IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 3215

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	Simon McGregor, Coroner
Deceased:	**Angelina Alviano**
Date of birth:	20 November 1950
Date of death:	5 July 2018
Cause of death:	Sudden unexpected death in epilepsy in a woman with schizophrenia and cardiomegaly
Place of death:	24 Snell Grove, Pascoe Vale Victoria 3044

INTRODUCTION

1. Angelina Alviano was a 67-year-old woman who was under the care of the Department of Health and Human Services (DHHS). She lived in Disability Accommodation at 24 Snell Grove, Pascoe Vale Victoria 3044 at the time of her death.

2. Ms Alviano suffered from epilepsy, schizophrenia and cardiomegaly and died unexpectedly at 24 Snell Grove, Pascoe Vale Victoria 3044 on 5 July 2018.

THE PURPOSE OF A CORONIAL INVESTIGATION

3. Ms Alviano's death was reported to the Coroner as it appeared unexpected, unnatural or to have resulted, directly or indirectly, from an accident and so fell within the definition of a reportable death in the *Coroners Act 2008.*

4. 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.

5. 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.

6. The Coroner's Investigator, Constable Matthew Reynolds prepared a coronial brief in this matter. The brief includes statements from witnesses, DHHS staff, the forensic pathologist who examined Ms Alviano, treating clinicians and investigating officers.

7. After considering all the material obtained during the coronial investigation I determined that I had sufficient information to complete my task as coroner and that further investigation was not required. 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.

8. I have based this finding on the evidence contained in the coronial brief. In the coronial jurisdiction facts must be established on the balance of probabilities.[1]

9. In considering the issues associated with this finding, I have been mindful of Ms Alviano's basic 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.

BACKGROUND

10. Ms Alviano was born in Italy and immigrated to Australia with her family. She moved into DHHS ongoing Disability Accommodation at 100 Arthur Street, Fairfield Victoria 3078 on 17 November 1987.[2]

11. Ms Alviano relocated to 24 Snell Grove, Pascoe Vale Victoria 3044 on 29 November 2003 and remained there until her death.

12. Ms Alviano suffered from severe epilepsy, which was managed by The Royal Melbourne Hospital. Despite a complex medication regimen, Ms Alviano continued to suffer seizures.[3]

13. In addition to epilepsy, Ms Alviano suffered from paranoid schizophrenia, which was usually controlled through medication and complicating behavioural issues related to her intellectual disability.[4]

14. In the few months prior to her death, Ms Alviano's treating clinician, Dr Helen Brough states that she was commenced on Citalopram. The medication was a trial to see if Ms Alviano's mood could be improved but resulted in difficulty with balance. Dr Brough further states that she assumed this was a result of interactions with the epilepsy medication.[5] Ms Alviano's Medication Records indicate that she was trialled on Escitalopram not Citalopram.[6]

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[1] This is 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.

[2] Statement of Marisa Gustowski dated 25 January 2019, Coronial Brief.

[3] Statement of Dr Helen Brough dated 10 June 2019, Coronial Brief.

[4] Ibid.

[5] Ibid.

[6] Citalopram and Escitalopram are similar drugs. Whilst it is possible that Dr Brough made an error in her statement, nothing turns on that in this investigation.

15. Dr Borough last saw Ms Alviano on 31 May 2018. During this consultation, Dr Borough confirmed that the balance issues had resolved, after returning Ms Alviano's medication to its long-standing regime.[7]

16. Ms Alviano had no known factors for coronary artery disease and had normal blood pressure, cholesterol and glucose levels.[8]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

17. On 4 July 2018, DHHS progress notes detail that Ms Alviano followed her usual routine.[9]

18. On 5 July 2018 at approximately 4.20am, DHHS support worker, Demara Kelly, noticed that Ms Alviano was not in her bed. Ms Kelly checked the bathroom next to Ms Alviano's bedroom but Ms Alviano was not in there. Ms Kelly walked through the house and found Ms Alviano unresponsive on the floor in the top bathroom.[10]

19. Ms Kelly called emergency services and commenced cardiopulmonary resuscitation (CPR). Ambulance Victoria arrived at approximately 4.45am and took over resuscitation efforts.[11]

20. At approximately 5.10am, Victoria Police arrived.[12]

21. Ambulance Victoria declared Ms Alviano deceased at 5.20am.[13]

IDENTITY AND CAUSE OF DEATH

22. On 6 July 2018, Constantina Spataro visually identified the body of her sister, Angelina Alviano, born 20 November 1950. Identity is not in dispute and requires no further investigation.

23. On 9 July 2018, Dr Heinrich Bouwer, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon Ms Alviano's body and reviewed a post mortem computed tomography (CT scan), The Royal Melbourne Hospital records and the Police Report of Death for the Coroner. Dr Bouwer provided a written report, dated 5 April 2019, in which he formulated the cause of death as '*I(a) Sudden unexpected death in epilepsy in a woman with schizophrenia and cardiomegaly*'.

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[7] Ibid.
[8] Statement of Dr Helen Brough dated 10 June 2019, Coronial Brief.
[9] DHHS Progress Notes: Angelina Alviano, entry: 4 July 2018, Coronial Brief.
[10] DHHS Progress Notes: Angelina Alviano, entry: 5 July 2018, Coronial Brief.
[11] Ibid.
[12] Statement of Constable Matthew Reynolds dated 26 March 2019, Coronial Brief.
[13] Ambulance Victoria, Verification of Death Form, Case No. 10182 dated 05 July 2018, Coronial Brief.

24. Toxicological analysis of post mortem samples taken from Ms Alviano identified the presence of lamotrigine[14], phenytoin[15], olanzapine[16], citalopram[17], clobazam[18] and paracetamol[19].

25. Dr Bouwer commented that the autopsy revealed some changes in the brain that were consistent with remote insult and borderline cardiomegaly.

26. Dr Bouwer further noted that epilepsy is a risk for sudden unexpected death (so called sudden unexpected death in epilepsy or SUDEP). Likewise, increased heart weight also predisposes a person to sudden cardiac arrythmia and death.

27. There was no post mortem evidence of violence or injury contributing to death.

28. On the basis of the information available to Dr Bouwer, he was of the opinion that Ms Alviano's death was due to natural causes.

29. I accept Dr Bouwer's opinion as to cause of death.

FINDINGS AND CONCLUSION

30. I express my sincere condolences to Ms Alviano's family for their loss.

31. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) The identity of the deceased was Angelina Alviano, born 20 November 1950;

    (b) The death occurred on 5 July 2018 at 24 Snell Grove, Pascoe Vale Victoria 3044 from sudden unexpected death in epilepsy in a woman with schizophrenia and cardiomegaly; and

    (c) The death occurred in the circumstances described above.

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[14] Lamotrigine is a substituted asymmetric triazine compound used as an anticonvulsant.
[15] Phenytoin is an anticonvulsant often used in the treatment of epilepsy and convulsions.
[16] Olanzapine is indicated for the treatment of schizophrenia and related psychosis. It can also be used for mood stabilisation and as an anti-manic drug.
[17] Citalopram or escitalopram are selective serotonin reuptake inhibitors with antidepressant activity.
[18] Clobazam is a 1,5-benzodiazepine derivative used as a sedative, anticonvulsant and anxiolytic.
[19] Paracetamol is an analgesic drug available in many proprietary products either by itself or in combination with other drugs such as codeine and propoxyphene.

32. Pursuant to section 73(1B) of the Act, I direct that this finding be published on the Internet.

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

    (a) Ms Constantina Spataro, senior next of kin

    (b) Constable Matthew Reynolds, Coroner's Investigator

Signature:

SIMON McGREGOR
CORONER
Date: 6 August 2019