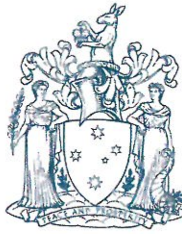
IN THE CORONERS COURT



Court Reference: COR 2015 5676

OF VICTORIA

AT MELBOURNE

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

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

I, AUDREY JAMIESON, Coroner having investigated the death of STEVEN PIMBLETT

without holding an inquest:
find that the identity of the deceased was STEVEN PIMBLETT
born 21 February 1968
and the death occurred on or about 6 November 2015
at 15 Bardia Street, Heidelberg West Victoria 3081
from:

1 (a) PNEUMONIA

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Steven Pimblett was 47 years of age at the time of his death. Steven lived with his brother Malcolm in Heidelberg West. The two brothers had lived at the family home their whole lives; both parents had passed away approximately eight to nine years earlier from cancer. Steven was believed to suffer from a mild intellectual disability. Malcolm was receiving disability services from the Banyule City Council, but Steven was not.

2. On Friday 6 November 2015 at approximately 8.00am, Malcolm awoke and tried talking to Steven, who was sitting with a blanket on the lounge room sofa watching the television. Steven would not answer; he had one eye open and his mouth was open. He was leaning to the side, so Malcolm moved him so he was sitting upright again. Malcolm went about his usual business, leaving Steven on the sofa. Later that day, Banyule City Council Care Worker Christine Panton arrived at the premises. Malcolm advised Ms Panton that he could not wake up his brother. Ms Panton tried to wake Steven, but realised that he was deceased. She called her office, who

contacted emergency services. Ambulance paramedics attended at 1.12pm and confirmed Steven was deceased.

INVESTIGATIONS

Forensic pathology investigation

3. Dr Sarah Parsons, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed an external examination upon the body of Steven, reviewed a post mortem computed tomography (CT) scan and referred to the Victoria Police Report of Death, Form 83. Dr Parsons reported that the post mortem CT scan showed remote right sided strokes, large cystic kidneys, left lower lobe consolidation and patchy coronary artery disease. Pneumonia was also identified on the post mortem CT scan. Dr Parsons ascribed the cause of Steven's death to pneumonia.

Victoria Police investigation

4. Upon attending the Heidelberg West premises after Steven's death, Victoria Police did not identify any evidence of third party involvement. The home was in a relatively neat and tidy state, with only moderate evidence of 'hoarding'.

5. Senior Constable (SC) Philip Pelgrim, the nominated coroner's investigator,[1] conducted an investigation of the circumstances surrounding Steven's death, at my direction, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by General Practitioner at the National Home Doctor Service Dr Vimal Chandran, Banyule City Council Home Support Worker Christine Panton and neighbours Victoria and Nicholas Sideras.

6. Victoria Sideras stated that she and her husband Nicholas had been neighbours and friends with the Pimblett family for approximately 18 years. Mrs Sideras said that both Steven and Malcolm suffered from mild intellectual disabilities, and lived relatively reclusively. However, they talked to Mrs Sideras and her husband almost every day. After the death of the brothers' elderly parents, Mr and Mrs Sideras provided basic neighbourly care and assistance. Mrs Sideras stated that this involved checking on them, making sure they were in good health, and

[1] A coroner's investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the coroner to assist the coroner with his/her investigation into a reportable death. The coroner's investigator takes instructions direction from a coroner and carries out the role subject to the direction of a corner.

assisting with tasks like cutting their hair and facial shaving. Mrs Sideras stated that they would also take them shopping and complete other tasks for them.

7. Mrs Sideras stated that Steven lived reclusively; he would refuse help from strangers, and steadfastly refused to accept outside assistance from council or health workers, beyond what was in place for Malcolm. Mrs Sideras had never known Steven to ever visit a doctor. Nicholas Sideras stated that both Steven and his brother were scared that someone would move them, and they did not want to be separated. Mr Sideras added that Steven would not go out anywhere.

8. Banyule City Council Home Support Worker Christine Panton stated that she attended Steven's home every Friday fortnight, as part of a weekly home care plan provided by the Council to Malcolm. Ms Panton confirmed that Malcolm was registered to receive intellectual disability services. Every alternate Friday, a fellow worker attended the same address. Home care duties included general vacuuming, mopping, toilet and bathroom cleaning, as well as changing bed linen.

9. Ms Panton stated that over the two months preceding Steven's death, she noticed his health was quite poor and deteriorating gradually. Steven was unable to stand or walk, and would wet his bed. Ms Panton stated that she would change Steven's bed linen and do a general clean up. She noticed that Steven's breathing was becoming quite laboured; his movements were very slow, he was barely able to put one foot in front of the other and he started to use a walking stick.

10. Approximately three weeks prior to Steven's death, Mrs Sideras stated that she noticed he was quite sick; his feet were very swollen, and he appeared to be housebound. Mrs Sideras said she was concerned for Steven's health, and contacted a doctor-on-call service for a home visit, approximately two weeks prior to his death.

11. General Practitioner Dr Vimal Chandran stated that he attended Steven's address on 23 October 2015, as an on call home visiting doctor with the National Home Doctor Service. Steven's right foot was swelling. Dr Chandran stated that Steven was alert but uncooperative and not responding verbally to his questions. As a result, Steven's history was collected with the assistance of the neighbours. At this consultation, Dr Chandran observed that Steven was not known to be on any medication and had a clear chest. The primary diagnosis was arthritis / inflammatory swelling.

12. Ms Panton said she was very concerned about Steven's condition on the last two visits she made to the brothers' home. She recalled saying to Malcolm, *'do you think he has had a stroke'?* Malcolm reportedly replied adamantly *'no he hasn't!'* Ms Panton said she did not mention this again fearing this would only aggravate matters with Malcolm. When she suggested to Malcolm that his brother needed to see a doctor, he would reportedly say *'I know'* in acknowledgment, but nothing would eventuate. Ms Panton said she hoped Malcolm would call a doctor, but she feared he would not, because Steven would refuse any assistance. She added that it was not her job to call or arrange for a doctor in this instance, as Malcolm was effectively the carer. Ms Panton said she could not override Malcolm if he never gave her consent, and he never did. She said that Malcolm had told her on previous visits, *'I am his carer, and I can't leave [him]'*. Ms Panton said she did not know whether Malcolm was Steven's official carer, but he had verbally intimated that he was.

13. Ms Panton stated that she did not report Steven's declining health to her manager Angela Brophy, as she presumed she would say they could not do anything, because he was not on the Banyule City Council's files so as to receive assistance. Ms Panton added that she had discussed the situation with Ms Brophy's Personal Assistant, who had checked the council's database and confirmed that Steven was not listed on the database as qualified to receive assistance. Ms Panton stated that Ms Brophy never told her directly that the council could not offer assistance to Steven, but she had reportedly said on a previous occasion that both Steven and Malcolm had rejected the suggestion of a case manager. Ms Panton said she felt at this time that the council could not do anything. She made the assumption that the council's hands were tied; they could not do anything because a case manager had not been assigned.

14. Ms Panton recalled that on either her second or third last visit to the brothers' home, she saw tablets on the coffee table in the lounge and was advised by Malcolm that they had called a night doctor attend. Ms Panton said she felt relieved that *'somebody had finally looked at'* Steven.

Coroners Prevention Unit review

15. Following the receipt of the coronial brief, I identified that Steven, a man with a mild intellectual disability, had died after he seemingly failed to receive appropriate medical attention while residing in the community. I asked the Coroners Prevention Unit[2] to review the

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[2] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the coroner with research in matters related to public health and safety and in relation to the formulation of

circumstances surrounding Steven's death, and to provide information about the processes in place to identify a person with a disability who requires support services.

16. As part of the review, further enquiries were directed to the Banyule City Council about its contact with Steven, and to determine if he was receiving disability support. By way of email dated 13 December 2016, John Minchinton, Coordinator of Home Support Services at Banyule City Council, advised the Court that: Steven was never referred to the council by any agency and there was no record of the council receiving a request to provide him with home support services; Malcolm was receiving home support services which would have benefitted the household; both Steven and Malcolm were receiving support from an outreach worker at the Department of Health and Human Services; all Aged Services staff have been trained to report all concerns about a client or the household to the relevant team leader in writing; and while a home support worker can refer a person to the Banyule City Council home and community care services, it does not guarantee services will be put in place. Each client is assessed for need and each client must approve their participation in the process. Mr Minchinton observed that if clients refuse service or contact, there is little the Council can do to assist.

17. The review identified that the original referral to the Council regarding the provision of home support services to the Pimblett household, was made by the then Department of Human Services in 1999. Further enquiries were made about regarding the Council's internal escalation process. Mr Minchinton outlined that staff are given a 'direction' to complete a 'Green Form', when escalating concerns about a client or a client's household. Mr Minchinton confirmed that the council did not receive a 'Green Form' or any written notification of Steven's deteriorating health.

18. By way of email dated 21 February 2017, Mr Minchinton provided further information to the Court. In particular, Mr Minchinton advised that the last review concerning the provision of home care assistance to Malcolm occurred in April 2014. At the time of the review, Steven was not present.

19. The review also sought information from the Department of Health and Human Services regarding its contact with Steven. It was ascertained that contact was first made in 1999 and a case management plan was organised, after he met with a mental health professional. At the time he was referred to an outreach program for four months, however, due to multiple changes

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prevention recommendations, as well as assisting in monitoring and evaluating the effectiveness of the recommendations. The CPU comprises a team with training in medicine, nursing, law, public health and the social sciences.

in case officer, the department's contact with Steven ceased. The Department advised that its most recent contact with Steven was in 2007, when he rejected an offer of assistance. The Department did not have record of any further contact with Steven.

20. The review concluded there were a number of issues relating to Steven's engagement with both the Department of Health and Human Services, and the Banyule City Council. In particular, the review identified that the Department lost contact with Steven in 1999, due to multiple changes in case workers. He was consequently not provided with individualised care and attention, but received only secondary care through his brother's contact with services.

21. In addition, the review identified that had a clear escalation policy and procedure for raising concerns about a client's household member, been in place at the Council, Steven's death may have been avoided in the circumstances. It was identified that instruction about completing the 'Green Form' takes place at induction training and that Council staff receive training up to four times a year. The last training session provided to Ms Panton was in May 2015, relating to workplace behaviour. Prior to 2015, the last training she received was in 2012.

FINDINGS

The investigation into Steven's death has identified that he suffered from a mild intellectual disability and lived reclusively, relying on his brother Malcolm and the kindness of his neighbours, as his health rapidly declined in the last months of his life. On the evidence available to me, Steven actively avoided seeking medical treatment and did not receive individualised support services from either the Department of Health and Human Services, or the Banyule City Council. It is concerning that despite Ms Panton's concerns about Steven's welfare and deteriorating health, a clear avenue for escalation at the Council – so that he could receive individualised support services, did not present itself. Consequently, significant opportunities were lost to provide specialised individual care to Steven in a coordinated manner.

I accept and adopt the medical cause of death as identified by Dr Sarah Parsons and find that Steven Pimblett died from natural causes, being pneumonia, in circumstances where I find that his death at home from this cause could have been avoided.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendations:

1. With the aim of providing appropriate services to people with disabilities and preventing like deaths, **I recommend that** the Banyule City Council develop and implement appropriate policies and procedures within the context of an overarching home care policy, for home care staff to support the escalation of health and welfare concerns about a client and/or household member.

2. AND **I further recommend** with the aim of providing appropriate services, that the Banyule City Council review its training for staff around their policies and procedures in general, but more specifically around the implementation of the new policies and procedures related to the home care policy as identified in Recommendation 1.

3. With the aim of providing appropriate services to people with disabilities and preventing the occurrence of like circumstances, **I recommend that** the Department of Health and Human Services, if it has not already done so, review its processes for maintaining a knowledge base about the needs of people requiring such services.

Pursuant to section 73(1A) of the *Coroners Act 2008,* I order that this Finding be published on the internet.

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

Mr Anthony Pimblett
Ms Kym Peake, Secretary of the Department of Health and Human Services
Banyule City Council

Signature:

AUDREY JAMIESON

CORONER

Date: **22 June 2017**