Coroners Act 1996

[Section 26(1)]

Western  ***Australia***

RECORD OF INVESTIGATION INTO DEATH

Ref No: 41/13

I, Barry Paul King, Coroner, having investigated the death of ***Robert Roll*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth,*** *on* ***14 and 15 to October 2013****, find that the identity of the deceased person was* ***Robert Roll*** *and that death occurred* ***between 22 July 2009 and 20 October 2009*** *at* ***Unit 38, 601 Wellington Street, Perth,*** in *the following circumstances:*

Counsel Appearing:

Kate Ellson assisting the Coroner
Carolyn Thatcher (State Solicitor's Office) appearing on behalf of the Housing Authority

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INTRODUCTION

1. Robert Roll (**the deceased**) was a socially isolated 75 year old pensioner who lived alone in a second floor unit rented from the Housing Authority.

2. On 20 June 2009 he attended Royal Perth Hospital where he was diagnosed with terminal lung cancer.

3. On 6 July 2009 the deceased left the hospital and returned home. Arrangements were made for Silver Chain Hospice Care nurses to assess him and provide care in his home, but after he refused their assistance care providers made no further contact with him.

4. By the end of July 2009 the deceased was no longer paying his utilities bills or withdrawing funds from his bank account. His rent continued to be paid automatically.

5. In mid-2010 other tenants on the same floor as the deceased noticed a foul smell, but the smell was thought to be coming from a unit other than the deceased's.

6. In July 2011 one of the deceased's neighbours with whom he had been friendly noticed that his mailbox on the ground floor was full, so she notified the building manager who undertook a welfare check on the deceased.

7. The building manager found the deceased in his unit, obviously dead and in an advanced state of decomposition.

8. Given the state of the deceased's body when it was found, it was not possible for forensic pathologists to determine the cause of death. Nor was there sufficient evidence upon which a finding of a manner of death could be based.

9. An inquest was held on 14 and 15 October 2013. One focus of the inquest was on the circumstances surrounding the delay of the discovery of the deceased

and on possible means by which such a delay could be avoided in similar circumstances in the future.

10. A source of confusion that has arisen since the inquest was the use of the terms 'Housing Authority' and 'Department of Housing' (the DOH).

11. Section 11 of the *Housing Act 1980* provides that a body corporate and Crown agency called the Housing Authority is, subject to the control and direction of the relevant Minister, responsible for the implementation of that Act and the *Government Employees Housing Act 1964*. The Housing Authority has a chief executive officer and officers under the *Public Sector Management Act 1994* but may make use of departmental officers and facilities.[1]

12. The *Residential Tenancies Act 1987* also refers to the Housing Authority and not to the DOH as the provider of social housing premises.[2]

13. That the Housing Authority was the owner and manager of the deceased's unit is consistent with the fact that Ms Thatcher of the State Solicitor's Office appeared at the inquest for the Housing Authority and its employees called to give evidence.[3]

14. However, correspondence between Counsel Assisting and the DOH that was accepted into evidence refers only to the DOH and not to the Housing Authority. The signatory of the correspondence from the DOH gave evidence in which he referred to the DOH and not to the Housing Authority, and the DOH website likewise makes no mention of the Housing Authority.

15. As a result, as a matter of convenience I have referred to the DOH as the owner and manager of the deceased's unit though the term should be taken to include the Housing Authority.

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[1] ss17 and 18A *Housing Act 1960*
[2] Part V, Div 3
[3] ts 2

THE DECEASED

16. The deceased was born in Newcastle in England on 26 March 1936. He had three sisters and one brother.

17. The deceased trained as a welder in the shipbuilding industry after he left school. He worked with his father in that trade. He worked in Bahrain before immigrating to Australia in November 1973.

18. Here in Australia the deceased worked as a welder in various places in Western Australia, on lobster fishing boats out of Dongara and as a maintenance mechanic on a farm. He loved working on the lobster fishing boats.[4]

19. In 1986 the deceased apparently fell and sustained a head injury causing a large intra-cerebral haematoma in the left parietal region with mass effect.[5] The fall may have been caused by a stroke.[6]

20. From 1986 to 2001 the deceased received a disability support pension. From 2001 he received the age pension.

21. The deceased was a talented painter and writer, and he was fond of racing dogs. He never married and lost contact with his family in England over the years, possibly because of the effects of the head injury in 1986.[7]

22. The deceased smoked and consumed alcohol regularly for many years. Between 1991 and 2005 he had a number of presentations at the emergency department of Royal Perth Hospital following falls associated with alcohol intoxication.[8] He continued to smoke until his death.

23. In June 1996 the deceased moved into Unit 38 in a block of units owned by the DOH at 601 Wellington Street in

[4] Ex 1, Vol 1, Tab 12
[5] Ex 1, Vol 1, Tab 37
[6] Ex 1, Vol 1, Tab 10
[7] Ex 1, Vol 1, Tab 15
[8] Ex 1, Vol 1, Tab 37

the Perth central business district. Of the 79 units in the block, the DOH managed 65. The DOH had offices at 605 Wellington Street in a building effectively within the same complex as the deceased's unit.

24. The deceased lived alone without a telephone or a computer. He had a television which, it appears, he watched regularly.[9] He had no close friends.

25. At least by 2009, few of his fellow tenants knew him. One exception was Barbara Mansell, who had lived on another floor in the block since 1994. At one stage she had organised a social club for tenants and had met the deceased through that club. As both she and the deceased were from the United Kingdom, they would joke about the deceased taking Ms Mansell back there if he won lotto. They would see each other two or three times a week in passing, but did not visit each other at their respective units. Ms Mansell would not go onto the floor on which the deceased lived because of ongoing problems she experienced with another tenant on that floor.

THE DECEASED'S LAST CONTACTS

26. On 20 June 2009, the deceased attended the emergency department at Royal Perth Hospital. After examinations he was found to be suffering from a large tumour in his left lung.

27. On 24 June 2009 a social work member of the respiratory team at Royal Perth Hospital assessed the deceased. The deceased told the social worker that he was not at his normal functional level and that he felt physically weak and forgetful. A plan to liaise with the treating team regarding his referral to the department of geriatric medicine was established to provide for further review.[10]

[9] Ex 1, Vol 1, Tab 12
[10] Ex 1, Vol 1, Tab 25

28. The following day, the deceased was transferred to the radiation oncology team which then referred him to the palliative care team for management advice. He was also referred to the hospital's department of geriatric medicine for an aged care assessment.[11] Hospital notes from Royal Perth Hospital made available to me after the inquest make clear that the fact that the deceased was 'very socially isolated and not likely to cope well with the effect of his lung tumour' was well known.

29. I infer from that history that the deceased's illness was assessed to be too far advanced to attempt treatment. It is likely that he had only weeks left to live.[12]

30. On 30 June 2009 the deceased spoke to the palliative care social worker from Royal Perth Hospital about signing an aged care client record (**ACCR**), which would have led to the deceased having access to Commonwealth funded aged care services.[13] He was reluctant to sign an ACCR and instead wanted to go home.[14] A plan was made to discharge him with a home care package and to refer him to Silver Chain Hospice Care (**Silver Chain**).[15]

31. Over the following week, the deceased became independent on the ward; he was pain free and asymptomatic. Arrangements were being made for him to be referred for an interim Royal Perth Hospital home care package which would have provided him with a few weeks of in-home care pending the provision of care from Silver Chain.[16]

32. On the morning of 6 July 2009 the deceased was to see a palliative care social worker to arrange for the home care package, but he discharged himself before these arrangements could be put in place.[17]

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[11] Ex 1, vol 1, Tab 25
[12] ts 72
[13] Ex 1, Vol 1, Tab 25
[14] Ex 1, Vol 2, Tab 4
[15] Ex 1, Vol 1, Tab 48
[16] ts 26-27
[17] Ex 1, Vol 1, Tab 25

33. The deceased returned to the hospital later in the day because he had forgotten to collect his keys and medication. As he was already discharged, he was no longer eligible for the interim home care package,[18] but he spoke to a palliative care social worker and agreed to receive in-home support services. He signed an ACCR for residential care.[19]

34. Although the deceased agreed to go into residential care, he was insistent on returning home for as long as he could manage.[20] He was referred to Silver Chain and an appointment was made for palliative radiotherapy on 18 August 2009 at Royal Perth Hospital.[21] It is possible that he also had an appointment on 9 July 2009 for radiotherapy which he did not attend, but this is unclear.

35. On 8 July 2009, a social worker from the department of geriatric medicine at Royal Perth Hospital phoned, and may have sent a facsimile referral to, Mercy Community Aged Care ('Mercy') and Bethanie Aged Care ('Bethanie') for the deceased to receive a community aged care package. Such a package would have entitled the recipient to receive five hours of assistance per week in the form of domestic assistance, shower assistance, meal preparation and shopping.[22]

36. Staff at Mercy placed Mr Roll on a waiting list the same day,[23] and the palliative care specialist at Royal Perth Hospital was informed. However, Mercy did not receive the necessary documentation from an aged care assessment team, so did not contact the deceased.[24] There is no record that any follow up call was made by anyone to determine if the deceased required his care package.[25]

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[18] Ex 1, Vol 1, Tab 25
[19] Ex 1, Vol 1, Tab 25
[20] Ex 1, Vol 1, Tab 48; Tab 27
[21] Ex 1, Tab 25
[22] Ex 1, Tab 27
[23] Ex 1, Vol 1, Tab 25, Tab 27
[24] Ex 1, Tab 27
[25] Ex 1, Vol 1, Tab 4, p 5

37. Bethanie had no record that it had received the referral at all.[26]

38. Fortunately, on 9 July 2009 Silver Chain registered nurse Susan Mary Rose went to the deceased's unit and, after getting no response at his door, elicited the help of the DOH office manager to let her into the unit where they found the deceased on his bed. He was distressed that they had entered his unit, but agreed for Nurse Rose to return on 13 July 2009.[27]

39. On 13 July 2009 Nurse Rose attended at the deceased's unit with a Dr Cummins in order to admit the deceased to the Silver Chain service. They noticed that the deceased was very thin and was a bit paranoid. They were concerned that the deceased may have been affected by alcohol. He wanted to speak only about 'Homeswest' (the DOH), so they were not able to complete the admission. At that stage, the deceased agreed that Nurse Rose could return later in the week. She planned to return with a mobile phone for the deceased to use.[28]

40. On 14 July 2009 Nurse Rose went back to the deceased's unit to complete the admission procedure and to leave him a mobile phone. The deceased was angry with her, stating that she and Dr Cummins had joined the conspiracy led by social workers at Royal Perth Hospital to control him. The deceased refused the mobile phone and refused assistance, and he accused Nurse Rose of stealing money and cards from him on the previous visit.

41. On 22 July 2009, Nurse Rose and Clinical Nurse Consultant Lorraine Gray went to the deceased's home. He would not let them in or talk to them. That was the last recorded instance of the deceased being seen alive.

42. On the next day, Silver Chain workers held a team meeting and decided to 'separate' the deceased from their care although they agreed that he was clearly in need of assistance. Silver Chain was then to take steps to notify

[26] Ex 1, Vol 1, Tab 4, p 5
[27] Ex 1, Vol 2 Tab 48
[28] Ex 1, Vol 2, Tab 48

the deceased of their decision by letter and to inform the referral source; namely the Royal Perth Hospital palliative team doctor and clinical nurse.[29] Documentary evidence supports the contention that Silver Chain did contact Royal Perth Hospital by fax, but mail found at the deceased's unit and in his mailbox did not include written notification from Silver Chain.

43. It is unlikely that the palliative team at Royal Perth Hospital attended the deceased's unit to attempt to provide follow-up assistance, and he could not be contacted any other way.[30]

44. The deceased's mental state had not been formally assessed at any relevant stage, but there was no indication that he was suffering from a mental illness during the time that he was admitted to Royal Perth Hospital.

AUGUST 2009 TO JULY 2011

45. The deceased did not attend his palliative radiotherapy appointment on 18 August 2009.[31]

46. On 24 August 2009, the deceased was sent a bill by Alinta Gas for $275.55 for gas consumption from 22 May 2009 to 20 August 2009. An overdue notice was sent on 14 September 2009, and a reminder notice was sent on 21 September 2009.

47. On 29 September 2009 Alinta sent the deceased a notice that the gas would be turned off for non-payment. The gas was turned off at the meter on 20 October 2009.

48. On 13 November 2009 Alinta sent the deceased another bill, this time for $256.55 for gas consumption from 20 August 2009 to 9 November 2009. A final reminder notice was sent on 4 December 2009 and on 14

[29] Ex 1, Vol 2, Tab 48; ts 88
[30] ts 91
[31] Ex 1, Tab 4, p 5, Running Sheet p12 re 14:20 12 July 2011

December 2009 Alinta sent the deceased notice of legal action to recover the debt. [32]

49. In the time the deceased had lived in his unit, he had never had a gas bill as large as the two bills of 24 August 2009 and 13 November 2009. It may have been that his gas room heater had been left on for much of the time covered by the bills.

50. On 20 November 2009 and 18 December 2009 Synergy sent the deceased warnings for non-payment of his electricity bill. On March 2010 his account was referred to Western Power for disconnection. His account was not paid and the electricity was disconnected on 21 May 2010.[33]

51. The deceased paid rent to the DOH by automatic deductions from his pension payments, so his rent continued to be paid until his remains were found in July 2011. He had last used his bank account on 10 July 2009 when he withdrew $500.

52. The DOH had a policy of conducting yearly inspections of its rental premises, but the last inspection of the deceased's unit before he was found was in April 2008.

53. Inspections of the deceased's unit had been scheduled for 2009, 2010 and 2011, but they did not occur. In the latter case, a housing service officer scheduled an inspection, knocked on the deceased's door and left a card for the deceased to contact her when he did not come to the door.[34]

54. A few weeks before the deceased was found, the deceased's friend Ms Mansell tried to contact the building manager by telephone to inform him that the deceased's letter box was full. She left a message on the answering machine to that effect.[35]

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[32] Ex 1, Vol 1, Tab 29
[33] Ex 1, Vol 1, Tab 28; Ex 1, Vol 1, Tab 4, p 6
[34] ts 61
[35] Ex 1, Vol 1, Tab 10; ts 52

55. After not seeing any removal of the deceased's mail by 6 July 2011, Ms Mansell again rang the building manager and this time was able to report the situation to Jeremy Auld, an employee of the DOH at 605 Wellington Street, Perth.[36]

56. After investigating records and potential contacts in an effort to determine whether the deceased had any next of kin or medical support, Mr Auld knocked on the deceased's door and left a card when there was no answer. He then went back to his office and emailed his area manager in order to get approval to carry out a welfare check.[37]

57. On 7 July 2011 Mr Auld and another DOH employee let themselves into the deceased's unit with a master key. The doorway had cobwebs draped across it. They found the deceased's body in the bedroom, decomposed to the state of a skeleton. They returned to their office and told their area manager, Lesley Jackson, of what they had found. Ms Jackson called the police, who attended shortly thereafter.[38]

REVIEWS OF DOH

58. Following the discovery of the deceased, the DOH conducted its own investigation[39] and commissioned a review by an independent consultant, Applied Innovation Centre,[40] to examine the circumstances and causes of the delay in finding the deceased.

59. Those investigations yielded the following major findings:

    a. a combination of management deficiencies, staff underperformance, high workloads, difficult and sometimes aggressive tenants, computer system and data deficiencies and lack of adequate training for

[36] Ex 1, Vol 1, Tab 23
[37] Ex 1, Vol 1, Tab 23
[38] Ex 1, Vol 1, Tab 23
[39] Ex 1 Vol 3, p 226
[40] Ex 1, Vol 2, Tabs 51 and 52

staff resulted in a serious departure from the policy of regular inspections;

b. there were no instances of staff behaviour warranting disciplinary action;

c. to address these deficiencies, better management by area managers and team leaders, greater stability of staffing, an improved computer system and proper training of that system were required;

d. the DOH had taken significant steps to rectify those deficiencies since the deceased was found;

e. the lack of inspections together with the deceased's refusal to allow Silver Chain to provide him with services led to his body not being detected for nearly two years;

f. even if inspections had been carried out every year, at least eight months would have elapsed before the deceased would have been found;

g. also relevant to the delay in finding the deceased were:

    i. the deceased's reclusive lifestyle;

    ii. the lack of interaction between tenants on the deceased's floor;

    iii. anti-social behaviour by one tenant on the floor which caused tenants from other floors not to visit;

    iv. the secluded position of the deceased's unit;

    v. a lack of significant odour from the decomposition of the deceased's body;

    vi. the lack of notice to the DOH by Alinta or Synergy of the disconnection of service to the deceased's unit; and

vii. the direct payment of the deceased's rent.[41]

60. The Applied Innovation Centre review recommended that the DOH implement a process of welfare checks of tenants who may be isolated for any reason and that the DOH establish a process whereby service utilities notify the DOH of unpaid bills by tenants when the tenants do not respond to notices in order to alert the DOH of the possible need for a welfare check.

61. The review also recommended that, with the respective tenant's consent, community support agencies notify the DOH that support is being provided and, if the support is reduced, that welfare checks may be necessary.

DOH IMPROVEMENTS

62. As a result of the reviews, the DOH made a number of changes to its procedures. In particular, inspections became mandatory once every 365 days with the focus being on ensuring that the properties are compliant with safety requirements instead of being on whether the properties were properly maintained.

63. The DOH reduced the workload of employees responsible for carrying out inspections, housing service officers, by reducing their role in dealing with anti-social behaviour. That change was implemented with the injection of substantially increased government funding and the consequent establishment of a specialist team, the Disruptive Behaviour Management Unit.[42] A new contact centre to deal with many tasks previously directed to housing service officers further reduced their workload.[43]

64. The DOH has also streamlined the inspection process by improving the mobile computing device used during inspections. This has apparently provided significant benefits including increased productivity.[44]

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[41] Ex 1, Vol 2, Tab 52
[42] Ex 8, p 4-5
[43] Ex 8, p 5
[44] Ex 8, p 5

WELFARE CHECKS BY DOH

65. As to the Applied Innovation Centre's recommendations relating to welfare checks, the Court was told that the DOH initiated a project to investigate whether the recommendations could usefully be applied to its tenancy management.[45] On 31 January 2012 the DOH appointed a project manager to oversee the DOH's progress in implementing the recommendations. As at 6 October 2013, the recommendations had either been implemented, were in the process of being implemented or had been fully considered and had not been implemented.

66. Despite barriers arising from privacy issues, the project concluded that an arrangement with utility services providers Synergy and Alinta could be implemented, but that it would not be effective because many tenants use an automated CenterPay system and are low users of power. It could take a tenant a year to reach the stage where disconnection is initiated. The costs associated with putting the process in place would be high and the value would be low.[46] The DOH determined not to implement this recommendation.[47]

67. The DOH is still considering whether it would be worth pursuing an arrangement with the Water Authority in which notification of low water bills might trigger a welfare check. This possibility has the advantage that the DOH is the account holder with the Water Authority, so the issue of confidentiality that attaches to Alinta and Synergy accounts would not arise.

68. The process of implementing a process of welfare checks based on low water bills is currently in abeyance pending the replacement of the DOH's new core computing technology.[48]

69. The project concluded that an arrangement could also be put in place for community support service providers

[45] Ex 7 p 1
[46] ts 144
[47] Exhibit 9, p 7
[48] ts 145

such as Silver Chain to notify the DOH if the service was reduced or discontinued, but that it would be impractical as it could only apply to tenants who consented.

70. The DOH considered the practicability of providing regular welfare checks of elderly tenants living alone, but determined that the value to be derived from the process would not justify the cost of resources to implement it.[49] An important consideration was the fact the DOH's statutory role is to provide affordable and safe accommodation; it is not a welfare provider.

71. That latter point was also emphasised by Steve Parry, the DOH General Manager Service Delivery, who provided the Court with comprehensive evidence of the DOH's consideration of issues relevant to this inquest.

72. Mr Parry advised that the DOH had determined not to provide formal and regular welfare checks effectively because it was not the DOH's role to do so.[50]

73. Mr Parry noted that, because of privacy reasons, community service agencies such as Silver Chain will not advise the DOH of its tenants' needs or issues, so it has little knowledge of its tenants.[51]

74. However, notwithstanding the limitations on the DOH's responsibilities, the DOH does provide welfare checks on an ad hoc basis. An experienced housing service officer, Vicki Piormalli, described how she conducts welfare checks if she is concerned about tenants because of information received, usually from doctors or social workers.[52] She said that there is no DOH procedure for such checks, but 'human nature kicks in and you just want to make sure that someone's ok.'

75. Ms Piormalli said that conducting welfare checks was beyond her normal duties but that it was not much of an imposition, especially when it came to elderly tenants.[53]

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[49] ts 152; Ex 7, p 2
[50] ts 149
[51] ts 125
[52] ts 66, 69
[53] ts 70

76. Mr Parry said that the process of ad hoc welfare checks has been in place for many years.[54] When staff members are approached to check on tenants, they are to ensure that they are not making inappropriate contact in contravention of the *Residential Tenancies Act 1987,* and they are to seek the permission of a senior officer. Mr Parry said that there is no formal system, and the DOH is not a human service agency, but when circumstances present themselves to the DOH, they try to play the role of a good citizen.[55] If the DOH does not have a key to the relevant unit, police are called to attend.[56]

77. Mr Parry said that his preference, and I infer that to mean his strong preference, is to maintain the existing process of ad hoc welfare checks when officers are contacted and asked to assist, but not to introduce a formalised process where the DOH undertakes regular checks of a particular cohort.[57]

DISCUSSION

78. As submitted by Ms Thatcher, it offends us as a society for the deceased to have died alone and to have his death not discovered until his remains were skeletal, especially when it occurred in a densely populated area with many other people so close by.[58]

79. When the deceased died and stayed undiscovered for so long in residential premises owned and managed by a government agency, we may well ask how such a thing could have occurred and what has been done to ensure so far as practicable that it does not happen again.

80. However, of much greater importance in my view is that, in the absence of procedure for regular monitoring, a socially isolated person with a serious illness may have

[54] ts 124
[55] ts 126
[56] ts 139
[57] ts 163-164
[58] ts 176

been alive and in distress for a prolonged time without any hope of being assisted.

81. The evidence at the inquest explored the potential role of the DOH in performing welfare checks, but there are a number of key factors relevant to the deceased's case that must be kept in mind.

82. First, as emphasised by the DOH, the DOH is empowered and obliged by legislation to deal with property, to develop and manage property, and to make loans in order to provide and improve housing in Western Australia; it is not empowered or obliged by statute to carry out a social assistance role outside its property-related functions. It could not oblige the deceased or community service providers to provide it with private or confidential information, and it could not disturb the deceased's right to quiet enjoyment under the terms of the tenancy agreement.

83. Second, to a degree beyond most private landlords, the DOH has a policy of leaving its tenants alone provided they, like the deceased, get on with their neighbours, look after their homes and pay their rent.[59] That policy is manifested in the DOH's annual inspections of properties rather than quarterly inspections as are carried out in the private rental market. I have no doubt that most, if not all, of the DOH's tenants prefer annual rather than quarterly inspections.

84. Third, the deceased had withdrawn from society. While in the end it appears that he may have turned away the assistance offered by Silver Chain because he was partially afflicted by paranoid delusions, that is not clear.

85. The deceased appears to have withdrawn from society well before his illness was diagnosed, but it is difficult to conceive that anyone would have consciously chosen to suffer the pain associated with terminal cancer when help in the form of free palliative care was available. Because of that, it is possible, if not probable, that the

[59] ts 125

deceased was unable to seek assistance for himself when he most needed it.

86. Fourth, had the DOH carried out inspections in 2009 and 2010 in accordance with its policy, the deceased would still not have been found for several months.

87. Fifth, arrangements had been made for the deceased to be provided with care in his home by Mercy but, for reasons not apparent, Mercy did not receive the necessary documentation from Royal Perth Hospital. It is unlikely that Mercy tried to contact the deceased at any stage, so that arrangement fell away.

88. Sixth and most significant, the deceased did receive assistance from Silver Chain until he refused to accept it. When he declined their assistance, they notified the referral source; namely, a doctor and a clinical nurse in the palliative team at Royal Perth Hospital. The faxed message to the doctor at Royal Perth Hospital stated that Silver Chain had requested that the deceased's GP or hospital specialist manage ongoing care.[60]

89. Nurse Rose said that she would have expected the Aged Care Assessment Team to contact the deceased since he had been awarded an Extended Aged Care at Home package and that, when he did not attend for his radiotherapy appointment on 18 August 2009, there would have been some follow-up to resume the monitoring of the deceased.[61]

90. Staff at Royal Perth Hospital may have attempted to contact the deceased by letter so that ongoing care could be managed, but that appears unlikely.[62] Letters found at the deceased's unit did not include such an offer from Royal Perth Hospital. It is clear that Royal Perth Hospital did not contact the DOH in order to request that it conduct an ad hoc welfare check of the deceased.

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[60] Ex 1, Vol 2, p 4; ts 88
[61] ts 90
[62] ts 88

91. Because of confidentiality issues, Silver Chain did not notify the DOH of the deceased's refusal of assistance.[63]

92. It can be seen that a process whereby the deceased was to have been provided with ongoing care by community service providers was arranged, but that process stopped without DOH being aware that it was even in place. Had it not stopped, the issue of the deceased not being found until long after he had died would not likely have arisen.

COMMENTS

93. Given the obvious need for the deceased to have received ongoing monitoring and eventual care, it seems to me that a primary concern must be the cause of the failure of that process after it had been instigated. That cause should be identified in order to attempt to prevent a similar failure from occurring in similar circumstances in future.

94. Silver Chain anticipated that staff at Royal Perth Hospital would take up the deceased's management once Silver Chain had notified them that the deceased refused Silver Chain's services, but there was no evidence to indicate that this happened. If Royal Perth Hospital did not attend the deceased's unit or arrange for someone else to do so, the deceased would be ignored.

95. The Royal Perth Hospital medical records for the deceased do not contain reference to the Silver Chain notification.

96. The evidence did not explore in detail Royal Perth Hospital's role in the event that Silver Chain was unable to continue to provide the deceased with care. Carla Francis, the Chief Social Worker at Royal Perth Hospital, provided a statement in which she stated that, once hospital social workers refer a patient to Silver Chain they do not routinely follow up.[64]

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[63] ts 88
[64] Ex, 1 Vol 1, Tab 25

97. Ms Francis told the inquest that on the whole Royal Perth Hospital social workers cease their involvement with palliative care patients once they have been referred to an agency like Silver Chain, but that there would be some times when the involvement might be continued depending on what is happening for the particular patient.[65]

98. Ms Francis agreed that after the deceased refused to continue to allow Silver Chain to assist him, the potential for his ongoing care evaporated. She indicated that there was no-one responsible to over-ride the deceased's choice to refuse care, but that if there were a suspicion that the deceased suffered from dementia or mental illness, the social workers at Royal Perth Hospital would have made an application for a guardian to be appointed.[66]

99. It seems clear that Silver Chain did not notify Royal Perth Hospital of the deceased's symptoms of paranoia, probably because it was thought that the symptoms were caused by alcohol consumption at the time.

100. In these circumstances, it is not clear whether the lack of follow up of the deceased was due to systemic gaps, an oversight or a conscious policy. I am therefore not in a position to offer a formal recommendation.

101. In any event, it appears to me self evident that there would be a benefit in hospital social work departments having effective systems of referral of patients to community service providers together with clear lines of communication. Such systems should include contingency plans for instances where patients are unwilling to accept the services of a community service provider or where that service is disrupted. Those contingency plans might provide for the arranging of welfare checks by police officers or DOH officers as appropriate, and could identify which agency was to contact the officers.

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[65] ts 21
[66] ts 32

102. As to the question of whether the DOH should implement a system of regular welfare checks, I make no formal recommendation. However, the DOH is in a unique position of landlord for many vulnerable and less privileged tenants. The community would benefit from welfare checks of these tenants, triggered by markers such as unpaid water bills and uncollected mail. The DOH may also wish to consider implementing a process of requesting a standard consent from tenants for welfare checks in nominated circumstances.

CAUSE AND MANNER OF DEATH

103. A post mortem examination was conducted on 14 July 2012 by forensic pathologist Dr G A Cadden and forensic anthropologist Dr A Buck. Given the decomposed state of the deceased's body, it was not possible for them to ascertain a cause of death. I therefore find the cause of death to be unascertainable.

104. Assessment of the deceased's skeletal remains did not raise the issue of a suspicious component of the cause of death. That fact is consistent with the facts that the door of the deceased's unit was locked when the DOH officer entered and found the deceased and that there was cash located in plain sight in the unit.

105. There was no evidence to support a finding that the deceased intended to take his life, and the medications available to him were not suited for that purpose.[67]

106. The position in which the deceased was found indicates that he died while resting with his torso and head on his bed and his lower body on the floor, consistent with him collapsing into that position.

107. Given the deceased's state of health and the lack of evidence to establish suicide or accident, it is likely that the deceased died from the effects of lung cancer, but it is not possible to determine the manner of death with any confidence.

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[67] ts 84

108. In the circumstances I make an open finding as to the manner of death.

TIME OF DEATH

109. The post mortem examination could not assist in determining a likely time of death.[68]

110. When the deceased discharged himself from hospital on 6 July 2009 he was assessed as having only weeks to live. He had an appointment for palliative radiography on 18 August 2009 which he did not attend.

111. He last withdrew funds, $500, from his bank account on 10 July 2009. The newspaper TV guide in his unit was left opened to the page that related to 17 July 2009.

112. He was last seen on 22 July 2009 by Nurse Rose of Silver Chain.

113. He paid no further Alinta or Synergy bills and the services for those utilities were disconnected on 20 October 2009 and 21 May 2010 respectively.

114. Given those circumstances, it is almost certain in my view that the deceased died between 22 July 2009 and 20 October 2009, and I so find.

B P King
Coroner
28 November 2013

[68] Ex 1, Vol 1, Tab 45