IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 3201

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	Simon McGregor, Coroner
Deceased:	**Leslie Roberts**
Date of birth:	26 January 1942
Date of death:	4 July 2018
Cause of death:	Hypothermia and multiorgan failure complicating compound left tibia and fibula fractures sustained in a fall
Place of death:	Bendigo Health (Bendigo Hospital), 100 Barnard Street, Bendigo Victoria 3550

INTRODUCTION

1. Leslie Roberts was a 76-year-old man who lived at 4/58 Panton Street, Golden Square Victoria 3555 at the time of his death.

2. Mr Roberts had a history of intellectual disability and was under the care of the Department of Health and Human Services (DHHS) at the time of his death.

THE PURPOSE OF A CORONIAL INVESTIGATION

3. Mr Roberts' death was reported to the Coroner as it appeared unexpected or unnatural or to have resulted, directly or indirectly, from an accident and so fell within the definition of a reportable death in the *Coroners Act 2008.*

4. 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.

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.

6. The Coroner's Investigator, Acting Sergeant Lincoln Owens prepared a coronial brief in this matter. The brief includes statements from witnesses, including carers, the forensic pathologist who examined Mr Roberts, treating clinicians and investigating officers.

7. After considering all the material obtained during the coronial investigation I determined that I had sufficient information to complete my task as coroner and that further investigation was not required. 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.

8. I have based this finding on the evidence contained in the coronial brief. In the coronial jurisdiction facts must be established on the balance of probabilities.[1]

[1] This is 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

9. In considering the issues associated with this finding, I have been mindful of Mr Roberts' basic human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

BACKGROUND

10. Mr Roberts suffered an intellectual disability and was under the care of the Department of Health and Human Services (DHHS). He had been under DHHS care since the late 1980s. Despite his mental impairment, he was able to live independently in rental accommodation with other Outreach clients and with the assistance of a carer twice a week.[2]

11. Department of Health and Human Services disability care worker, Greg Hunt, was Mr Roberts' carer for a period of approximately thirteen years. Mr Hunt would visit Mr Roberts every Tuesday and Friday at approximately 10.00am, to assist him with tasks such as reading mail, shopping and transportation to appointments.[3]

12. Mr Roberts was transitioning into aged care at the time of his death and was also receiving Friday visits from Bendigo Community Health worker, Jenny O'Hara. This relieved Mr Hunt from his usual Friday appointment with Mr Roberts.[4]

13. On 29 June 2018, Ms O'Hara contacted Mr Hunt and informed him that she was caught up with other commitments. She asked that Mr Hunt visit Mr Roberts. Mr Hunt visited and found Mr Roberts to be in good spirits. He left the visit with no reasons for concern.[5]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

14. On 2 July 2018, Golden Square Pharmacy attended Mr Roberts' unit to deliver his medication. Mr Roberts did not answer the door. This was unusual because he was always at home to receive his medication delivery.[6]

15. On Tuesday 3 July 2018, Mr Hunt was away from work on sick leave. He sent an email to his supervisor detailing his scheduled appointments, including Mr Roberts'. No one was rostered on to replace Mr Hunt. Subsequently, no one visited with Mr Leslie on 3 July

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the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[2] Statement of Lexie Williams dated 21 February 2019, Coronial Brief.

[3] Statement of Glen Hunt dated 25 January 2019, Coronial Brief.

[4] Ibid.

[5] Ibid.

[6] Statement of Glen Hunt dated 25 January 2019, Coronial Brief.

2018.[7] Mr Hunt's supervisor, Lexi Williams made a phone call to Mr Roberts but he did not answer. This did not cause Ms Williams concern. Ms Williams had tried to unsuccessfully call him in the past, with Mr Roberts later stating that he did not hear the phone ring.[8]

16. On 4 July 2018, Mr Hunt received a call from the Bendigo Hospital (the hospital) informing him that Mr Roberts was in a critical condition. The hospital asked Mr Hunt if he wanted Mr Roberts to be placed on life support. Mr Hunt replied that he was not the appropriate person to ask.[9] Mr Hunt immediately relayed the conversation to Ms Williams, who in turn went to the hospital.[10]

17. Once at the hospital, Ms Williams was advised that Mr Roberts had been brought in by ambulance with a broken leg.[11] Paramedics had located Mr Roberts unresponsive in his home after conducting a welfare check because moans had been heard from Mr Roberts' residence. Mr Roberts suffered a severe break to his lower left leg near his ankle.[12] Doctors advised that they had done everything they could do. Due to Mr Roberts' organs failing, the decision was made to palliate.[13]

18. Ms Williams sat with Mr Roberts for approximately two hours, before leaving to go back to work.[14] Mr Roberts was pronounced dead at 3.35pm.[15] Hospital staff called Ms Williams at approximately 3.45pm to advise that Mr Roberts had passed away.[16]

19. Ms Williams completed an incident report and forwarded it through to her manager. A debrief was conducted with all staff to raise concerns and check staff welfare. Ms Williams and Mr Hunt also held a debriefing to try and ascertain if anything could have been performed in a better way. Ms Williams states that it was deemed that everything had been completed as per usual procedure. 'Where a client lives alone, they are considered to be independent to a certain level, where 24hr [sic] care and monitoring is not necessary.'[17]

20. Mr Roberts' general practitioner, Dr John Kiefer of Bendigo Medical, states that Mr Roberts was not especially prone to falls and that his mental state and general health were good. Dr

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[7] Ibid.
[8] Statement of Lexie Williams dated 21 February 2019, Coronial Brief.
[9] Statement of Glen Hunt dated 25 January 2019, Coronial Brief.
[10] Ibid.
[11] Ibid.
[12] Statement of Senior Constable John Owens dated 13 February 2019, Coronial Brief.
[13] Statement of Lexie Williams dated 21 February 2019, Coronial Brief.
[14] Ibid.
[15] Statement of Senior Constable John Owens dated 13 February 2019, Coronial Brief.
[16] Ibid.
[17] Statement of Lexie Williams dated 1 July 2019, Coronial Brief.

Kiefer was surprised to hear that Mr Roberts had sustained such a serious lower limb injury, stating that he had no medical condition that would make him prone to falls or loss of consciousness.[18]

IDENTITY AND CAUSE OF DEATH

21. On 4 July 2018, Lexi Williams visually identified the body of her employer's client, Leslie Roberts, born 26 January 1942. Identity is not in dispute and requires no further investigation.

22. On 6 July 2018, Dr Linda Iles, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an external examination of Mr Roberts' body and reviewed a post mortem computed tomography (CT scan), the Bendigo Medical Centre Medical Record and the Police Report of Death for the Coroner. Dr Iles provided a written report, dated 25 July 2018, in which she formulated the cause of death as '*I(a) Hypothermia and multiorgan failure complicating compound left tibia and fibula fractures sustained in a fall*'.

23. Toxicological analysis of post mortem samples taken from Mr Roberts did not identify the presence of ethanol, common drugs or poisons.

24. I accept Dr Iles' opinion as to cause of death.

REVIEW OF CARE

25. In a subsequent statement obtained from Ms Williams, she states that upon Mr Hunt notifying her that he would be away on sick leave, she immediately checked the roster diary to see who could attend Mr Roberts' address. Ms Williams' initial statement details that 'no one was available to replace Greg on this day…'[19] Her office does 'not have the luxury of spare staff'.[20]

26. Ms Williams further states that she called Mr Roberts' several times throughout the day but there was no answer. This did not give rise to concern for Ms Williams' because Mr Roberts' was known to often be out and about during the day. 'He was very much a creature of habit, often getting home just before Greg attended his address as he knew these times.'[21]

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[18] Statement of Dr John Kiefer of Bendigo Medical dated 20 November 2018, Coronial Brief.
[19] Statement of Lexie Williams dated 21 February 2019, Coronial Brief.
[20] Statement of Lexie Williams dated 1 July 2019, Coronial Brief.
[21] Ibid.

27. She further states that when Mr Roberts' failed to answer his call after several attempts, she sent another care worker around to check on him. There was no answer at Mr Roberts' door. Again, no concerns were held because Mr Roberts' was known to often be out.[22]

28. Concern should have reasonably arisen when various attempts to contact Mr Roberts' both via phone and physical attendance were not met with a response. Especially, when some of these attempts were appropriately made at the time of Mr Roberts' appointment. According to Ms Williams' statements, Mr Roberts was always home at appointment times. He therefore, should have been home and able to answer the phone and door. His failure to do so should have been a trigger for a welfare check.

29. I note Ms Williams' statement that her office is only a small DHHS service and that the majority of the eight staff members are part-time workers. I further note that she does not have the authority to mandatorily call staff members in when they are not rostered on.[23]

30. I appreciate the efforts of DHHS workers operating in rural areas, often with limited resources and greater logistical requirements. I take issue not with the fact that Mr Hunt was not able to be covered on 3 July 2018 but rather, that an adequate welfare check was not conducted when every ordinary attempt to contact Mr Roberts' had failed.

31. In the absence of the capacity to attend directly (although I note another case worker was sent in between jobs), it would not have been an unreasonable stretch of available resources to make one more phone call Victoria Police or Ambulance Victoria to attend at Mr Roberts' residence. The decision to do so could have potentially saved Mr Roberts' life, although I am unable to say with the requisite certainty what level of probability, low or high, might have attached to that outcome.

32. Therefore, although I consider Mr Roberts' death to have been a preventable death, I intentionally refrain from making any finding or comment about whether the welfare check oversight had any causative role in the death.

[22] Ibid.
[23] Ibid.

FINDINGS AND CONCLUSION

33. I express my sincere condolences to Mr Roberts' family for their loss.

34. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) The identity of the deceased was Leslie Roberts, born 26 January 1942;

    (b) The death occurred on 4 July 2018 at Bendigo Health (Bendigo Hospital), 100 Barnard Street, Bendigo Victoria 3550 from hypothermia and multiorgan failure complicating compound left tibia and fibula fractures sustained in a fall; and

    (c) The death occurred in the circumstances described above.

35. Pursuant to section 73(1B) of the Act, I direct that this finding be published on the Internet.

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

    (a) Ms Leanne Bateson, senior next of kin

    (b) Jacinda de Witts, Department of Health and Human Services, interested party

    (c) Ms Stacy Thackray, Bendigo Health, interested party

    (d) Acting Sergeant Lincoln Owens, Victoria Police, Coroner's Investigator

Signature:

SIMON McGREGOR
CORONER
Date: 23 September 2019