IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004039

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paul Lawrie
Deceased:	Danielle Jade Pezzutti
Date of birth:	13 January 1989
Date of death:	15 July 2024
Cause of death:	1a: RESPIRATORY FAILURE 1b: COMMUNITY ACQUIRED PNEUMONIA IN A WOMAN WITH CEREBRAL PALSY AND CRI DU CHAT SYNDROME
Place of death:	Sunshine Hospital 176 Furlong Road, St Albans Victoria 3021
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 15 July 2024, Danielle Jade Pezzutti was 35 years old when she died at Sunshine Hospital.

2. At the time of her death, Ms Pezzutti resided at 5 Baltusrol Close, Sunbury, a Specialist Disability Accommodation (**SDA**) dwelling enrolled under the National Disability Insurance Scheme. Ms Pezzutti received funded daily independent living support due to her diagnoses of intellectual disability secondary to cri du chat syndrome, cerebral palsy and epilepsy. Supports were provided by disability service provider, Possability Victoria.

3. Ms Pezzutti was mostly non-verbal, although she had a limited vocabulary. She was able to use body language and facial expressions to communicate with others. Her other medical conditions included incontinence, dysphagia, reflux, thoracolumbar scoliosis, various medication allergies and previous episodes of pneumonia.

4. Ms Pezzutti was described as a generally happy person who enjoyed listening to music and watching television.

THE CORONIAL INVESTIGATION

5. Ms Pezzutti's death fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**) as she was a 'person placed in custody or care' within the meaning of the Act, as a person with disability who received funded daily independent living support and resided in an SDA enrolled dwelling immediately prior to her death.[1] This category of death is reportable to ensure independent scrutiny of the circumstances leading to death given the vulnerability of this cohort. The coroner is required to investigate the death, and publish their findings, even if the death has occurred as a result of natural causes.

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.

[1] This class of person is prescribed as a 'person placed in custody or care' under the *Coroners Regulations 2019* (Vic), r 7(1)(d).

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 Danielle Jade Pezzutti 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.[2]

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

Circumstances in which the death occurred

9. On 11 July 2024, Ms Pezzutti attended her day placement service, Distinctive Options, as per her usual routine. However, after a short while, staff at Distinctive Options called Ms Pezzutti's carers as she was unwell and unsettled. Her carers collected her early and brought her home. Her temperature was normal and she had some afternoon tea without issue.

10. That evening, Ms Pezzutti refused her dinner and presented as sweaty with erratic breathing. Staff took her temperature and found it was elevated. They called Nurse-On-Call for advice, who in turn called an ambulance.

11. Paramedics arrived a short time later and transported Ms Pezzutti to the Sunshine Hospital Emergency Department. At Sunshine Hospital, she was diagnosed with right-sided pneumonia and was commenced on broad-spectrum antibiotics. Despite this treatment Ms Pezzutti's condition deteriorated and she was unable to tolerate an oxygen face mask. Following consultation with her mother, staff intubated Ms Pezzutti and transferred her to the Intensive Care Unit (**ICU**) on 12 July 2024.

12. In the ICU, staff consulted with Ms Pezzutti's family to discuss their wishes concerning active resuscitation should the need arise. Ultimately, they decided against this intervention.

[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.

13. On 13 July 2024, Ms Pezzutti's condition deteriorated significantly and she required high levels of ventilation support. ICU staff consulted with her family again and they jointly agreed to transition her to palliative care. Ms Pezzutti passed away in the early hours of 15 July 2024 surrounded by her family.

Identity of the deceased

14. On 16 July 2024, Danielle Jade Pezzutti, born 13 January 1989, was visually identified by her mother, Sharon Pezzutti.

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

Medical cause of death

16. Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine conducted an examination on 18 July 2024 and provided a written report of his findings dated 22 July 2024.

17. Examination of the post-mortem CT scan showed bilaterial lung consolidation, large effusions and possible radiopaque foreign body in the right midzone. The post-mortem examination was otherwise unremarkable.

18. Dr Burke provided an opinion that the death was due to natural causes the medical cause of death was 1(a) Respiratory failure secondary to 1(b) Community acquired pneumonia in a woman with cerebral palsy.

19. I accept Dr Burke's opinion save for the need to recognise a further underlying condition.

20. After Dr Burke completed his report, further information about Ms Pezzutti's medical history was provided, namely her diagnosis of cri du chat syndrome. While I accept Dr Burke's opinion, I intend to modify the cause of death to include cri du chat syndrome.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Danielle Jade Pezzutti, born 13 January 1989;

b) the death occurred on 15 July 2024 at Sunshine Hospital 176 Furlong Road St Albans Victoria 3021 from respiratory failure secondary to community acquired pneumonia in a woman with cerebral palsy and cri du chat syndrome; and

c) the death occurred in the circumstances described above.

22. There is nothing to suggest that the care received by Ms Pezzutti was anything other than appropriate.

ACKNOWLEDGEMENTS

I convey my sincere condolences to Ms Pezzutti's family, friends and carers for their loss.

I thank the Coronial Investigation and those assisting for their work in this investigation.

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.

Pursuant to section 49(2) of the Act, I direct the Registrar of Births, Deaths and Marriages to amend the cause of death to the following "1(a) RESPIRATORY FAILURE, 1(b) COMMUNITY ACQUIRED PNEUMONIA IN A WOMAN WITH CEREBRAL PALSY AND CRI DU CHAT SYNDROME".

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

Sharon Pezzutti, Senior Next of Kin

Western Health

First Constable Francis Keenan, Coronial Investigator

Signature:

Coroner Paul Lawrie

Date: 30 March 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.