IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 002565

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Catherine Fitzgerald
Deceased:	Marcello Sardo
Date of birth:	1 August 1963
Date of death:	9 May 2024
Cause of death:	1a: Aspiration pneumonitis in a man with Down syndrome
Place of death:	Austin Hospital 145 Studley Road Heidelberg Victoria 3084
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 9 May 2024, Marcello Sardo was 60 years old when he died at the Austin Hospital, Heidelberg.

2. At the time of his death, Mr Sardo lived in Specialist Disability Accommodation (**SDA**) in Preston. He also received daily independent living support, which was provided by disability service provider Scope Australia. Both his accommodation and disability supports were funded by the National Disability Insurance Scheme (**NDIS**).

THE CORONIAL INVESTIGATION

3. Mr Sardo's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**).[1] 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 appears to have been from natural causes. Mr Sardo was a "*person placed in custody or care*" pursuant to the definition in section 4 of the Act, as he was "*a prescribed person or a person belonging to a prescribed class of person*" due to his status as an "*SDA resident residing in an SDA enrolled dwelling*".[2]

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, the identity of the deceased, the medical cause of death, and the 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.

5. 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.

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[1] Section 4(1), (2)(c) of the Act.

[2] Pursuant to Reg 7(1)(d) of the *Coroners Regulations 2019*, a "*prescribed person or a prescribed class of person*" includes a person in Victoria who is an "*SDA resident residing in an SDA enrolled dwelling*", as defined in Reg 5. I have received information that Mr Sardo resided at an address where the residents meet these criteria.

6. Victoria Police assigned First Constable Rebekah Brough to be the coronial investigator for the investigation of Mr Sardo's death. The coronial investigator conducted inquiries on my behalf and submitted a coronial brief of evidence.

7. This finding draws on the totality of the coronial investigation into the death of Marcello Sardo, including evidence contained in the coronial brief 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.[3]

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

Circumstances in which the death occurred

8. Mr Sardo lived with Down Syndrome and had developed early onset Alzheimer's Dementia, which led to a significant decline in his physical and cognitive function in the last two years of his life. His medical presentation also included epilepsy, intellectual impairment, hearing impairment, gout, behavioural issues, falls and pressure sores. Due to his intellectual impairment, Mr Sardo was unable to make decisions relating to his health and financial matters.

9. Mr Sardo had lived at the Scope residence in Preston since December 2019, after previously living with his mother. He received additional support from disability service provider Milparinka and he was regularly visited by his mother and brother. Mr Sardo required assistance with all his daily living activities and personal care and used an attendant-operated wheelchair for mobility.

10. Mr Sardo received regular medical care from General Practitioners which included consultation with his carers, preparing and reviewing treatment plans, arranging referrals to specialists and allied health professionals, arranging immunisations and general care as needed and conducting regular Comprehensive Health Assessments.

11. Since his diagnosis of Alzheimer's in 2019, Mr Sardo had been under the care of Geriatrician Dr Rohan Wee. Dr Wee documented on 21 February 2024 that Mr Sardo was "approaching

[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.

the end of his life due to his dementia". At that time, Dr Wee also discussed "end of life planning" and encouraged the involvement of community palliative care.

12. Between March and April 2024, Mr Sardo received palliative care from Melbourne City Mission's Palliative Care Team while continuing to reside at his accommodation. During this time, he continued to receive daily support from Scope staff, he was visited by Nuse Next Door services, and he received ongoing medical support from a GP.

13. On 24 April 2024, Scope staff noticed Mr Sardo was flushed, tired and had a fever. His breathing became laboured and he experienced tremors. He was transferred by ambulance to the Austin Hospital Emergency Department. He was treated and returned to his baseline. The hospital's palliative care team identified goals of care as comfort care only and he was discharged from hospital on 1 May 2024.

14. Mr Sardo developed another fever on 5 May 2024. After experiencing breathing difficulties that evening, he was transferred by ambulance back to the Austin Hospital, where it was assessed that his condition had acutely deteriorated. He had a new cough and decreased Glasgow Coma Scale score. A chest radiograph confirmed pneumonia. Despite treatment with antibiotics and intravenous fluid therapy, his condition continued to deteriorate. He was transitioned to end of life care, and on 6 May 2024 he was admitted to the hospital's palliative care ward.

15. Mr Sardo died peacefully at the Austin Hospital on 9 May 2024.

Identity of the deceased

16. On 9 May 2024, Marcello Sardo, born 1 August 1963, was visually identified by his residential carer Ebony Smith at the Austin Hospital. Identity is not in dispute and requires no further investigation.

Medical cause of death

17. Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine conducted an external examination of Mr Sardo's body on 13 May 2024 and provided a written report of his findings dated 14 May 2024.

18. A post-mortem CT scan showed peri-bronchial thickening and "tree in bud" pulmonary changes, and atrophic brain with symmetrical dilation of lateral ventricles.

19. The external examination was otherwise unremarkable.

20. Dr Burke found no evidence to suggest the death was due to anything other than natural causes.

21. Dr Burke provided an opinion that the medical cause of death was: "1(a) Aspiration pneumonitis in a man with Down Syndrome".

22. I accept Dr Burke's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Marcello Sardo, born 1 August 1963;

    b) the death occurred on 9 May 2024 at the Austin Hospital, 145 Studley Road, Heidelberg, Victoria 3084, from 1(a) aspiration pneumonitis in a man with Down Syndrome; and

    c) the death occurred in the circumstances described above.

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

I convey my sincere condolences to Mr Sardo'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:

Rosaria Sardo, Senior Next of Kin (C/- Pino Sardo)

Austin Health

Dr Mark Michail (C/- Avant Law)

Senior Constable Rebekah Brough, Coronial Investigator

Signature:

Coroner Catherine Fitzgerald

Date: 16 February 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.