IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 4317/10

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of PATRICIA JUNE ANDREW

Delivered On:	23 January 2012
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne
Hearing Dates:	23 January 2012
Findings of:	IAIN TRELOAR WEST, DEPUTY STATE CORONER
Police Coronial Support Unit:	Senior Constable Kelly Ramsey

I, IAIN TRELOAR WEST, Deputy State Coroner having investigated the death of PATRICIA ANDREW

AND having held an inquest in relation to this death on 23 January 2012
at Melbourne

find that the identity of the deceased was PATRICIA JUNE ANDREW

born on 24 December 1936

and the death occurred on 9 November 2010

at Wantirna Health, 251 Mountain Highway, Wantirna, Victoria 3152

from:

1a. END STAGE RENAL FAILURE

in the following circumstances:

1. Patricia Andrew, was a 73 year old woman who resided at a Department of Human Services community residential unit, situated at 3 Shelley Court, Ashwood. Ms Andrew suffered from Downs Syndrome and her medical history indicated an intellectual disability, Type 2 diabetes, Renal impairment and diabetic retinopathy. She had been in the Department's care since she was approximately 8 years of age and was transferred to the residential unit upon the closure of the Kew Cottages in 1997.

2. Ms Andrew's health had been deteriorating for some time and on 5 November 2010, she spent the day in bed and on the following day, staff noted that she was quite lethargic after consuming her lunch. Ms Andrew was given a shower and went to bed, with her being regularly checked on by staff during the afternoon. At approximately 4.00pm staff located Ms Andrew on the floor of her room, with it being apparent that she had fallen from her bed. After being placed in the recovery position she vomited, resulting in staff requesting ambulance attendance and her transfer to the Box Hill Hospital. Examination revealed that Ms Andrew was suffering a decreased level of consciousness and that cardio respiratory arrest was imminent. Ms Andrew's medical history clearly noted that she was not for cardio pulmonary resuscitation and accordingly, arrangements were made on 7 November for her to be transferred to a palliative care centre. On 9 November 2010, Ms Andrew was transferred to the Wantirna Palliative Care Unit in Wantirna, where she subsequently died later that day in the presence of her sister.

3. No autopsy was performed in this case as the coroner, on advice from Dr Sarah Parsons, Forensic Pathologist with the Victorian Institute of Forensic Medicine, directed that no autopsy was required. Dr Parsons performed an external examination of Ms Andrew at the mortuary, reviewed the circumstances of her death, the medical deposition and clinical notes, the post mortem CT scan and provided a written report of her findings. Dr Parsons reported that in all the circumstances a reasonable cause of death appeared to be end stage renal failure.

4. I find that Patricia Andrew died from natural causes with the cause of death being end stage renal failure.

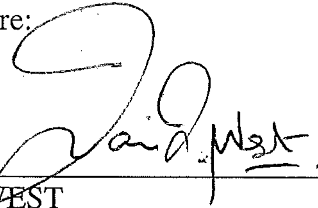
Pursuant to section 67(3) Of the **Coroners Act 2008**, I make the following comment connected with the death:

I find that there is no evidence to suggest that Ms Andrew's management was other than within the normal parameters of reasonable health care practice.

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

- Family of the deceased
- Department of Human Services

Signature:



IAIN WEST
DEPUTY STATE CORONER

23 January 2012