

FORM 38

Rule 60(2)

**FINDING INTO DEATH WITHOUT INQUEST**

*Section 67 of the Coroners Act 2008*

Court reference: 3060/08

In the Coroners Court of Victoria at Melbourne  
I, **KIM M.W. PARKINSON**, Coroner

having investigated the death of:

**Details of deceased:**

Surname: **CAMPBELL**  
First name: **ANDREW**  
Address: 6/2 Enfield Street, St Kilda. 3182

without holding an inquest,

find that the identity of the deceased was Andrew Campbell  
and the death occurred on 16 July 2008  
at the Alfred Hospital, Commercial Road, Melbourne Victoria 3004

From:

- 1a. CARDIAC ARREST**
- 1b. ISCHAEMIC HEART DISEASE**
- 1c. HYPERTENSION, INSULIN DEPENDANT DIABETES MELLITUS**

**Pursuant to section 67(2) of the Coroners Act 2008, an inquest into the death was not held and the deceased was not immediately before the person died, a person placed in custody or care; but there is a public interest to be served in making findings regarding the following circumstances:**

1. Mr Andrew Campbell was a disability pensioner. He was 51 years of age, born 14 November, 1956. The circumstances of Mr Campbell's death have been the subject of investigation by Victoria Police. Senior Constable Mark Kelly of Melbourne West Police Station, provided a brief to the coroner dated 20 January 2009. Further inquiries were made by the Coroner's Assistant Senior Constable Kelly Ramsay with Telstra, and other authorities in relation to the circumstances. These responses included a report from Telstra as to the procedure for

installation of fixed phone connections and the circumstances applicable to Mr Campbell. I have drawn from all of these investigations in my factual findings.

2. Mr Campbell resided alone 6/2 Enfield Street, St Kilda. These premises were newly completed residential flats provided by the Port Philip Housing Association. Mr Campbell moved into the premises from private rental accommodation on 10 July 2008. He utilised a number of community supports including nursing, medical and home and personal care. He was in receipt of meals on wheels and home nursing visits from the community health nurses. Mr Campbell suffered a number of medical conditions including Type 1 Insulin Dependant Diabetes, Cardiovascular disease, Hypertension, Depression, Renal Failure, Peripheral Neuropathy and frequent falls. He fractured his pelvis in 2007. In 2003 he suffered a cerebral vascular accident (stroke), myocardial infarction in 2004 and a Cerebral Shunt was inserted in 2007. His financial affairs were administered by the Public Trustee. His general practitioner and health care workers reported that he was often non-compliant with his medication regime and preventative health measures, including the wearing of his personal emergency communication device. Mr Campbell smoked approximately 30 cigarettes per day. He had a personal emergency communication device which required connection to a fixed land line telephone to operate. Health care workers reported that Mr Campbell required frequent encouragement in relation to caring for himself, including encouragement to utilise the personal emergency device. Community Health Nurses Ms Tania Richie and Ms Jackie Wallace reported:

"Mr Campbell failed to follow through with health care advice and his behaviour in relation to a number of issues, including diabetic management, his general prioritising of issues such as food and rental security, attendance at medical appointments, safeguarding from falls such as wearing his MEPACS alarm and numerous other areas of concern".

3. On 10 July 2008, Telstra attended as arranged at Enfield Street, to connect the fixed land line service. It was ascertained that there was insufficient street cabling to enable the connection to be made that day. Telstra reported that they had not recorded the connection as being a medical priority connection prior to attending the premises. It is unclear whether this is because they were not advised, or in error had not recorded that matter. A temporary interim phone connection was installed by the technician. Mr Campbell and the community nurse, Ms Richie were advised that it would not support the personal emergency device and that it would be some time before the street cabling could be upgraded. Mr Campbell also had a mobile phone, however, according to Ms Richie he often had insufficient credit to operate the phone. Despite the personal emergency system not being available, Mr Campbell had moved into the premises.

4. On 16 July, a welfare check was made at his premises after he had not responded to meal delivery services for two days. When entry was gained to the premises Mr Campbell was located, conscious but distressed. He was transported by ambulance to the Alfred Hospital. Mr Campbell died at 16.28 hours on 16 July 2008. The cause of death as provided by the certifying doctor was

Cardiac Arrest, Ischaemic heart disease, hypertension and insulin dependant diabetes mellitus. This was reviewed by Dr Malcolm Dodd Forensic Pathologist with the Victorian Institute of Forensic Medicine and Dr Dodd confirmed that there was no evidence to suggest that the cause of death was anything other than natural causes, and that the cause of death stated on the death certificate was reasonable in the circumstances. I am satisfied that Mr Campbell died of natural causes.

5. Ms Tanya Richie expressed concern that the lack of available emergency response system contributed to Mr Campbell's death by his being unable to call for assistance. The evidence does not identify how long Mr Campbell had been unwell prior to being located by Housing Association staff, and consequently there is no evidence to suggest that the failure to connect the service contributed to his death by delaying the provision of medical assistance. Having regard to Mr Campbell's significant health issues, it is not possible to conclude that earlier medical assistance would have resulted in a different outcome for Mr Campbell. Nor having regard to his history of non compliance with utilising the personal emergency device, is it possible to conclude that he would have utilised it, had it been connected.

6. However, Ms Richie raises a matter of relevance to the issue of prevention of possible future deaths and therefore appropriate for recommendation. I note that Telstra Corporation by its legal counsel, Ms Rachel Falk has advised that infrastructure issues relating to the premises at Enfield Street, St.Kilda have been resolved and adequate infrastructure exists for future connections.

7. I find that Mr Andrew Campbell died on 16 July 2008 and that his death was due to natural causes.

## COMMENTS

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

1. As greater provision is made for disabled and elderly persons to remain living independently, through the provision of community care, it is important that there be communication between responsible bodies to ensure that support services are co-ordinated and that safety equipment is operative. It is clear that there are some measures which may be taken for the possible prevention of future deaths in cases where persons are dependant upon personal emergency devices. They include ensuring the installation of necessary telecommunication equipment which will support personal emergency devices prior to occupancy, additional welfare checks where devices are known to be inactive, provision of mobile telephones rather


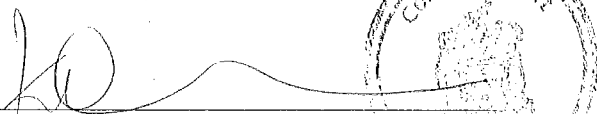
than fixed phones as interim measures and greater communication between community carers, housing providers and telecommunications providers as to requirements and service availability.

**RECOMMENDATIONS:**

**Pursuant to Section 72(2) of the Coroners Act 2008, I make the following recommendation(s) connected with the death:**

1. That upon being notified by the community care provider or housing provider of the reliance upon a personal emergency device, the telecommunications provider ascertain the status of cabling and availability of services to the proposed premises, and arrange for any necessary upgrades in advance of the scheduled connection date.
2. That in any case where a person in receipt of community care is reliant upon a personal emergency device requiring a fixed line phone connection that the community care provider or housing provider ensure that suitable connections are in fact available prior to the person moving into the premises.
3. In the event that urgent occupancy is required, that community care providers consider additional welfare checks for persons vulnerable to medical conditions when their personal emergency device is known to be inoperative.
4. That telecommunications provider consider providing hand held mobile telephones as an interim device rather than a fixed telephone which may be more difficult to access in an emergency situation.
5. I direct that a copy of this finding and the recommendations be provided to Telstra Corporation, Department of Human Services (Victoria) Disability Services and Aged Care, Municipal Association of Victoria, City of Port Phillip, Inner South Community Health Service Inc. and the Port Phillip Housing Association Inc.

Signature:



KIM M.W. PARKINSON

Coroner

Date: 5 March 2010