IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 003818

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Silvio Rolfo
Date of birth:	22 October 1967
Date of death:	13 July 2023
Cause of death:	1(a) Sudden and unexpected death in epilepsy
Place of death:	113 The Boulevard, Thomastown, Victoria, 3074
Keywords:	In care, epilepsy, intellectual disability

INTRODUCTION

1. On 13 July 2023, Silvio Rolfo was 55 years old when he died following an epileptic seizure at home. At the time of his death, Silvio lived at 113 The Boulevard, Thomastown, Victoria, a Supported Independent Living residence operated by Aruma.

2. Silvio was born in Australia and came from an Italian background.[1] He had a medical history that included lifelong intellectual disability, autism, anxiety, longstanding infrequent epilepsy, hyperlipidaemia, obsessive compulsive disorder with psychosis unspecified (schizophrenia related disorder) and severe behavioural problems.[2] He also had diagnoses of autism and anxiety,[3] had always been non-verbal, and required assistance with activities of daily living.[4]

3. Silvio grew up living with his parents and older brother, Aldo, but after his father died the family struggled to care for Silvio and he moved into state care at around the age of 14. With the assistance of social workers and advocacy on his behalf, Silvia eventually moved to the Aruma residence at around the age of 21,[5] where he remained living until his passing.

4. Aruma provides supports to people with disability, including home and living supports. At this particular location, Silvio had three housemates and support workers were present at the residence at all times, including a 'non-active sleepover shift', during which the rostered support worker would generally sleep from 10:00 pm until 6:30 am unless needed by one of the residents.[6]

5. Silvio had been a patient of the Lalor Plaza Medical Centre since 1999 and had been consulting with Dr Bikash Choudhury since March 2020. Silvio's last face-to-face consultation at the clinic was on 5 April 2023, at which time Dr Choudhury observed Silvio's behaviour to be reasonably stable and no other issues where identified.[7]

6. From March 2020, Dr Choudhury arranged annual reviews with neurologist Associate Professor John Archer to manage Silvio's epilepsy. At the time of his last review on 13 July 2022, A/Prof Archer considered that Silvio's behaviour had been stable, that there seemed to

[1] Statements of Aldo Rolfo and Daniella Jovanovski, Coronial Brief.
[2] Statement of Dr Bikash Choudhury, Coronial Brief. At the time of his passing, Silvio was prescribed Benztropine l mg BD, Citalopram 20mg, Clonazepam 0 .5mg, Epilium 1200mg mane and 1000mg nocte, Topiramate 50mg BD, Tegretol SR 200mg mane and 400mg nocte, Olanzapine 10mg QID, Neulactiul 10mg BD and Lipitor 20mg daily.
[3] Statement of Daniella Jovanovski, Coronial Brief.
[4] Statements of Dr Bikash Choudhury and Aldo Rolfo, Coronial Brief.
[5] Statement of Aldo Rolfo, Coronial Brief.
[6] Statement of Daniella Jovanovski, Coronial Brief.
[7] Report of Dr Bikash Choudhury, Coronial Brief.

have been a slight increase in seizures (one seizure in the preceding nine months, where previously seizures had occurred once every few years), but that Silvio's anti-epilepsy medication regime was appropriate and did not require alteration.[8]

THE CORONIAL INVESTIGATION

7. Silvio'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 is from natural causes, but in such a case, there is no requirement to hold an inquest.[9]

8. 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.

9. 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.

10. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Silvio's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, eye witnesses, support workers, treating clinicians, the forensic pathologist and investigating officers – and submitted a coronial brief of evidence.

11. This finding draws on the totality of the coronial investigation into the death of Silvio Rolfo 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.[10]

[8] Letter from A/Prof John Archer to Dr Bikash Choudhury dated 13 July 2022, Coronial Brief.
[9] Section 52(3A) of the Act
[10] 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

12. In considering the issues associated with this finding, I have been mindful of Silvio'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

13. Since 2022, Silvio was the subject of eight incident reports at his residence, and these were appropriately documented and triaged. In the eyes of his carers, there had been no recent decline in his health or deterioration of his behaviour.[11]

14. On 12 July 2023 at approximately 8:00 pm, Silvio retired to bed. At around 9:00 pm, support worker Neil Thrower gave Silvio his nightly medications in his bedroom. This medication included cholesterol medication, antipsychotics and other medications for his behavioural issues, anticonvulsants and other medications for his epilepsy and vitamins. At approximately 10:45 pm, Mr Thrower checked on Silvio and he appeared to be sleeping.[12]

15. On 13 July 2023 at 6:30 am, Mr Thrower recommenced duty. As per the normal morning routine for the household, Mr Thrower did not enter Silvio's bedroom, as being woken early was a trigger for Silvio's behaviours of concern as he struggled to wait for support staff to take him out for coffee.[13]

16. At approximately 8:05 am, the day shift support worker, Suren Lamichhane, entered Silvio's room to commence Silvio's morning routine, as was their usual practice if Silvio was not awake by this time. Mr Lamichhane found Silvio lying face-down on the floor next to his bed, body parallel to the bed, in a position consistent with him having fallen out of bed overnight. Ms Lamichhane attempted to lift Silvio, but realised he was cold to the touch.[14] Ms Lamichhane immediately contacted emergency services.

17. Ambulance Victoria members arrived at 8:25 am and Silvio was formally declared deceased at 8:34 am.[15]

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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.

[11] Statement of Danielle Jovanovski, Coronial Brief.

[12] Ibid.

[13] Ibid. See also Behaviour Support Plan – Comprehensive, dated 16 December 2022, Coronial Brief.

[14] Incident Report dated 13 July 2023 (Incident record number 445168), Coronial Brief.

[15] Ibid.

Identity of the deceased

18. On 13 July 2023, Silvio Rolfo, born 22 October 1967, was visually identified by his disability support worker, Neil Thrower. Identity is not in dispute and requires no further investigation.

Medical cause of death

19. Specialist Forensic Pathologist Dr Melanie Archer from the Victorian Institute of Forensic Medicine conducted an autopsy on 18 July 2023 and provided a written report of her findings dated 29 November 2023.

20. The post-mortem examination revealed noted a duplex left renal artery, thickened skull,[16] an abrasion over the right forehead, patchy chronic inflammation and foamy macrophages[17] in the lungs and mesial temporal sclerosis.[18]

21. Toxicological analysis of post-mortem blood samples identified the presence of prescribed medications consistent with the history given,[19] and did not identify the presence of any alcohol or other commons drugs or poisons.

22. Dr Archer provided an opinion that the medical cause of death was 1(a) sudden and unexpected death in epilepsy.

23. I accept Dr Archer's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Silvio Rolfo, born 22 October 1967;

    b) the death occurred on 13 July 2023 at 113 The Boulevard, Thomastown, Victoria, 3074, from sudden and unexpected death in epilepsy; and

[16] Hyperostosis frontalis interna.
[17] White blood cells which counter infections.
[18] Scarring in the deep part of the temporal lobe of the brain, typically associated with epilepsy.
[19] Citalopram (~0.2 mg/L), Carbamazepine (~5.8 mg/L), Carbamazepine 10,11-epoxide (~2.0 mg/L), Topiramate ~3.5 mg/L), Pericyazine (~0.02 mg/L), and Olanzapine (~0.4 mg/L) were detected in the sample.

c) the death occurred in the circumstances described above.

25. Having considered all of the circumstances, I am satisfied Silvio's care and treatment were appropriate, and that his death was the result of natural causes.

I convey my sincere condolences to Silvio's family and his carers for their loss.

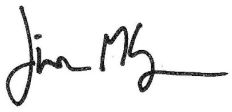
Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Aldo Rolfo, Senior Next of Kin

Senior Constable Danielle Ciavarella, Coroner's Investigator

Signature:



Coroner Simon McGregor

Date : 23 September 2024

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.