



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 005255

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	Coroner Kate Despot
Deceased:	Neville Stanley Andrews
Date of birth:	16 December 1953
Date of death:	20 September 2023
Cause of death:	1(a) Pericarditis
Place of death:	West Gippsland Hospital Landsborough Street Warragul, Victoria 3820
Keywords:	In care, disability support, natural causes

INTRODUCTION

1. On 20 September 2023, Neville Stanley Andrews (**Mr Andrews**) was 69 years old when he passed away at West Gippsland Hospital (**WGH**).
2. At the time of his passing, Mr Andrews resided in a Supported Disability Accommodation (**SDA**) in Drouin. He also received National Disability Insurance Scheme (**NDIS**) funded support and services.¹
3. Mr Andrews' medical history included atrial fibrillation, chronic kidney disease, congestive cardiac failure, and Fragile X Syndrome.²
4. The available evidence indicates Mr Andrews had an extensive period of hospital admissions between December 2022 and March 2023 due to cardiac and renal failure. According to Mr Andrews' disability home manager, his health condition had been in decline since discharge.³

THE CORONIAL INVESTIGATION

5. Mr Andrews' 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.
6. Mr Andrews death was reported to the Coroner because it fell within the definition of a reportable death in the Coroners Act 2008 (the Act). The reason for the report was that Mr Andrews was a "person placed in... 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". 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.
7. 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

¹ Court File (**CF**), NDIS plan belonging to Neville Andrews.

² CF, NDIS plan belonging to Neville Andrews and e-Medical Deposition completed by Dr Raymond Kaining.

³ Ibid.

purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

8. This finding draws on the totality of the coronial investigation into the death of Mr Andrews. 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.⁴

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

Circumstances in which the death occurred

9. On 19 September 2023, at 11:05 am, Mr Andrews was taken to the WGH Emergency Department (**ED**) with dyspnea after he sustained an unwitnessed fall.⁵
10. Mr Andrews was triaged and assessed by an ED physician at 12:07 am and was provided with a working diagnosis of an acute pulmonary oedema with congestive heart failure.⁶
11. Shortly after Mr Andrews was assessed, his respiratory condition deteriorated rapidly. At 2:20 pm, he was placed on a bilevel positive airway pressure (**BIPAP**) machine to assist his breathing.⁷
12. On the morning of 20 September 2023, treating physicians noted Mr Andrews' condition had not improved whilst he was on the BIPAP machine. A further discussion with his family was held, and they made a joint decision to transition Mr Andrews to comfort care. He sadly passed away at 10:20 am that morning.⁸

Identity of the deceased

13. On 20 September 2023, Neville Stanley Andrews, born 16 December 1953, was visually identified by his niece, Ms Linda Hair.⁹

⁴ 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.

⁵ CF, e-Medical Deposition completed by Dr Raymond Kaining.

⁶ Ibid.

⁷ Ibid.

⁸ Ibid.

⁹ CF, Statement of Identification dated 20 September 2023.

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

Medical cause of death

15. Forensic Pathologist Dr Paul Bedford (**Dr Bedford**) from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 26 September 2023 and provided a written report of his findings dated 9 November 2023.¹⁰

16. Dr Bedford provided an opinion that the medical cause of death was 1(a) Pericarditis. Dr Bedford determined that the death was due to natural causes.¹¹

17. I accept Dr Bedford's opinion.

FINDINGS AND CONCLUSION

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

- a) the identity of the deceased was Neville Stanley Andrews, born 16 December 1953;
- b) his death occurred on 20 September 2023 at West Gippsland Hospital Landsborough Street, Warragul, Victoria 3820 from pericarditis; and
- c) his death occurred in the circumstances described above.

I convey my sincere condolences to Mr Andrews' family and loved ones 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:

Ms Hazel Maurice, Senior Next of Kin

First Constable Emily Brook, reporting member

¹⁰ CF, Medical Examiners report of Dr Paul Bedford dated 9 November 2023.

¹¹ Ibid.

Signature:



Coroner Kate Despot

Date: 25 March 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.
