IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 006497

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paul Lawrie
Deceased:	Loris Lesley O'Meara
Date of birth:	2 October 1944
Date of death:	26 November 2019
Cause of death:	1(a) RENAL FAILURE AND KETOACIDOSIS IN A WOMAN WITH CHRONIC ALCOHOLISM AND TYPE 2 DIABETES MELLITUS
Place of death:	1/8 Chivers Avenue, Glen Waverley, Victoria, 3150

INTRODUCTION

1. On 26 November 2019, Loris Lesley O'Meara was 75 years old when she was found deceased in her home. At the time of her death, Mrs O’Meara lived at 1/8 Chivers Avenue, Glen Waverley, Victoria, with her husband, John O’Meara, and son, Matthew O’Meara.

THE CORONIAL INVESTIGATION

2. Mrs O’Meara’s 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.

3. 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.

4. 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.

5. Coroner Audrey Jamieson initially had carriage of this matter. Victoria Police assigned an officer to be the Coroner’s Investigator for the investigation of Mrs O’Meara’s death. The Coroner’s Investigator conducted inquiries on Coroner Jamieson’s behalf, including taking statements from witnesses – such as family members, the forensic pathologist, treating clinician and investigating officers – and submitted a coronial brief of evidence.

6. This finding draws on the totality of the coronial investigation into the death of Loris Lesley O'Meara including evidence contained in the coronial brief. 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.[1]

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[1] 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.

BACKGROUND

7. Mrs O'Meara was married to John O'Meara. They had three children together, one son and two daughters, all of whom were adults at the time of Mrs O'Meara's death.

8. In 2009, Mrs O'Meara suffered a stroke. She was admitted to hospital and required several months of rehabilitation. After Mrs O'Meara returned home, Mr O'Meara became her full-time carer.

9. Mr O'Meara stated that Mrs O'Meara became more housebound after the stroke, and reduced the activities she had previously participated in, such as going on regular walks. In the lead up to her death, she also spent a lot of time in bed.

10. Mrs O'Meara suffered from a range of health issues including bladder atonia, generalised severe weakness and a difficult gait, which led to her suffering frequent falls. She required assistance with moving, and reportedly refused to use a walker. Mrs O'Meara also had Type 2 Diabetes, which required her to have regular insulin injections, and she used a catheter and bag on an ongoing basis.

11. In 2015, Mrs O'Meara was assessed by the Peter James Centre Aged Care Assessment Service (**ACAS**). She was found to be eligible for a package which included assistance in the home. However, Mrs O'Meara does not appear to have ever engaged the services available through this package.

12. In 2016, Mrs O'Meara's son, Matthew O'Meara, began living with his parents at their home in Glen Waverley. He provided some assistance to Mr O'Meara in caring for Mrs O'Meara.

13. Mr O'Meara, Matthew and Mrs O'Meara experienced issues with alcohol abuse and their home life was volatile. There were a significant number of family violence incidents reported to police from 1993 until the time of Mrs O'Meara's death. Most of these reports related to incidents of family violence between Mr O'Meara and Matthew. However, several incidents also related to family violence allegedly perpetrated against Mrs O'Meara by Mr O'Meara and Matthew.

14. In June 2017, Mr O'Meara reported to police that Matthew had physically assaulted him, and verbally abused Mrs O'Meara. Police applied for and obtained an interim Family Violence Intervention Order (**FVIO**) which prohibited Matthew from attending his parent's address. Mr O'Meara declined an offer by police of a referral to further support services.

15. On 18 September 2017 and 28 October 2017, Matthew was located by Victoria Police at his parent's residence in breach of the FVIO. On both occasions he was removed from the premises and charged with breaching the FVIO. There was however no allegation that he had committed family violence on either of the two occasions.

16. When police attended the O'Meara residence on 18 September 2017, they noted that the home was in a state of squalor, that Matthew and Mr O'Meara appeared to be experiencing issues with alcohol abuse, and that Mrs O'Meara appeared to have 'mental health issues'. Consequently, police submitted referrals to support services.

17. On 2 December 2018, Matthew's sister contacted Victoria Police and reported that she had overheard a family violence incident whilst on the phone to Matthew. When police attended the residence, Matthew declined to provide a statement. The attending police members noted that the house was 'in a state of disrepair and there [was] rotten food, rubbish and cat faeces around the floors and the benches with lots of flies inside the house'. They also stated that they had 'concerns for the health and safety of all the occupants due to the state of the house'. All the O'Meara's refused referrals offered by Victoria Police to support services for substance abuse or to address the state of the house.

18. On 4 December 2018, Sergeant John Wallington from Oakleigh Police Station contacted Monash City Council because of his concern regarding the conditions in which Mrs O'Meara, Mr O'Meara and Matthew were living. Notes taken from this call indicate that Sergeant Wallington reported that the residents of the house were living in 'horrible conditions', that there was 'rubbish and faeces throughout the entire house' and that he believed the residents were experiencing issues with alcohol abuse. The address of the residence was provided to Monash City Council but the details of the residents, such as their names and contact numbers, were not noted.

19. On 6 December 2018, a Monash City Council Environmental Health Officer (**EHO**) contacted Victoria Police, seeking clarification regarding the initial report. The EHO noted that there were 'alcohol and possibly other social problems' that may have been contributing to the state of the property, and no cooking facilities were available due to the amount of rubbish. The EHO informed police that the Council could organise an assessment by their Home and Community Care team if the residents consented, and asked police to provide the names and contact details of the residents.

20. On 11 December 2018, the EHO made a follow up call to police, as they had not been provided with the contact details of the residents at the O'Meara's address and left a message. Police appear to have made no further contact with Monash City Council and, on 18 December 2018, Monash City Council marked the enquiry for no further action.

21. On 31 March 2019, Mr O'Meara called Victoria Police to report a family violence incident. On this occasion it was alleged that Mr O'Meara had physically assaulted Matthew with a wine glass, causing lacerations to his face, and had thrown the contents of a glass of wine at Mrs O'Meara. Mr O'Meara was arrested, charged, and subsequently found guilty of unlawful assault and assault with a weapon.

22. Police issued a Family Violence Safety Notice (**FVSN**) protecting Mrs O'Meara and Matthew from Mr O'Meara and submitted referrals to support services. A final FVIO was issued by the Ringwood Magistrates' Court on 8 April 2019 which prohibited Mr O'Meara from perpetrating family violence towards Mrs O'Meara and Matthew but allowed him to reside at the same premises.

23. On 9 April 2019, police contacted Matthew to discuss the recent family violence incident. During this conversation Matthew made several threats towards Mr O'Meara and, as a result, police applied for a FVIO to protect Mr O'Meara from Matthew. This order prohibited Matthew from residing with Mr and Mrs O'Meara. Despite this, Matthew continued to visit and reside at their home in breach of the FVIO.

24. On 16 April 2019, Mrs O'Meara contacted Victoria Police to report a further family violence incident. On this occasion she alleged that Mr O'Meara had verbally abused her, hit her repeatedly with his elbow, grabbed her arms and pushed her out of the bed, causing her to fall on the floor. Mr O'Meara was charged with unlawful assault and breaching a FVIO.

25. Mrs O'Meara advised police that she did not want the existing FVIO varied to exclude Mr O'Meara from the property, as he was her carer and the only member of the household who was able to drive**.**

26. On 27 October 2019, Matthew contacted Victoria Police and alleged that Mr O'Meara had grabbed a rubbish bag from Mrs O'Meara whilst she was taking it to the bin. When police attended, they observed bruising on Mrs O'Meara's wrists, however Mrs O'Meara denied that these had been caused by Mr O'Meara or that he had assaulted her.

27. During this attendance police observed the home to be in 'extreme disarray' noting that there were 'heavy piles of rubbish, newspapers, alcohol bottles, cat faeces, urine etc' around the home. They were also concerned about Mrs O'Meara's cognitive state, noting that she misreported her age and appeared confused as to what day it was. Given these concerns, police sought permission to contact Mrs O'Meara's General Practitioner (GP), Dr Keith Davis at Glenmount Medical Clinic.

28. Dr Davis informed police that Mrs O'Meara's health was deteriorating, and she was having frequent falls. The GP also reported that Mr O'Meara appeared to be in denial about Mrs O'Meara's declining health and that neither he nor Mrs O'Meara would agree to her undertaking further testing. Police noted that the matter was 'being handled with medical intervention re dementia' and do not appear to have taken any further action.

29. On 29 October 2019, Mrs O'Meara attended an appointment with Dr Davis and was observed to have bruises and small lacerations on both of her wrists. She informed her GP that these injuries had been caused by Mr O'Meara 'holding and shaking her' when she had been trying to put rubbish in the bin. Mrs O'Meara also advised the GP of a past incident where Mr O'Meara had allegedly hit her with an ashtray several years prior. The GP noted that she was 'quite distressed' and 'talking about divorce'.

30. On 21 November 2019, Mrs O'Meara again saw Dr Davis. During this consultation Mrs O'Meara stated that her husband was drinking to excess and that she wanted to leave but had 'nowhere to go'. This was the last appointment she attended prior to her death.

31. Evidence provided to the court suggests that, in the years leading up to her death, Mrs O'Meara was isolated from the community and only left her home to attend medical appointments. Family members stated that she often remained in bed and slept throughout the day.

32. Dr Davis stated that there was a noticeable decline in Mrs O'Meara's health in the lead up to her death, and that she sometimes displayed confusion during consultations. Although the GP and a nurse had previously attended upon Mrs O'Meara at her home, these visits had stopped several years earlier when Mr and Mrs O'Meara made it clear that medical staff were not welcome at their home.

33. Mrs O'Meara's children were concerned about Mr O'Meara's ability to care for Mrs O'Meara due to his age, alcohol consumption and cognitive function. One of their children stated that

they were concerned about Mr O'Meara's ability to administer Mrs O'Meara's medication and had witnessed him giving her more than her prescribed dose on more than one occasion. They did not suggest that this was deliberate.

34. I note that Mr O'Meara was diagnosed with dementia in the years following Mrs O'Meara's death.

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

Circumstances in which the death occurred

35. On Sunday 24 November 2019, Mr O'Meara assisted Mrs O'Meara to go to bed at approximately 8.00pm. He stated that they had some alcohol after dinner, however Mrs O'Meara 'would have only had a couple of small glasses of wine'. He stated that he would occasionally give Mrs O'Meara Mogadon to assist her with sleeping, but he did not recall giving her any medication on this occasion.

36. Later in the evening Mr O'Meara noticed that Mrs O'Meara had fallen out of the bed. She did not appear to be awake. Matthew assisted his father to move Mrs O'Meara back into the bed. She did not rouse or make any noises and appeared to Mr O'Meara to be asleep. When Mr O'Meara retired to bed at some time between 10.00pm and 11.00pm, Mrs O'Meara was in bed asleep.

37. When Mr O'Meara woke late on the morning of Monday 25 November 2019, Mrs O'Meara was again on the floor beside the bed and appeared to be asleep. Matthew again assisted his father to put Mrs O'Meara back into the bed.

38. Mrs O'Meara remained in bed for most of the day. At around lunchtime, she had a sandwich and coffee in bed. Later in the day Mrs O'Meara got up and watched some television and, in the evening, Mr O'Meara assisted her to go back to bed. Mr O'Meara was unable to recall if he gave her any medication at this time. When Mr O'Meara went to bed at approximately 11.00pm, Mrs O'Meara was in the bed asleep.

39. On Tuesday 26 November 2019, Mr O'Meara awoke in the morning at approximately 10.00am and found Mrs O'Meara on the floor beside the bed. Matthew assisted Mr O'Meara to lift her back into the bed.

40. In the late afternoon, Mr O’Meara returned to the bedroom and found Mrs O’Meara again on the floor. Matthew again assisted to lift Mrs O’Meara back into the bed. At this point Mr O’Meara noticed that she did not seem to be moving or breathing.

41. Matthew contacted emergency services and, in accordance with their instructions, attempted to revive Mrs O’Meara using Cardiopulmonary Resuscitation (CPR). Victoria Police and Ambulance Victoria paramedics attended shortly afterwards and Mrs O’Meara was declared deceased at the scene.

42. Photographs taken at the home after Mrs O’Meara’s death confirm that the house was in a state of disarray and significant squalor, consistent with the description of police members who had previously attended. There were significant amounts of rubbish, empty alcohol bottles and animal faeces in and around the residence.

Identity of the deceased

43. On 26 November 2019, Loris Lesley O'Meara, born 2 October 1944, was visually identified by her husband, John O’Meara.

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

Medical cause of death

45. Forensic Pathologist Dr Gregory Young, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 29 November 2019 and provided a written report of his findings on 2 June 2020.

46. The post-mortem examination revealed:

    a) Mild changes of decomposition. Wischnewski spots were observed in Mrs O’Meara’s stomach, and her lungs showed changes of chronic obstructive pulmonary disease. Her heart was mildly enlarged (cardiomegaly) and showed calcification of the mitral valve annulus and mild myocardial fibrosis. Mrs O’Meara’s liver was cirrhotic.

    b) Acetone was detected in Mrs O’Meara’s blood (~112 mg/L) and vitreous humour (~124 mg/L), indicative of ketoacidosis. Vitreous humour biochemistry also showed markedly elevated urea and creatinine (31 mmol/L and 663 µmol/L, respectively), and a glucose of 6.7 mmol/L. Whilst the glucose level was not high, Dr Young noted it may have been

higher at the time of death, given the time interval between the death and the autopsy, and the presence of mild decomposition.

c) Serum markers of inflammation (procalcitonin and CRP) were not elevated. Urine cultured a mixed growth of enteric flora, which Dr Young suggested was likely representative of post-mortem contamination. Given that the autopsy did not show any evidence of infection, these results indicated that there was no significant infection that caused or contributed to Mrs O'Meara's death.

d) Acute anterolateral fractures of the right 4th-5th and left 4th-6th ribs were also observed, which Dr Young noted may be attributable to chest compressions in the setting of attempted CPR.

e) Chronic changes were seen in the hyoid bone in Mrs O'Meara's neck. Some bruises were observed on the backs of Mrs O'Meara's hands, a small bruise was also observed on her back, and a small abrasion was seen on her right upper eyelid. However, there was no post-mortem evidence that any of these injuries caused or contributed to Mrs O'Meara's death.

47. Dr Young noted that ketoacidosis is a metabolic state associated with high levels of ketone bodies (including acetone) in the blood and other tissues. It may be seen as a complication of alcoholism (especially when there has been an abrupt cessation of alcohol), starvation or diabetes (and hyperglycaemia), or any combination of the above. Ketoacidosis is associated with dehydration, diuresis, renal failure and other metabolic derangements, which may be fatal.

48. Toxicological analysis of post-mortem samples identified the presence of metformin, quetiapine, metoprolol, nitrazepam (and metabolite 7-aminonitrazepam), diazepam (and metabolite nordiazepam), doxylamine, paracetamol and sitagliptin. Ethanol (alcohol) and carboxyhaemoglobin were not detected.

49. Dr Young provided an opinion that the medical cause of death was 1 (a) RENAL FAILURE AND KETOACIDOSIS IN A WOMAN WITH CHRONIC ALCOHOLISM AND TYPE 2 DIABETES MELLITUS.

50. I accept Dr Young's opinion.

FURTHER INVESTIGATIONS AND CORONER'S PREVENTION UNIT REVIEW

51. As Mrs O'Meara's death occurred in circumstances involving recent family violence, Coroner Jamieson requested that the Coroners Prevention Unit (**CPU**)[2] examine the circumstances of Mrs O'Meara's death as part of the Victorian Systemic Review of Family Violence Deaths.[3]

52. The CPU noted that Mrs O'Meara experienced physical, emotional, and verbal abuse from her husband, and that this abuse escalated in the lead up to the fatal incident. In addition, they noted that Mrs O'Meara also appeared to have been a victim of verbal and emotional abuse from Matthew.

53. The CPU suggested that Mrs O'Meara's experience of family violence was likely affected by the additional challenges presented by her health issues, alcoholism, mobility, and age. At the time of her death, Ms O'Meara was solely reliant on her husband to meet her daily care needs, was suffering from possible cognitive impairment, was unable to leave the home unassisted, and was isolated from support services and social networks.

54. There is also evidence which suggests that the care provided by Mr O'Meara was a barrier to Mrs O'Meara seeking additional protection. For example, on at least one occasion Mrs O'Meara requested that Mr O'Meara not be excluded from her residence by police due to her reliance on him for care. The barriers Mrs O'Meara faced were also illustrated in a consultation with her GP in the days prior to her death, where she indicated that she wanted to leave Mr O'Meara but had 'nowhere to go'.

Medical services provided to Mrs O'Meara by Glenmount Medical Centre

55. Mrs O'Meara attended Glenmount Medical Centre regularly from 1975 until her death. Records from her consultations at the centre from 2012 onwards were provided to the court.

56. These records indicate that Mrs O'Meara's GP was aware that she was vulnerable due to her health issues and was being cared for by her husband and, occasionally, her son. They also noted that Mrs O'Meara experienced issues with alcohol abuse. During her appointments at

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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 prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[3] The VSRFVD provides assistance to Victorian coroners to examine the circumstances in which family violence deaths occur. In addition, the VSRFVD collects and analyses

the clinic, Ms O'Meara repeatedly disclosed that she was a victim of family violence, and she was observed by her GP to have injuries on multiple occasions. Mrs O'Meara appears to have made over 20 disclosures of being subjected to family violence from both Matthew and Mr O'Meara to her treating GP. Mrs O'Meara was also noted to frequent the clinic smelling of urine and appearing unkempt.

57. Victoria Police spoke with Mrs O'Meara's treating GP on 9 May 2019 and 12 November 2019. On both occasions they advised the GP that Mrs O'Meara was the victim of family violence from her husband and had suffered injuries. During the conversation on 12 November 2019, they also informed the GP that Mrs O'Meara's residence was 'filthy' with 'cat excreta everywhere'. In notes from this conversation, the GP recorded that the police queried whether Mrs O'Meara had dementia and noted that she was probably under the influence of alcohol. The GP spoke to Mrs O'Meara the same day and noted that she appeared reasonable and 'aware of all' and she advised them that she was 'getting on better' with her husband and son.

58. Mrs O'Meara's GP stated that he never observed signs of physical abuse on Mrs O'Meara, aside from injuries to her wrists which they stated were 'generally accepted as possibly heavy-handed attempts to lift her up from her many falls'. However, the medical notes provided by the GP also indicate that Mrs O'Meara stated that Mr O'Meara had assaulted her, resulting in these injuries, and made several disclosures of having been subjected to physical abuse.

59. Based on the available material, it does not appear that the GP took any action in relation to the reports of family violence or sought any further information or assistance from external support services. Mrs O'Meara was last assessed for aged care support in 2015, with her family ultimately not utilising the services that were offered following this assessment.

60. The current Practice Manager of Glenmount Medical Centre, Sophie Edgar, provided a statement range detailing the range of resources that the GPs at their clinic can access via external services if they see a patient who is experiencing family violence. Ms Edgar was not at the practice at the time of these events and could not comment on the practices adopted by Mrs O'Meara's GP.

Service contact with Monash City Council

61. In a statement to the Court, Monash City Council advised that there were no notes in their records as to why the report made to their Environmental Health team in December 2018 was closed as requiring 'no further action' on 18 December 2018. However, they noted it was likely that either: a police officer had offered to pass on the details of the council's Home and Community Care (**HACC**) team to the O'Meara family but they had declined this offer; or police had chosen to refer the matter to a relevant welfare authority.

62. Monash City Council stated that they can only conduct HACC assessments with the consent of the person(s) involved and therefore could only act when they have the name and contact details of a potential client. The Council stated that, without the contact details of the residents, it was not possible to provide support.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

63. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the cautions identified in *Briginshaw v Briginshaw*.[4] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

General Practitioner responses to family violence

64. In 2016 the Royal Commission into Family Violence (**RCFV**) highlighted the important role that GPs play in responding to family violence and found that women are most likely to disclose their experience of family violence to their GP outside of their social network.

[4] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

65. The RCFV highlighted a significant knowledge gap among health professionals in identifying and responding to family violence and made several recommendations aimed at increasing the capacity of the sector to respond to family violence.

66. The Royal Australian College of General Practitioners (**RACGP**) manual *Abuse and Violence: Working With our Patients in General Practice* (also known as the White Book) provides GPs with guidance on how to work with patients experiencing family violence. It states that GPs 'have a role in prevention, early identification, responding to disclosures of intimate partner abuse, and follow-up and support of patients and their children experiencing the health effects of violence and abuse'. This guidance directs clinicians to encourage accountability, prioritise the safety of women and children and to identify the most appropriate program or support service for the patient.

67. In 2018, following a recommendation from the RCFV, a new Multi-Agency Risk Assessment and Management Framework (**MARAM**) was introduced. The MARAM has been rolled out in stages across Victoria since that time. It provides guidance to services and workers to assist in identifying family violence, assessing family violence risk, and responding when family violence is suspected or identified.

68. Unlike publicly funded health services, private GPs are not prescribed agencies under the MARAM and so are not legally obligated to align their services with it. However, the RACGP White Book was updated in December 2021, with reference to updated risk assessment tools such as the MARAM. The RACGP has also embedded family violence education into the Curriculum for Australian General Practice and makes references to the White Book for all new medical practitioners seeking accreditation with the college.

69. The RACGP provided a statement to the court which indicated that, whilst family violence training is not compulsory for GPs, they are 'expected to achieve general practice family violence management competencies'. The RACGP noted that it offered a range of resources aimed at supporting GPs to respond to family violence; including an online education package, Continued Professional Development activities, educational webinars, and publications in their peer-reviewed journal. They have also undertaken work with the 1800RESPECT helpline and the University of Melbourne 'to enable the helpline to also provide guidance to GPs on how to respond to patients and also to raise awareness of the service'.

70. The RACGP stated that they do 'not support a 'one-size' approach for family violence training and [do] not support specific once-off mandatory training' given the 'complex mixture of communication and diagnostic skills' required to respond to family violence. They noted that the competencies required to respond to family violence form a part of the core skills taught to GPs as part of the standard curriculum.

71. I note that GP responses to disclosures of family violence have been examined in several cases investigated by this court. Most recently, this issue was considered by the State Coroner, Judge Cain, in his finding into the death of Fatima Batool,[5] which was handed down on 10 October 2022. In this finding, Judge Cain commended the RACGP for its continued work in promoting family violence education amongst its members but noted that a number of recently closed coronial investigations evidenced 'a continued lack of occupation-specific understanding of family violence…amongst GPs treating the general public'.

72. Judge Cain further observed:

> *Given the prevalence of family violence in Australia and the critical role of GPs in responding to family violence as a first point of contact for most individuals, it is inadequate to rely on the self-direction of GPs to undertake training in this area and note that without mandated family violence training, a portion of GPs will remain unskilled and ill-equipped to respond to patients' disclosures of family violence.*

73. Judge Cain made a recommendation to the National Federation Reform Council on this issue as follows:

> *With the aim of promoting public health, preventing deaths and supporting medical practitioners to address family violence, I recommend that the National Federation Reform Council (**NFRC**) review the current registration standards required of medical practitioners with a view to updating CPD requirements for General Practitioners. A specific portion of CPD training undertaken by General Practitioners should be dedicated to family violence to reach an occupation-specific level of family violence understanding and referrals for further support where a patient is identified as experiencing or suspected to be experiencing family violence.*

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[5] COR 2018 3266.

74. In response to this recommendation, the Prime Minister of Australia, Anthony Albanese, confirmed that the Commonwealth Government supports reforms to enable GPs, psychologists and psychiatrists to better identify and intervene in cases of family, domestic and sexual violence. Prime Minister Albanese asked the Hon Mark Butler MP, Minister for Health and Aged Care, to work with the Health Ministerial Council in 'developing options to enhance family, domestic and sexual violence training in the health workforce. These options are to include [Judge Cain's] recommendation of mandatory family violence CPD components for GPs, psychiatrists and psychologists'.

75. I also note that the recent Royal Commission into Aged Care Quality and Safety report, published in 2021, contained damning stories of abuse and neglect of older people in Australia. One of the recommendations made in the report was for the development of a new online training package, funded by the Department of Health and developed for GPs and other healthcare professionals, 'Abuse of the older person: eLearning program for Health Professionals'. The package is designed to enhance the skills of health professionals to support older people at risk of or experiencing abuse through enhanced risk identification and referral action.

76. I also note that in May 2022, the Family Violence Reform Implementation Monitor (**FVRIM**) released a report, 'Early identification of family violence within universal services', which examined the implementation of RCFV recommendations targeted toward supporting workforces in universal health and education services, including GPs, to identify and respond to family violence.

77. The FVRIM report noted that 'considerable work has been undertaken and funding provided to equip staff in universal health and education services to identify and respond to family violence' and highlighted the work of the University of Melbourne's Safer Families Centre, which has been funded by the Victorian Government to create a Victoria-specific version of their national family violence training program for primary health providers.

78. The FVRIM report outlined work undertaken by the MARAM and Information Sharing Advisory Group, convened by the Safer Families Centre, which has included the incorporation of information from the MARAM into the Whitebook, the development of an information sharing e-learning module, and the delivery of a virtual, practice-centred learning program at 22 sites.

79. The FVRIM also noted that whilst most GPs ‘want to improve their ability to identify and respond to family violence to support better outcomes for their patients’, resourcing is a major barrier. As there are no family-violence related Medicare items, ‘any extra time a doctor spends collaborating with other services, exploring referral pathways and sharing information is done outside of the standard consultation time, and is therefore unpaid activity’.

80. This issue was also highlighted by the RCVF, which recommended that

> *The Victorian Government, through the Council of Australian Governments, encourage the Commonwealth Government to consider a Medicare item number for family violence counselling and therapeutic services distinct from a general practitioner mental health treatment plan. In the longer-term consideration should be given to establishing a Medicare item number or a similar mechanism that will allow medical practitioners to record a family violence–related consultation or procedure and so more accurately ascertain the public cost of family violence [within 12 months][6].*

81. The RCFV recommendation has been recorded as implemented by the Victorian Government, who noted that they have encouraged the Commonwealth Government to consider a Medicare item for family violence counselling. Despite this advocacy, however, a Medicare item for family violence related counselling or other family violence related matters has not been created to date.

82. The recent draft *National Plan to End Violence Against Women and Children 2022-2032* recognises the need for additional resourcing in this area, and states that GPs ‘need to be supported through resources, time and education to identify and respond to family, domestic and sexual violence’. In their report, the FVRIM reiterated the need for a specific Medicare item for family violence related matters and recommended that ‘Victoria advocate with the Commonwealth for the creation of Medicare items relating to family violence to support General Practitioner’s identification and management of family violence as envisioned in the National Plan’.

[6] Royal Commission into Family Violence Final Report (March 2016), Recommendations, 74

Adult safeguarding legislation and services in Victoria

83. Mrs O'Meara's GP was aware that she was dependent on Mr O'Meara and Matthew for her daily needs, and that she had disclosed being subjected to family violence by each of them. Mrs O'Meara's GP was also aware that she often presented to the clinic unclean and was living in an environment that was unhygienic.

84. There were clear indications that Mrs O'Meara's care needs were not being met, and this should have warranted a report being made by her GP to an adult safeguarding agency for investigation, or a referral being made to appropriate supports.

85. I note, however, that there is a significant gap in the Victorian service system for vulnerable older persons. There is also no mandated requirement for professionals, including GPs, to report the abuse or neglect of an adult patient with care or support needs in Victoria.

86. This is an issue that was examined in the finding into the death of Patricia Grant,[7] handed down by the State Coroner, Judge John Cain, on 6 January 2022. In that finding, Judge Cain noted that:

> *The RACGP clinical guides alert GPs to some of the various organisations which play a role in supporting older adults who have needs for care and support and who may be experiencing abuse, including the Office of the Public Advocate (OPA), Victoria Police and Seniors Rights Victoria. However, these agencies each have a limited role in responding to allegations of abuse. Victoria does not have a safeguarding service which is mandated to investigate and co-ordinate a response to all allegations of abuse and neglect against older adults with needs for care and support. As such, the RACGP guidance is unable to provide a clear referral pathway for Victorian GPs who suspect that abuse of an older person is occurring.*
>
> *The Australian Law Reform Commission (ALRC) released a report entitled Elder Abuse – A National Legal Response (ALRC Report) in 2017, which recommended that adult safeguarding laws, similar to those in the United Kingdom and Canada, be enacted in each state and territory in Australia. The ALRC Report recommended that these laws give adult safeguarding agencies the role of safeguarding and supporting at-risk adults by investigating and co-ordinating*

[7] COR 2013 4627

responses to allegations of abuse against them. At-risk adults are defined as people aged 18 years and over who '(a) have care and support needs; (b) are being abused or neglected, or are at risk of abuse or neglect; and (c) are unable to protect themselves from the abuse or neglect because of their care and support needs'…

The ALRC Report makes several recommendations as to how safeguarding agencies should investigate and respond to allegations of abuse, including actions which safeguarding agencies should take to support and protect adults who have experienced abuse. The ALRC advised that they did not recommend a mandatory reporting requirement for professionals due to concerns that such mandates may reduce the rights and autonomy of adults with care and support needs. Instead, the ALRC recommended that prioritization should be given to developing clear protocols for professionals which provide comprehensive guidance on 'when it might be appropriate for professionals to report abuse to safeguarding agencies'.

In response to the ALRC Report the National Plan to Respond to the Abuse of Older Australians (Elder Abuse) 2019-2023 (National Plan) was published in 2019. In response to the National Plan and the ALRC Report, the Victorian Government agreed to review its existing legislation relating to safeguarding and support for at-risk adults to identify gaps in safeguarding provisions.[8] *The Department of Families, Fairness and Housing (DFFH) and the Department of Justice and Community Safety indicated that this would be completed over the years 2019-2020. In a statement provided to the Court in April 2021, however, the DFFH confirmed that the finalisation of this review had been delayed due to the COVID-19 pandemic. They indicated that the review was expected to be completed during 2021 and they would provide the Victorian Government with options to consider improving Victoria's framework of adult safeguarding laws.*

87. I requested a statement from the Department of Justice and Community Safety (**DJCS**) seeking an update on the status of their review of Victorian legislation to identify gaps in safeguarding provisions. In a statement dated 20 March 2023, the DJCS advised that this

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8 Council of Attorneys-General, *National Plan to Respond to the Abuse of Older Australians (Elder Abuse) 2019-2023* (Report, 2019), 32 <National-plan-to-respond-to-the-abuse-of-older-australians-elder 2019.pdf (internal.vic.gov.au)>; Council of Attornys-General, *Implementation Plan to Support the National Plan to Respond to the Abuse of Older Australians 2019-2023* (2019), 27 <National Plan to respond to the abuse of older people 2019 2023 Victoria Implementation_Plan.pdf (internal.vic.gov.au)>.

review had been completed on 18 August 2022 by the Office of the Public Advocate (**OPA**) on behalf of the Victorian Government.

88. The findings of the review were released in the OPA report 'Line of sight: Refocussing Victoria's adult safeguarding laws and practices' (**the OPA Report**). The OPA Report noted that the role of:

> *Victorian Government safeguarding functions, such as the Community Visitors Program and the Public Advocate's safeguarding roles under the Disability Act 2006 (Vic), are not keeping pace with the changing disability service environment – with new funding and support models, and providers, emerging rapidly. There are also instances where safeguards do exist but are not operating effectively due to resource constraints, lack of awareness, or information sharing barriers.*

89. The OPA Report made seven recommendations targeted towards improving Victoria's adult safeguarding laws and practices. I support the implementation of these recommendations by the Victorian Government.

90. The DJCS also noted that the Disability Royal Commission into violence, abuse, neglect and exploitation of people with a disability (**DRC**) has also heard evidence about adult safeguarding laws, and that the DJCS are continuing to engage with the DRC on the best approach for protecting and supporting at-risk adults in Victoria.

91. The DJCS noted that the DRC report is due to be released in September 2023 and they will ensure the Victorian Government response to the DRC report also considers other relevant recommendations, including those in the OPA report.

92. Further to the essential work of the DJCS and DRC, it is also important to recognise that not every vulnerable older person with care and support needs will have a disability, and any adult safeguarding framework must properly consider this cohort.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Loris Lesley O'Meara, born 2 October 1944;

    b) the death occurred on 26 November 2019 at 1/8 Chivers Avenue, Glen Waverley, Victoria, 3150, from renal failure and ketoacidosis in a woman with chronic alcoholism and type 2 diabetes mellitus; and

    c) the death occurred in the circumstances described above.

RECOMMENDATIONS

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

1. I recommend that the Commonwealth Government consider adding specific Medicare item numbers relating to family violence, to support the identification and management of family violence by General Practitioner's, as envisioned in the draft *National Plan to End Violence Against Women and Children 2022-2023*.

I convey my sincere condolences to Mrs O'Meara's family for their loss.

Pursuant to section 73(1A) 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:

Nicole Campaign, on behalf of John O'Meara, Senior Next of Kin

Hayley Leitch, State Trustees Victoria

Kate Houghton, Department of Justice and Community Safety

The Hon. Mark Butler MP, Minister for Health and Aged Care

Senior Constable Tristan Gouldthorpe, Coroner's Investigator

Signature:

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Coroner Paul Lawrie

Date : 27 July 2023

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.