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IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 002370

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Kate Despot
Deceased:	Nadia Alderuccio
Date of birth:	24 July 1976
Date of death:	4 May 2025
Cause of death:	1a: Coronary artery atherosclerosis
Place of death:	77 Leonard Avenue Glenroy Victoria 3046
Keywords:	Specialist Disability Accommodation, SDA, supported independent living, disability support, natural causes

INTRODUCTION

1. On 4 May 2025, Nadia Alderuccio **(Ms Alderuccio)** was 48 years old when she died at her Specialist Disability Accommodation (SDA) dwelling enrolled under the National Disability Insurance Scheme (NDIS). supported accommodation in Glenroy.

2. Ms Alderuccio remained close with her parents and regularly spent time with them. She has two brothers and many nieces and nephews.

3. Ms Alderuccio had a relevant medical history including an intellectual disability and Trisomy 16.

THE CORONIAL INVESTIGATION

4. Ms Alderuccio'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 in Victoria who was an '*SDA resident residing in an SDA enrolled dwelling'* immediately prior to her death.[1]

5. 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.

6. This finding draws on the totality of the coronial investigation into the death of Nadia Alderuccio including reports provided by police and the forensic pathologist, 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 necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

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[1] *Coroners Regulations 2019* (Vic), r 7(1)(d).

[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.

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

Circumstances in which the death occurred

7. On 3 May 2025, Ms Alderuccio had dinner at 5:30pm. She did not finish the entire portion, took her medication and went to bed. She did not complain of pain or feeling unwell.

8. At 1:20am the following morning, Ms Alderuccio woke and indicated to her support worker that she was hungry and requested food. The leftovers from dinner were reheated, which she ate. Ms Alderuccio was assisted to return to her room and went back to bed.

9. Approximately ten minutes later, the support worker observed the hallway light to be turned on. The support worker located Ms Alderuccio on the floor of the main bathroom and observed her not to breathing. The support worker was unable to obtain a response and called emergency services prior to commencing cardiopulmonary resuscitation (CPR).

10. Fire Rescue Victoria and Ambulance Victoria (**AV**) attended the scene and continued CPR efforts, which were ultimately unsuccessful. There were no signs of trauma or other identifiable injuries that would indicate any suspicious circumstances.

11. Ambulance Victoria provided a verification of death certificate noting the time of death at 1:45am.

Identity of the deceased

12. On 4 May 2025, Nadia Alderuccio, born 24 July 1976, was visually identified by her support worker, Oparine Bongwa.

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

Medical cause of death

14. Forensic Pathologist Dr Joanne Ho from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 7 May 2025 and provided a written report of her findings dated 2 July 2025.

15. The post-mortem examination revealed severe atherosclerosis of the left anterior descending coronary artery, which was in excess for someone of Ms Alderuccio's age.

16. Dr Ho stated that

"*Coronary artery atherosclerosis occurs when there is a build-up of cholesterol and other material in the blood vessels that supply oxygen and other nutrients to the heart. This accumulation of material narrows the vessels and when this occurs, the amount of oxygen supplied to the heart is compromised and the ability of the heart to supply the body with oxygenated blood is compromised. These situations result in oxygen and other nutrients not being supplied to the heart and often cause sudden death. Risk factors for coronary atherosclerosis include increasing age, smoking, hypertension, family history, diabetes mellitus, obesity, and other factors such as hyperlipidaemia (high cholesterol)*."

17. A computed tomography (CT) scan showed coronary artery calcifications, a small pericardial effusion and bilateral pleural effusions, an old rib fracture.

18. Toxicological analysis of post-mortem samples identified therapeutic levels of prescribed medications. No alcohol was detected.

19. Dr Ho concluded the medical cause of death was 1(a) Coronary artery atherosclerosis.

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

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 is Nadia Alderuccio, born 24 July 1976;

    b) Ms Alderuccio's death occurred on 4 May 2025 at 77 Leonard Avenue, Glenroy, Victoria 3046 from 1a: Coronary artery atherosclerosis; and

    c) her death occurred in the circumstances described above.

22. The available evidence does not support a finding that there was any want of clinical management or care on the part of the service provider.

23. Having considered all the available evidence, I find that Ms Alderuccio'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 her death and to finalise the investigation of Ms Alderuccio's death in chambers.

I convey my sincere condolences to Ms Alderuccio'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:

Mrs Maria Alderuccio & Francesco Alderuccio, Senior Next of Kin

Senior Constable April Warren, Coroner's Investigator

Signature:

Coroner Kate Despot

Date: 21 July 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.