December 2024 and provided a written report of his findings dated 27 December 2024.

15. The post-mortem CT scans revealed evidence of cerebral atrophy, no intracranial haemorrhage, a large left pleural effusion associated with left lung collapse and coronary artery calcification.

16. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or other common drugs or poisons.

17. Dr Young provided an opinion that the medical cause of death was 1(a) CHOKING and I accept his opinion.

FAMILY CONCERNS

18. In their statements to the court dated 26 April 2025 and 14 April 2025 respectively, Nick Pietropaolo and Mario Peters, expressed the following concerns:

- a) Frustration with the alleged delay in CraigCare (Berwick) staff responding to the incident of Saba choking on coffee; and
- b) The resourcing of staff at CraigCare (Berwick).

AGED CARE QUALITY AND SAFETY COMMISSION INVESTIGATION

19. The Aged Care Quality and Safety Commission (ACQSC) conducted an extensive investigation into the care and services provided to Saba by CraigCare (Berwick), including an extensive review of information and evidential material provided by CraigCare (Berwick) and other witnesses.

20. CraigCare (Berwick) provided the ACQSC with an incident report and internal documentation including a "Dignity of Risk" consent form signed by Nick Pietropaolo. The records confirm that Saba's family reviewed the "Dignity of Risk" document and it was signed against Berwick's advice to not provide Saba with thin liquids.

21. The ACQSC found that CraigCare’s (Berwick) actions taken to support and assist Saba during the incident, their use of open disclosures and their analysis of the incident did not indicate that any further action was warranted.

FINDINGS AND CONCLUSION

22. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.⁵ Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.
23. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
 - a) the identity of the deceased was Saba Pietropaolo, born 10 February 1934;
 - b) the death occurred on 22 December 2024 at CraigCare (Berwick), 25 Parkhill Drive, Berwick, Victoria, 3806, from 1(a) CHOKING; and
 - c) the death occurred in the circumstances described above.
24. Having considered all of the circumstances, I am satisfied that Saba’s death was the unintended consequence of consuming thin liquids in circumstances where she had a restricted dietary intake.
25. After careful consideration of the evidence in this matter, including the outcomes of the ACQSC investigation and the material provided by CraigCare (Berwick), I am satisfied that the care and services provided to Saba were reasonable and appropriate.
26. I convey my sincere condolences to Saba’s family for their loss.

⁵ *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: ‘The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters “reasonable satisfaction” should not be produced by inexact proofs, indefinite testimony, or indirect inferences...’.

27. Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

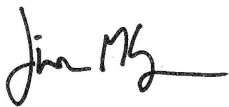
28. I direct that a copy of this finding be provided to the following:

Nick Pietropaulo, Senior Next of Kin

Kathleen Jansen, Peninsula Health

First Constable Jack Van Brummelen, Coronial Investigator

Signature:



Coroner Simon McGregor

Date: 28 April 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.
