IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 000929

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Agostino Di Clemente
Date of birth:	8 August 1941
Date of death:	16 February 2024
Cause of death:	1a: Multiple injuries sustained in a motor vehicle incident (car vs. tree, driver)
Place of death:	Whittlesea-Yea Road Flowerdale Victoria 3717
Keywords:	Motor vehicle accident, recent diagnosis of Alzheimer's disease, fitness to drive, mandatory reporting, geriatrician, general practitioner

INTRODUCTION

1. On 16 February 2024, Agostino (**Gus**) Di Clemente was 82 years old when he died following a motor vehicle collision. At the time of his death, Gus lived alone at 31 North Road Reservoir Victoria 3073.

2. Gus was a loved father to Dino Di Clemente and Tania Di Clemente (**Tania**) and step-father to Daryl and Garry. Gus doted on his grandchildren and great-grandchildren.

3. Gus was born in Italy and was one of eight children born to Giuseppe and Costanza Di Clemente. Gus played an active role in family life from a young age and was known in the family for assisting his parents with cooking and caring responsibilities for his siblings.

4. In 1960 the Di Clemente family migrated to Australia by ship. Giuseppe and Gus' brother Albert went before the rest of the family in order to set up the family home in Thornbury. Gus reportedly took up the position as the head of the family when the rest of the family took the journey to Australia where he was noted to have become the entertainer to the passengers of the ship playing his beloved organetto (piano accordion) to the delight of the other passengers.

5. Gus was employed in numerous roles in his life including stints as a spray painter, taxi driver, carpenter, and a maintenance worker; a role he enjoyed until he was aged in his 70s before retiring.

6. In his spare time Gus enjoyed engaging with the local soccer club and playing ten pin bowling. He also enjoyed singing in a multi-lingual choir and busking with his organetto. He would play concerts at nursing homes and at community celebrations. Gus was also known for taking great joy in sharing the Christmas spirit with the local community, by decorating the house and preparing bags of lollies to give out to local children, who would stop by to marvel at his decorating efforts.

7. Gus had a complex medical history including diagnoses of chronic obstructive pulmonary disease (**COPD**), prostate cancer, emphysema, hyperlipidaemia, hypertension, pulmonary nodules, osteoarthritis and gastro-oesophageal reflux disease. Gus was under the care of a general practitioner, Dr Rasheed at Polaris Medical Centre.

8. In 2021, Gus was diagnosed with depression following the death of his wife and pet dog. His depression was managed by prescription medication. Despite this, Gus was lovingly described as having an overall positive outlook with a passion for helping family and friends.

9. In late 2023 Gus was referred to a geriatrician following a noted cognitive decline. In early 2024 he was diagnosed with (emerging) Alzheimer's disease. Discussions with his geriatrician were underway at the time of his death regarding reporting his condition to VicRoads, with his geriatrician noting on 23 January 2024, '*I have informed Agostino about his obligations to advise VicRoads about his diagnosis of dementia, as a medical condition which can potentially impact on his driving*'.

THE CORONIAL INVESTIGATION

10. Agostino'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.

11. 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.

12. 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.

13. Victoria Police assigned an officer, Senior Constable Hayden Diepeveen to be the Coronial Investigator for the investigation of Gus's death. The Coronial Investigator conducted inquiries on my behalf and submitted a thorough and comprehensive coronial brief of evidence.

14. This finding draws on the totality of the coronial investigation into the death of Agostino Di Clemente 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.[1]

[1] 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

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

Circumstances in which the death occurred

15. On Friday 16 February 2024 at 3.15pm, Gus had an appointment with general practitioner (**GP**) Dr Andrew Jacobs (**Dr Andrews**) at Polaris Medical Centre. Dr Andrews was not Gus' regular treating GP but worked at the same medical practice as his regular general practitioner. Gus was late and arrived at approximately 3.45pm.

16. The GP examined Gus and was of the opinion that he was suffering from a lower respiratory infection with possible mild confusion. Concerned about his condition, the GP recommended that Gus be admitted to hospital for monitoring and intravenous antibiotics.

17. At approximately 4.10pm the GP contacted Tania by telephone to advise her of Gus' condition and asked her to pick him up in order to take him to the hospital.

18. Gus was told to wait in an empty consulting room for Tania to arrive and the receptionist was asked to observe Gus.

19. Tania went to the GP clinic and arrived approximately 10 minutes after she was called. Tania went into the clinic to collect Gus but he was not able to be located. She found him in the carpark in his white Toyota Hiace van with the driver's door open and the engine running. She told him that she would take him to the hospital in her car, but he insisted on taking the van home first and requested she follow him to then take him to the hospital from there.

20. Tania recounted that '*he took off straight away'* and left without waiting for her to follow him, but she caught up to him and noted that he turned in the wrong direction from his house. He had turned right in a north easterly direction onto Plenty Rd and proceeded towards Whittlesea.

21. Tania recounts that at first she thought perhaps he intended on taking his van to her house but he instead continued past where they would usually turn to go there. Confused about where he was going, she pulled up next to him and signalled for him to wind down his window so she could find out what he was doing. He signalled 'no' and gestured to her to continue to follow him.

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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.

22. Tania rang her husband for advice who suggested she continue following him. She then thought perhaps Gus intended on leaving the van at his brother's house in Whittlesea. She continued to follow him. Gus continued on Plenty Rd until it turned into Whittlesea Yea road and travelled beyond Whittlesea.

23. Tania describes becoming increasingly alarmed and concerned that Gus had become confused and was not sure about where he was going. She rang her aunt for advice while continuing to follow him. Her aunt suggested that she stop following him in the hope that he may also stop driving. Tania pulled over and stopped but Gus continued driving the van.

24. When Gus did not stop, Tania continued on with the intention of following him. When she caught up to him, she attempted to further signal to him to stop by flashing her high beam headlights and beeping the horn of her car. She called emergency services for assistance as she realised that *"something was definitely wrong"* with Gus and thought police may be able to assist by intercepting him. However, Tania reported that emergency services had difficulty in establishing the location of the vehicles because her mobile phone was having difficulty in maintaining mobile phone reception.

25. It was at this time that the vehicles were travelling along Whittlsea Yea Rd towards Yea. Whittlesea Yea road is a sealed road that has a single carriageway in each direction with a sign posted speed of 100 km/h. The road runs in a northeast to southwest direction and undulates around bends. The section of road where Gus was travelling at the time was surrounded by bushland. The side of the road has a grass shoulder with a steep decline into a wooded gully with numerous juvenile trees and shrubbery.

26. Gus and Tania's vehicles were eventually also being followed by several cars which were banked up behind them as Gus was observed to be going approximately 70km per hour which was below the sign posted speed limit.

27. An eyewitness (**eyewitness**) was driving in their vehicle, following behind Tania and Gus, when he observed Gus' van veer off the road and strike a tree.

28. The eyewitness estimated that the collision occurred just before 6pm. The collision occurred on Whittlesea Yea Rd between Break O'Day Road and Old Spring Valley Road. The van came to rest down an embankment on the side of the road.

29. At 6.01pm, emergency services were called.

30. The eyewitness went to the passenger side of the vehicle and noted that Gus was unconscious and had not been wearing a seatbelt. As a result of the impact, Gus had fallen to the passenger side so that his head was out the passenger side window. The eyewitness recounted that he supported Gus' head to protect his neck. Other bystanders including an off-duty paramedic and nurse also provided support to Gus.

31. Gus regained consciousness. The eyewitness noted that Gus was conscious but was '*not very coherent*'. Gus told the nurse told her he was having trouble breathing. She recounted that she assessed him and noted he was breathing but was clearly having difficulty, she noted that he "*seemed stable*" but was bleeding from his head.

32. Gus was uncomfortable and agitated and there were concerns expressed regarding the stability of the van as it was rested on an incline against some small trees. A decision was made among those at the scene to extract him from the vehicle.

33. Together, they got Gus out of the vehicle and found a place nearby to lay him flat.

34. Tania recalls Gus saying to her at the time that he "*had to hurry up and get better because he had promised me he was coming Sunday to prune a tree at my house.*"

35. The bystanders continued to provide reassurance to Gus along with first aid until the Country Fire Authority (**CFA**) and State Emergency Service (**SES**) arrived and took control of the scene. The off-duty paramedic and nurse continued to provide support to the emergency services at the scene.

36. At 6.41pm, paramedics from Ambulance Victoria arrived. They were further supported by the arrival of the air ambulance.

37. Tania was distressed and was escorted to the rear of the ambulance where she was supported by paramedics.

38. The off-duty paramedic noted that Gus' condition was rapidly deteriorating. Gus went into cardiac arrest. Those at the scene including the off-duty paramedic, nurse and members of the emergency services took it in turns providing cardiopulmonary resuscitation (**CPR**) and airway support to Gus.

39. After approximately 20 minutes of CPR, it was determined that Gus could not be revived.

40. At 6.57pm, Gus was declared deceased.

Identity of the deceased

41. On 16 February 2024 Agostino Di Clemente, born 08 August 1941, was visually identified by his daughter, Tania Di Clemente.

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

Medical cause of death

43. On 19 February 2024, Forensic Pathologist Dr Hans H. de Boer (**Dr de Boer**) from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination and computed tomography (**CT**) scan of Gus' body. Dr de Boer provided me with a written report of his findings dated 20 February 2024.

44. The post-mortem examination revealed atrophic brain, a subarachnoid haemorrhage in the right parietal region, various fractures, subcutaneous emphysema, bilateral pneumothoraces and mild coronary artery calcification.

45. Toxicological analysis of post-mortem samples did not identify the presence of alcohol but identified the presence of prescription and over-the-counter medication in keeping with therapeutic doses.

46. Dr de Boer provided an opinion that the medical cause of death was 1*(a): Multiple injuries sustained in a motor vehicle incident (car vs. tree, driver*).

47. I accept Dr de Boer's opinion.

FURTHER INVESTIGATION

Collision Investigation

48. Victoria Police commenced an investigation into the cause of the collision.

49. They noted that the van had travelled 11 metres after it left the road with no obvious signs as to why it had left the road. There were no skid marks or marking in the loose gravel on the side of the road to suggest evasive action was undertaken to avoid the collision.

50. On 10 April 2024, a mechanical investigator situated within the Collision Reconstruction and Mechanical Investigation Unit (**CRMIU**) conducted a mechanical examination of Gus' van. The investigator examined the driver's side seatbelt and noted that it had no damage or

evidentiary markings which would be typical in a similar collision. This led to the opinion that the seatbelt was not worn at the time of the collision. The investigation did not reveal any mechanical fault of failure which may have caused or contributed to the collision.

51. The Victoria Police investigation outlined that:

   a) Gus was an experienced driver who was fully licensed at the time of the collision;

   b) Drugs, alcohol or speed were not contributing factors to the collision;

   c) The possibility that Gus may have been suffering from fatigue could not be determined;

   d) Environmental factors were not considered to contribute to the cause of the collision. The road was dry and weather was warm and clear on the day. There was a moderate amount of traffic on the road and there was no evidence of any stray livestock or wildlife observed at the scene that may have caused Gus to swerve;

   e) The investigator noted that Gus had health conditions but was (usually) fit to drive. The investigator noted that Gus was a man with Alzheimer's disease and had presented to his GP with potential confusion on the day of the collision.

   f) The investigator noted that Gus had a generally positive outlook on life and loved to help his family and friends in any way he could. The investigator could not find any evidence to suggest that Gus deliberately drove off the road in order to end his own life.

52. The investigator was ultimately of the opinion that the cause of the collision was unknown.

<u>Review of General Practitioner Conduct</u>

53. In considering potential prevention opportunities, I sought to review the GP's decision to request that Gus be transported to hospital by family rather than via emergency services.

54. I sought a statement from his treating GP along with Gus' medical records.

55. The GP explained that Gus presented as appearing unwell but did not appear to be in respiratory distress, and had independently climbed stairs to attend his appointment.

56. The GP noted that Gus appeared mildly confused but given it was the first time he had seen Gus, he was not certain as to his baseline mental state. Gus was noted as compliant with directions.

57. The GP examined Gus, and using a scoring system for pneumonia, determined that Gus was a 'moderate risk' which required monitoring and intravenous antibiotics.

58. The GP informed Gus that he would need to go to hospital. The GP told him that he would have to be picked up and taken to there. The GP believed that he understood and agreed with the plan moving forward.

59. The GP recounted that he made a decision not to call an ambulance because Gus was not in respiratory distress and his oxygen levels appeared consistent with his diagnosis of COPD. The GP considered he '*also seemed lucid and so he may have waited hours for an ambulance as he would not be considered an emergency or high risk. I thought he would be seen quicker if a family member picked him up and took him to the hospital*'.

60. The GP explained that he didn't consider Gus to be a risk to himself or others. He recalled that he had directed Gus wait in a consulting room at the clinic and report to the receptionist or himself if he was feeling worse. The GP instructed the receptionist to keep an eye on Gus and then attended to other patients.

61. At some point Gus left the consulting room where he was waiting and went out to his van. It is unclear when this occurred however Tania located him in the van after she arrived. The GP had not realised that he had left the clinic alone.

62. I referred the statement of the GP to the Coroners Prevention Unit to assist me to determine whether the conduct of the GP was reasonable in the circumstances and to assist in identifying any further prevention opportunities for similar deaths.[2]

63. The CPU considered the GP's conduct to be reasonable given what was known and observed of Gus that day. The CPU agreed that the GP's rationale that emergency medical transport

[2] The Coroners Prevention Unit (**CPU**) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

services would have taken longer than family and also noted that confused patients are usually more agreeable to a course of action where a familiar face is involved.

64. The CPU identified no concerns in regard to the care provided to Gus by the GP, and I accept this advice.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Agostino Di Clemente, born 08 August 1941;

    b) the death occurred on 16 February 2024 at Whittlesea-Yea Road Flowerdale Victoria 3717, from 1(a): Multiple injuries sustained in a motor vehicle incident (car vs. tree, driver);

    c) the death occurred in the circumstances described above.

66. Having considered all of the evidence, I find that Gus' death was the unintended consequence of a motor vehicle collision which occurred when his vehicle ran off the road whilst he was driving in a confused state, having recently been diagnosed with emerging Alzheimer's, and having presented to the GP with symptoms of a respiratory condition that required immediate medical attention. I find that at the time of the collision, Gus was not wearing a seatbelt, which may have contributed to the severity of his condition following the collision, but I cannot definitively determine if it would have altered the tragic outcome.

67. I find the clinical care provided to Gus on the day of his death was appropriate and that his death was sadly not able to be prevented by his GP, his daughter or any other person. In the circumstances, I have not identified any immediate prevention opportunities. However, Gus' tragic death gives rise to certain comments connected with his death, to which I now turn.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

68. I note that, at the time of his death, Gus had very recently been diagnosed with emerging Alzheimer's disease, and that his geriatrician, Dr Yves Choi, had had a conversation with him and with his daughter Tania about reporting his condition to VicRoads, advising that it was *'a medical condition which can potentially impact on his driving*'.

69. While the geriatrician advised Tania and Gus that there was a mandatory self-reporting requirement, there is no evidence before me that Gus or Tania had reported his condition to VicRoads (or rather to Transport Victoria, which is the entity who takes such reports) following his diagnosis of emerging Alzheimer's disease. However, Gus had only been formally diagnosed about three weeks prior to the collision, and there were no obvious safety concerns regarding Gus' overall capacity to drive up until the day of his death. Indeed, his geriatrician had noted that in the absence of such concerns, '*he can continue with his driving, but it will be important for his family to continue monitoring his driving ability in the coming months and years*'.

70. In the circumstances, it is not possible to determine that an earlier report to Transport Victoria would have changed the outcome for Gus, noting that the medical review process that eventuates after such report would likely still have been in its early stages, and that his geriatrician had not identified any specific concerns at that stage. It is also clear that Gus' daughter Tania was distressed and surprised by the unexpected manner of his driving on the day of the collision, given that she had previously observed his driving a motor vehicle and had not detected any issues of concern. The decision for her to follow Gus to drive a short distance home was reasonable given the lack of prior concern regarding Gus' driving and that the plan in any event had been for Tania to drive him to hospital from his home in her own car.

71. I note that fitness to drive in relation to elderly people, and those with medical conditions that may impact their driving, has been the subject of other coronial investigations which have resulted in coronial recommendations for reform relating to the fitness to drive reporting regime and to increase public education regarding medical conditions, mandatory reporting and safe driving.[3] While Gus' case does not clearly fall into the category of cases in which an earlier report of his medical condition would likely have resulted in licence loss, likely averting a fatal motor vehicle accident and thus avoiding his death, I have elected to notify my finding to VicRoads and Transport Victoria to ensure that future prevention efforts in this space are informed by Gus' tragic death and the distressing driving events that preceded it.

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[3] *See most recently* COR 2024 5436 – Finding into the death without inquest of Linette Ann Hawkins, State Coroner Judge Sanger, 8 January 2026. *See also* Finding into the death without inquest of Frederick Hylla (COR 2016 4011), Coroner Audrey Jamieson, 28 August 2017; Finding into the death without inquest of Pamela Elsdon (COR 2016 55554), Coroner Audrey Jamieson, 7 September 2017; Finding into the death without inquest of Stanislaw Czubryj (COR 2017 1790), Coroner Audrey Jamieson, 22 February 2018; Finding into death with inquest of Jackson Eales (COR 2016 6147), then-Deputy State Coroner Jacqui Hawkins, delivered on 18 August 2023; Finding into death without inquest of Robin Banks (COR 2020 0256), Deputy State Coroner Paresa Spanos, 12 March 2025.

I convey my sincere condolences to Gus' family and loved ones for their loss. It is evident that he was both loving and well-loved by those that knew him, and was a deeply valued member of his community. His death would have been shocking and distressing for his family and friends.

ORDERS AND 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:

Tania Di Clemente, Senior Next of Kin

Dr Andrew Jacobs, Polaris Medical Centre

Dr Yves Choi, Consultant Geriatrician

VicRoads

Transport Victoria

Senior Constable Hayden Diepeveen, Coronial Investigator

Signature:

Coroner Ingrid Giles

Date: 19 June 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.