IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 007153

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Kate Despot
Deceased:	Wayne Thomas Pistrucci
Date of birth:	5 August 1968
Date of death:	9 December 2024
Cause of death:	1a: End stage renal failure in a man with cerebral palsy
Place of death:	Bacchus Marsh Hospital 29-35 Grant Street Bacchus Marsh Victoria 3340
Keywords:	Specialist Disability Accommodation, SDA, supported independent living, disability support, natural causes

INTRODUCTION

1. On 9 December 2024, Wayne Thomas Pistrucci **(Mr Pistrucci)** was 56 years old when he died at Bacchus Marsh Hospital, Victoria.

2. Mr Pistrucci had cerebral palsy, intellectual disability and other medical conditions, including end stage renal failure and liver disease.

3. At the time of his death, Mr Pistrucci resided at a Specialist Disability Accommodation (**SDA**) dwelling enrolled under the National Disability Insurance Scheme (**NDIS**) and received 24-hour support from Possability.[1]

4. Mr Pistrucci maintained close family contact, especially with his mother and sister, and engaged in activities such as music, movies, art and craft, and socialising with friends.

THE CORONIAL INVESTIGATION

5. Mr Pistrucci's death fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**) as he was a '*person placed in custody or care*' within the meaning of the Act, as a person in Victoria who was an '*SDA resident residing in an SDA enrolled dwelling'* immediately prior to his death.[2]

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.

7. This finding draws on the totality of the coronial investigation into the death of Wayne Thomas Pistrucci including reports provided by police, the forensic pathologist, Possibility, and information from the National Disability Insurance Agency (**NDIA**). Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or

[1] Registered NDIS Disability Services Provider.
[2] *Coroners Regulations 2019* (Vic), r 7(1)(d).

necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[3]

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

Circumstances in which the death occurred

8. From late October 2024, Mr Pistrucci's health progressively deteriorated, including declining kidney and liver function, increased fatigue and sleepiness, reduced oral intake, and frequent vomiting.

9. On 1 November 2024, a Community Palliative Care nurse assessed Mr Pistrucci and created a palliative care plan to provide him with comfort care.

10. By early December 2024, his oral intake had significantly reduced, and he was observed to be displaying signs of increased distress and discomfort.

11. On 6 December 2024, Possability staff contacted his general practitioner, Dr Ravin Sadhai (**Dr Sadhai**), due to concerns about pain, minimal fluid intake, and overall deterioration. That same day, Dr Sadhai completed an assessment which identified that Mr Pistrucci was actively dying and required a higher level of symptom management.

12. Mr Pistrucci was transferred to the palliative care ward at Bacchus March Hospital for end of life care.

13. On 9 December 2024, Mr Pistrucci died at 4:20am.

Identity of the deceased

14. On 9 December 2024, Wayne Thomas Pistrucci, born 5 August 1968, was visually identified by a Possibility support worker, Tammy Bennet.

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

Medical cause of death

[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.

16. Forensic Pathologist Dr Joanne Ho from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 10 December 2024 and provided a written report of her findings dated 17 December 2024.

17. The post-mortem examination and a computed tomography (CT) scan were consistent with the clinical history. Toxicological analysis was not required.

18. Dr Ho provided an opinion that the medical cause of death was '*1(a) End stage renal failure in a man with cerebral palsy'.*

19. I accept Dr Ho's opinion that the cause of death was due to natural causes.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased is Wayne Thomas Pistrucci, born 5 August 1968;

    b) Mr Pistrucci's death occurred on 9 December 2024 at Bacchus Marsh Hospital, 29-35 Grant Street, Bacchus Marsh Victoria 3340 from 1a: End stage renal failure in a man with cerebral palsy; and

    c) his death occurred in the circumstances described above.

21. Having considered all the available evidence, I find that Mr Pistrucci's death was from natural causes and that no further investigation is required. As such, I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into his death and to finalise the investigation of Mr Pistrucci's death in chambers.

I convey my sincere condolences to Mr Pistrucci's family, friends and 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:

Brian Pistrucci, Senior Next of Kin

Jennifer McGuinness, Senior Next of Kin

Senior Constable Tinderpal Sidhu

Signature:

Coroner Kate Despot

Date: 04 August 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.