IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 002032

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paul Lawrie
Deceased:	Filippo Pignataro
Date of birth:	21 April 1971
Date of death:	10 April 2024
Cause of death:	PULMONARY THROMBOEMBOLISM
Place of death:	25 Hyde Street, Hadfield Victoria 3046
Keywords:	In care, natural causes

INTRODUCTION

1. On 10 April 2024, Filippo Pignataro was 52 years old when he passed away at his home in Hadfield, Victoria. At the time of his death, Mr Pignataro lived in specialist disability accommodation (**SDA**) operated by Life without Barriers.

2. Mr Pignataro was diagnosed with Autism and had an intellectual disability of "unknown specific diagnosis"[1]. He also experienced acute mental health issues, including psychotic episodes, as well as Type 2 diabetes mellitus, hypertriglyceridemia, osteoporosis and sleep disorder.

3. Mr Pignataro was cared for by his father until 2015, when moved into the Hadfield residence due to the advanced level of care that he required. He reportedly enjoyed living at this accommodation.

4. Mr Pignataro was close to his brother, whom he spoke to daily and saw regularly. He enjoyed riding his bike, going to the library, painting, watching movies, and supporting the Essendon Football Club.

5. Mr Pignataro was known to have a fear of hospitals and to sometimes express apprehension about going to hospital.

THE CORONIAL INVESTIGATION

6. Mr Pignataro'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 is a mandatory report to the coroner, even if the death appears to have been from natural causes. Mr Pignataro was a "person placed in custody or care" within the meaning of section 4 of the Act, as he was a "prescribed class of person"[2] due to his status as an "SDA resident residing in an SDA enrolled dwelling".

7. Senior Constable Jye Simpson was assigned as the Coronial Investigator for the investigation of Mr Pignataro's death. Senior Constable Simpson conducted inquiries on my behalf and compiled a coronial brief of evidence.

[1] Coronial brief, Statement of Dr Ian Bush.
[2] Section 4(2)(j)(i), *Coroners Act 2008* (Vic).

8. This finding draws on the totality of the coronial investigation into the death of Mr Pignataro 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.[3]

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

Circumstances in which the death occurred

9. On 24 March 2024, Mr Pignataro became unwell, exhibiting a fever, cough and runny nose.

10. On 25 March 2024 he attended a telehealth consultation with his general practitioner, Dr Ian Bush, who diagnosed him with a viral infection and advised him to take Panadol.

11. Mr Pignataro attended a face-to-face consultation with Dr Bush the following day, on 26 March 2024. Dr Bush took a nasopharyngeal swab for COVID-19 and other viral respiratory illnesses (which later returned a negative result) and made a differential diagnosis of viral or bacterial bronchitis or lower respiratory tract infection. He prescribed amoxycillin.

12. On 31 March 2024, Mr Pignataro was admitted to Northern Hospital in Epping, after his illness worsened. He was diagnosed with bacterial pneumonia and treated with antibiotics before being discharged on 6 April 2024, under the care of his general practitioner.

13. On 8 April 2024 Mr Pignataro attended a face-to-face consultation with Dr Bush. Mr Pignataro's cares reported that had not eaten well since his return from hospital, and he appeared weak. The following day, one of Mr Pignataro's carers advised Dr Bush that Mr Pignataro looked more energetic and his appetite was improving.

14. At 5.15pm on 10 April 2024, Mr Pignataro collapsed in the hallway of his residence. There were two disability support worker's present at this time. They responded immediately with cardio-pulmonary resuscitation (CPR) and contacted emergency services and Mr Pignataro's brother. After a very short period of CPR Mr Pignataro became responsive, and yelled "no paramedics, no hospital". Ambulance Victoria paramedics arrived a short time later at 5.30pm.

[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.

15. Mr Pignataro resisted attempts by the attending paramedics to monitor and examine him. The clinical findings they were able to obtain suggested he was medically unstable, and their primary concern was that he had a pulmonary embolism.

16. Despite attempts by paramedics to reassure Mr Pignataro, he continued to resist their efforts to manage his condition and transport him to hospital.

17. Paramedics administered 10mg of olanzapine. They also arranged for Mr Pignataro to speak to his brother on the phone, in the hope that this would assist him to accept medical care. However this was ultimately unsuccessful, and Mr Pignataro remained agitated.

18. Shortly afterwards, Mr Pignataro attempted to stand and immediately collapsed into cardiac arrest. The attending paramedics attempted life saving measures for approximately 40 minutes. Despite these efforts, Mr Pignataro could not be revived, and he was confirmed deceased at 7.00pm.

19. Members of Victoria Police attended and conducted an examination of the scene. They identified no suspicious circumstances in connection with Mr Pignataro's death.

Identity of the deceased

20. On 10 April 2024, Filippo Pignataro, born 21 April 1971, was visually identified by his brother, Vito Pignataro.

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

Medical cause of death

22. Forensic Pathologist, Dr Judith Fronczek from the Victorian Institute of Forensic Medicine conducted an autopsy on 16 April 2024 and provided a written report of her findings dated 5 July 2024.

23. The post-mortem examination revealed bilateral pulmonary embolism, mild chronic bronchitis in the left lung, patchy mild organising pneumonia (with no acute pneumonia), a remote infarct at the junction of the posterior wall to the left ventricle and the intraventricular septum, and moderate to severe hepatic steatosis (fatty liver).

24. Toxicological analysis of post-mortem samples identified the presence of metformin, sitagliptin, atropine, and hydroxyrisperidone. This was consistent with Mr Pignataro's prescribed medications and medications administered by the attending paramedics.

25. Dr Fronczek provided an opinion that the medical cause of death was "1(a) pulmonary thromboembolism".

26. Dr Fronczek further opined that Mr Pignataro's death was due to natural causes.

27. I accept Dr Fronczek's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Filippo Pignataro, born 21 April 1971;

    b) the death occurred on 10 April 2024 at 25 Hyde Street, Hadfield, Victoria, from pulmonary thromboembolism, and

    c) the death occurred in the circumstances described above.

29. There is nothing to suggest that the medical care provided to Mr Pignataro was anything other than appropriate.

I convey my sincere condolences to Mr Pignataro's family for their loss.

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

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:

Domenico Pignataro, Senior Next of Kin

Life Without Barriers

Ambulance Victoria

Senior Constable Jye Simpson, Coronial Investigator

Signature:

Coroner Paul Lawrie

Date: 13 January 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.