IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 006157

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge John Cain, State Coroner
Deceased:	YTR
Date of birth:	[redacted]
Date of death:	11 November 2020
Cause of death:	1(a) Complications of prolonged immobility and malnutrition in a woman with retroperitoneal lymphoma
Place of death:	Eastern Health, Maroondah Hospital, 1-15 Davey Drive, Ringwood East, Victoria, 3135
Keywords:	Elder rights; adult safeguarding; mental health

INTRODUCTION

1. On 11 November 2020, YTR was 78 years old when she passed away at Maroondah Hospital. YTR is survived by her two adult children, PLK and IJN. YTR was married to CVB; however, he passed away in 2008. After CVB's passing, IJN became YTR's carer and continued to live at the family home in a regional Victorian town, with YTR.

2. YTR's medical history included schizophrenia, depression, hypothyroidism, hypercholesterolaemia, type 2 diabetes, hypertension and hypokalaemia. Her regular medications included asenapine, bisoprolol, indapamide, levothyroxine, perindopril, and quetiapine. PLK noted that her mother did not appear to attend her general practitioner (**GP**) as often as she should. She tried to encourage YTR to keep her appointments, however PLK opined that it was difficult to get information out of either YTR or IJN. IJN's medical history is largely unknown; however, he reportedly also has a schizophrenia diagnosis.

THE CORONIAL INVESTIGATION

3. YTR'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.

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

5. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

6. Victoria Police assigned Sergeant Angie Clark to be the Coronial Investigator for the investigation of YTR's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating paramedics and investigating officers – and submitted a coronial brief of evidence.

7. This finding draws on the totality of the coronial investigation into the death of YTR 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]

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

Identity of the deceased

8. On 16 November 2020, YTR, born [redacted], was visually identified by her daughter, PLK.

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

Medical cause of death

10. Forensic Pathology Fellow Dr Chong Zhou, supervised by Dr Linda Iles from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 16 November 2020 and provided a written report of her findings dated 3 March 2021.

11. The post-mortem examination supported the clinical impression of sepsis complicating multiple decubitus ulcers (pressure sores), with resultant circulatory collapse, multi-organ failure, and death. The severe pressure sores and secondary infection developed as a complication of prolonged immobility and an impaired immune system (due to malnutrition and cancer) in the setting of a delay in adequate provision of preventative measures and medical treatment.

12. The deceased had a large lymphoma (a cancer of the lymphatic system) within the right retroperitoneum which invaded nerves that innervate the right leg. This may have been the cause or a significant contributing factor in her immobility. Cancer-associated thrombosis within a major vein that drains blood back to the heart from the right leg was the likely cause of her recent leg swelling. Cancer can also weaken the immune system and predispose a person to severe infections.

[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.

13. The deceased showed multiple complications of prolonged immobility including several deep areas of decubitus ulceration and rhabdomyolysis (breakdown of skeletal muscle).

    a) Decubitus ulcers can become infected, and the infection may extend deeply into the underlying bone causing osteomyelitis (as was seen in this case). Infection can also extend into the bloodstream causing septic shock, circulatory collapse, and death.

    b) Rhabdomyolysis is the breakdown of muscle, which may be seen in those who are immobile for a prolonged period of time. The breakdown of muscle releases proteins into the bloodstream that can contribute towards renal impairment.

14. Ante-mortem blood test results showed evidence of malnutrition, dehydration, and acute renal failure, which is indicative of inadequate oral intake to meet the metabolic demands of the body. Malnutrition occurs when there is a deficiency of calories/energy, water, fibre, and nutrients such as vitamins, minerals, protein, carbohydrates, and fats, that are essential to bodily functions. Furthermore, at times of acute illness/stress (such as in the presence of infections), the body has increased metabolic demands requiring increased supply of energy and nutrients to prevent malnutrition. The deceased's cancer may have contributed towards a catabolic state. Potential consequences of malnutrition include compromised immune function leading to an increased risk of infections, decreased sensory input, impaired motor function, and reduced physiologic reserve.

15. Toxicological analysis of ante-mortem samples from Maroondah Hospital (taken 4 November 2020) showed ketosis, which was likely multifactorial, secondary to sepsis, reduced oral intake, and hypothermia.

16. Dr Zhou provided an opinion that the medical cause of death was *1(a) complications of prolonged immobility and malnutrition in a woman with retroperitoneal lymphoma.*

17. I accept Dr Zhou's opinion as to the medical cause of death.

Circumstances in which the death occurred

18. At 6.18am on 3 November 2022, IJN called 000 to request ambulance assistance. He reported that his mother had swollen legs, a sore neck, had not been eating or drinking and groaned in pain when her shoulder was touched. Paramedics arrived on scene at 6.29am and were greeted by IJN, who directed them to YTR.

19. Paramedics observed YTR sitting on the couch with "*her head slumped forward*" and a "*very strong smell of urine and faeces*". Attending paramedics noted that YTR was in a poor physical state. She had low blood pressure, decreased conscious state, was confused, and was hypothermic with a body temperature of 35°C. IJN told paramedics that his mother had a decreased conscious state and had been sitting in the same position on the couch for about one week. He noted that she had not consumed much food or water during that time and that her legs were swollen, which was unusual.

20. When the paramedics moved YTR from the couch, they observed that her clothing was encrusted with faecal matter and urine, and her clothes were adhered to the couch. Paramedics treated YTR by raising her body temperature, then conveyed her to the local regional Hospital.

21. At the regional Hospital, clinicians commenced intravenous (**IV**) antibiotics and oral analgesia. Clinicians noted that she was very unkempt, had dry lips and was unable to state the reason for being in hospital. She had multiple linear bruises on her back, bilateral pitting oedema, Grade 4 pressure ulcers on her buttocks and lower back area, maceration in the perineal area and a pressure ulcer on both heels. Staff recorded concerns for YTR's welfare and queried whether a guardianship order or power of attorney was required.

22. At about 3.40pm, the Nurse in Charge (**NIC**) called the local Police Station to request they perform a welfare check on IJN. Staff had been unable to reach him via phone throughout the day and they wanted to give him an update about YTR's condition.

23. The regional Hospital contacted Adult Retrieval Victoria (**ARV**) to facilitate YTR's transfer to another hospital, given her poor condition. Both the Royal Melbourne Hospital (**RMH**) and the Austin Hospital were unable to accept YTR as they had no available beds. Later that afternoon, ARV secured a bed at Maroondah Hospital.

24. That evening, IJN arrived at the regional Hospital. One of the attending nurses stepped away from YTR and when she returned, she observed IJN speaking into YTR's ear. IJN stopped talking with the nurse entered the room. According to the nurse, YTR's eyes were wide open, which was unusual as they were predominantly closed throughout the day. The nurse documented that IJN "*over confidently [spoke] about pts [YTR's] dentures not fitting and struggling with food and eating which is why she hasn't eaten*". When IJN was out of the room, the nurse asked YTR if there was anything she wanted to say and that she was in a safe place, however YTR did not respond at all.

25. YTR arrived at Maroondah Hospital later that evening and was admitted to the intensive care unit (**ICU**) for treatment with antibiotics, antivirals and inotropic support. The clinician impression was of septic shock from an unknown source, pressure ulcers, hypokalaemia, malnourished, neck and right upper quadrant pain, and renal failure. Staff notified Victoria Police, due to concerns about YTR's condition.

26. Detectives from the Croydon Family Violence Investigation Unit (**FVIU**) attended Maroondah Hospital and spoke one of YTR's treating clinicians. The doctor advised that YTR was experiencing renal failure secondary to malnutrition and dehydration, she had an infection of unknown causes, was not engaging with medical staff despite not having a language barrier, possibly had mental health issues and had a significant open wound on her back as well as other pressure sores. The detective asked whether YTR's condition was life-threatening and was reportedly advised that her prognosis was positive.

27. Later that afternoon, uniform police members from the regional Police Station and detectives from the regional FVIU attended IJN and YTR's home to execute a search warrant. IJN showed the members the couch that YTR was lying on when she was at home. He also showed the members to his bedroom, YTR's bedroom and their shared bathroom. IJN noted there was a mattress outside in the backyard, which was previously YTR's mattress. He explained that he replaced the mattress as YTR had urinated on it. The laundry was flooded due to the sink overflowing and the toilet did not appear to be in working condition as the water in the toilet bowl was black. After searching and photographing the house, IJN was arrested and conveyed to the regional Police Station.

28. At the regional Police Station, IJN participated in a recorded interview with detectives from the regional FVIU. When police asked why YTR was in hospital, IJN replied "*She wasn't eating*". IJN also noted that YTR had not taken her tablets for a week but struggled to explain why she was unable to take the tablets. IJN explained that he could not recall the last time YTR attended her GP, but she did not want to go, and she missed a telehealth appointment in about September 2020. He was unsure what her prescriptions were for and was uncertain about her health conditions, other than schizophrenia and high blood pressure.

29. When questioned about the last time YTR ate, he said that she ate on Grand Final day, and the day after Grand Final day. He believed it had been a week since she last ate. The detective confirmed he was referring to the AFL Grand Final day (24 October 2020). Following that

time, IJN said he encouraged YTR to drink through a straw, however her fluid intake appeared to decline. He noted that she had also consumed a bit of ice-cream on 2 November 2020.

30. IJN recalled that YTR appeared to decline from September 2020. Previously, she was able to mobilise around the house and cook her own meals, however from about September 2020 she was unable to mobilise. IJN explained that YTR did not want anyone coming to the house to help with cooking or cleaning.

31. IJN explained that YTR had been on the couch in the living room for about a week and he was unable to move her. He noted that she was relieving herself in that location as she could not stand up, and she reportedly refused whenever he offered to call an ambulance. He reported that he tried to clean her by washing her face and hair. He thought she had not had a shower since her decline in September. He noted that previously when YTR was in her bed, he used to place her in a chair and push the chair to the bathroom where YTR relieved herself over the edge of the bathtub.

32. When asked about the bruising to YTR's body, IJN opined that the bruises to her arm were likely caused when he lifted her up or moved her onto a chair. Police showed IJN photos of YTR's pressure sores and ulcers taken by medical staff in hospital. He believed the one on her foot was present for about a month. He noted that he had seen the pressure sores on YTR's buttocks when she was urinating, however he stated that YTR did not want to see a doctor for the wounds. Police applied for a Family Violence Intervention Order (**FVIO**) against IJN to protect YTR.

33. Maroondah Hospital commenced communication with YTR's daughter, PLK, given the FVIO in place against IJN. YTR underwent a CT scan which revealed a retroperitoneal mass extending inferiorly from below the right kidney into the pelvis associated with mild bony destruction of the L5 vertebral body and superior portion of the sacrum.

34. YTR's conscious state fluctuated in the days that followed, and her condition deteriorated. A joint decision was reached between YTR's family and the treating team, and YTR was transitioned to palliative care. She passed away on the evening of 11 November 2020.

35. Following YTR's passing, police investigated IJN to determine whether his actions or omissions caused or contributed to YTR's poor condition. Following a comprehensive investigation, police did not charge IJN in relation to YTR's death.

FURTHER INVESTIGATIONS

36. As there were allegations that YTR may have experienced neglect prior to her passing, I requested that the Coroners Prevention Unit (**CPU**)[2] examine the circumstances of YTR's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[3]

37. I make observations concerning service engagement with YTR as they arise from the coronial investigation into her death and are thus connected thereto. However, the available evidence does not support a finding that there is any direct causal connection between the circumstances highlighted in the observations made below and YTR's death.

38. I further note that a coronial inquiry is by its very nature a wholly retrospective endeavour, and this carries with it an implicit danger in prospectively evaluating events through the "*the potentially distorting prism of hindsight*".[4]

39. I also note that there have been no charges laid or proven against IJN in relation to his mother's passing. The Court provided IJN with an opportunity to respond to the allegations and concerns raised by the hospital and Victoria Police. IJN responded by stating that he did not know there was anything wrong with his mother and YTR did not mention same. IJN explained that he tried to wash her arms and legs and brush her hair, however YTR refused as she was sore when touched. He also noted that she had the "*shakes*".

40. I make no comment or judgment about criminal or civil liability in this matter, as it is not my position to do so. However, I highlight the alleged issues with YTR's care as part of a broader discussion about adult safeguarding.

Expert report

41. As part of the investigation into YTR's death, an expert report was obtained from Dr Stephen Campbell, general physician and geriatrician. Dr Campbell was asked to consider YTR's

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[2] The CPU was established in 2008 to strengthen the prevention role of the coroner. The CPU assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. CPU staff include health professionals with training in a range of areas including medicine, nursing, and mental health; as well as staff who support coroners through research, data and policy analysis.

[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 information on family violence-related deaths. Together this information assists with the identification of systemic prevention-focused recommendations aimed at reducing the incidence of family violence in the Victorian Community.

[4] *Adamczak v Alsco Pty Ltd (No 4)* [2019] FCCA 7, [80].

condition at the point she presented to the regional Hospital, and how long YTR was likely immobile prior to her presentation.

42. Dr Campbell opined that YTR's mechanism of death was "*unfortunate*" and that she likely "*experienced physical distress towards the end of her life*". He explained that her decreased mobility, weight loss, right leg swelling and decreased mobility were almost certainly the result of her underlying lymphoma. Although lymphoma can respond well to treatment, YTR's frailty meant that she was unlikely to have tolerated anything other than palliative care by the time her lymphoma was discovered.

43. YTR was noted to be malnourished, however this did not necessarily reflect neglect, as many patients with significant malignancy can experience cachexia (severe muscle and weight loss) due to the disease. On post-mortem examination, YTR's weight was noted to be within the normal range for her height (body mass index of 27.3).

44. YTR had full-thickness pressure wounds in a distribution indicative that they occurred from both a lying and sitting position. The presence of established osteomyelitis indicates that they had been present for longer than a week, however the exact duration could not be accurately determined.

45. YTR had a prior history of schizophrenia, however there was limited history to indicate that this condition limited or impacted her decision-making capacity. Her brain imaging was noted to be unusual, however without a full collateral history, Dr Campbell was unable to give an opinion about YTR's cognitive capacity and state.

46. Dr Campbell opined that the extent to which YTR would have experienced pain and suffering as a result of pressure sores depended upon the degree of nerve damage associated with the documented malignant invasion of her spine by her lymphoma. He considered that YTR's decreased mobility towards the end of her life was associated with nerve damage secondary to the malignancy, which was surrounding and/or adjacent to many of the nerve roots and nerves. Any lack of sensation may have contributed to the development of the pressure sores, as commonly seen in people with paraplegia. With respect to her eventual dehydration and sepsis, it is unlikely that she was fully conscious at the time and was potentially unaware of her thirst.

47. Dr Campbell concluded that based solely upon the evidence provided, he was unable to determine the degree to which YTR suffered pain or discomfort at the end of her life. I accept Dr Campbell's opinion.

Adult safeguarding

48. It appears that YTR was largely invisible until she was transported to regional Hospital. It is unclear how long she lived in these circumstances, however at a minimum, the evidence suggests this was occurring for several weeks. PLK tried to get information from her brother and her mother but struggled to obtain any comprehensive details about her mother's condition.

49. Victoria does not have a comprehensive adult safeguarding framework for protecting at-risk adults from abuse, neglect and exploitation. Therefore, if PLK or YTR's GP wanted to raise concerns about YTR's wellbeing, there was no specific agency that they could contact. Similarly, when YTR first presented to hospital, clinicians queried whether they should contact police or the Victorian Civil and Administrative Tribunal (**VCAT**). In this instance, clinicians contacted police, who applied for an FVIO and initiated a criminal investigation. This was an appropriate response by clinicians and police, within the context of the current Victorian system. However, this case highlights the need for a comprehensive adult safeguarding framework to protect at-risk adults.

50. In the United Kingdom, adult safeguarding involves the investigation of, and coordination of responses to, suspected abuse and neglect of 'at-risk' adults. At-risk adults are defined as people aged 18 years and over who:

    a) Have care and support needs; and

    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.

51. Adult safeguarding is important because people with a disability are often more likely to experience violence, abuse, and neglect, than people without a disability,[5] often from people

[5] Australian Government, *Australia's Disability Strategy 2021-2031* (Strategy, December 2021) 14; Centre of Research Excellence in Disability and Health, *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability Research Report: Nature and Extent of Violence, Abuse, Neglect and Exploitation Against People with*

on whom they depend upon for care and support.[6] Further, the 2021 *National Elder Abuse Prevalence Study* found that older people living in community dwellings in Australia experience abuse at a rate of 14.8%,[7] with those experiencing poor physical or psychological health and higher levels of social isolation more likely to experience abuse.[8]

52. People with needs for care and support face added barriers to accessing and engaging with support when they are experiencing abuse and neglect. These include an inability to independently seek out support services, and challenges associated with reporting and addressing abuse perpetrated by people they are dependent on for care and support.[9] Therefore, a specialised response to reports of abuse and neglect of at-risk adults is required.

53. Adult safeguarding may include actions such as:

a) Taking reports from professionals and community members, and raising own-motion reports about alleged abuse and neglect of at-risk adults

b) Investigating allegations of abuse and neglect of at-risk adults

c) Proactively making enquiries to establish whether any action needs to be taken to prevent abuse or neglect, and if so, by whom

d) Considering the mental capacity of the at-risk adult to engage in the adult safeguarding process and to make decisions related to it, including in relation to safety planning

e) Facilitating decision-making support for at-risk adults

f) Assessing risk associated with neglect and abuse

g) Cooperating with other agencies, including care providers, legal and medical services, to promote the at-risk adult's safety

h) Reporting the abuse to police

Disability in Australia (Report, March 2021) 9; *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* (Final Report, September 2023) vol 11, 171.

[6] *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* (Final Report, September 2023) vol 11, 25.

[7] Australian Institute of Family Studies, National Elder Abuse Prevalence Study: Final Report (July 2021), 53 https://aifs.gov.au/sites/default/files/publication-documents/2021_national_elder_abuse_prevalence_study_final_report_0.pdf.

[8] Ibid, 68.

[9] ALRC, *Elder Abuse – A National Legal Response* (Final Report, May 2017), 379; *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* (Final Report, September 2023) vol 11, 25.

i) Applying for an intervention order in relation to the person allegedly causing harm to the at-risk adult

54. If adult safeguarding legislation and/or an agency were implemented in Victoria, YTR would have likely met the criteria for an adult safeguarding response due to her care and support needs, her mental health conditions, her immobility, her risk of experiencing neglect and the fact that her care and support needs likely would have prevented her from protecting herself. If available, PLK, YTR's GP or any other person who was concerned could have reported their concerns to the agency and the safeguarding agency would have the power to thoroughly investigate. The safeguarding agency also could have considered whether YTR required a guardianship order, where another person could make decisions about her medical treatment.

55. YTR's case is not the first case before the Court that highlights the need for a comprehensive adult safeguarding framework. In my finding into the death of CFT[10], I made 10 recommendations to the Office of the Public Advocate (**OPA**) and the Department of Families, Fairness and Housing (**DFFH**). This is discussed further below.

1) That the Office of the Public Advocate whenever they become aware of any allegations of neglect or abuse of a represented persons where a guardianship and administrative order is made by VCAT conduct a thorough investigation. This investigation could be carried out by the Office of the Public Advocate or another agency at their request. The outcome of the investigation should inform the guardian advocate's decision-making, where appropriate.

2) When implementing the VAGO recommendation that the Office of the Public Advocate "*review and update its guidance about allocating orders and balancing the risk of harm when making decisions*", the Office of the Public Advocate should review their training, policies, procedures and guidelines to ensure guardian advocates have the guidance and skills necessary to appropriately assess the risks of harm to represented people which may emanate from neglect and unmet care needs.

3) That the Victorian Government make available appropriate funding to the Office of the Public Advocate to enable it to implement all of the recommendations from the VAGO report.

[10] Finding into death without inquest – CFT (COR 2020 4205).

4) The Victorian Government implement as a priority, adult safeguarding legislation to establish adult safeguarding functions including but not limited to the assessment and investigation of, and coordination of responses to allegations of abuse, neglect, and exploitation of at-risk adults.

5) In framing legislation, the Victorian Government review the circumstances of CFT's passing and similar cases together with the safeguarding recommendations of the ALRC, the OPA and the DRC.

6) That any new adult safeguarding agencies be adequately funded by the Victorian Government to function in an effective manner.

7) That the Victorian Government, when establishing a new safeguarding agency, should ensure that the agency works cooperatively with other service providers to facilitate the timely provision of, or changes to, the support services provided to at-risk adults.

8) That the Victorian Government introduce legislation to permit an adult safeguarding agency to receive and share information in a timely manner, including information about neglect, with police, healthcare entities, government departments, the Office of the Public Advocate and any other agencies involved.

9) That the Victorian Government implement the recommendation of the Office of the Public Advocate, namely, to build the capacity of mainstream service providers to be able to identify and respond to the abuse of at-risk adults.

10) That the Victorian Government make funding available for regular community awareness, media engagement and education campaigns about any new adult safeguarding function, as suggested by the Disability Royal Commission.

FINDINGS AND CONCLUSION

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

a) the identity of the deceased was YTR, born [redacted]

b) the death occurred on 11 November 2020 at Eastern Health, Maroondah Hospital, 1-15 Davey Drive, Ringwood East, Victoria, 3135, from *1(a) complications of prolonged immobility and malnutrition in a woman with retroperitoneal lymphoma*; and

c) the death occurred in the circumstances described above.

COMMENTS

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

1. I endorse recommendations 4 to 10, made in my Finding into the death of CFT,[11] namely:

   4. *The Victorian Government implement as a priority, adult safeguarding legislation to establish adult safeguarding functions including but not limited to the assessment and investigation of, and coordination of responses to allegations of abuse, neglect, and exploitation of at-risk adults.*

   5. *In framing legislation, the Victorian Government review the circumstances of YTR's passing and similar cases together with the safeguarding recommendations of the ALRC, the OPA and the DRC.*

   6. *That any new adult safeguarding agencies be adequately funded by the Victorian Government to function in an effective manner.*

   7. *That the Victorian Government, when establishing a new safeguarding agency, should ensure that the agency works cooperatively with other service providers to facilitate the timely provision of, or changes to, the support services provided to at-risk adults.*

   8. *That the Victorian Government introduce legislation to permit an adult safeguarding agency to receive and share information in a timely manner, including information about neglect, with police, healthcare entities, government departments, the Office of the Public Advocate and any other agencies involved.*

   9. *That the Victorian Government implement the recommendation of the Office of the Public Advocate, namely, to build the capacity of mainstream service providers to be able to identify and respond to the abuse of at-risk adults.*

   10. *That the Victorian Government make funding available for regular community awareness, media engagement and education campaigns about any new adult safeguarding function, as suggested by the Disability Royal Commission.*[12]

2. In response to my finding into CFT's death, the Department of Families, Fairness and Housing (**DFFH**) responded to advise that it has taken all of the above recommendations into consideration. It further noted that the Victorian Government is working with the Disability

[11] Finding into death without inquest – CFT (COR 2020 004205).
[12] Finding into death without inquest – CFT (COR 2020 004205).

Reform Ministerial Council to consider reform options in response to the Disability Royal Commission, which also recommended the introduction of adult safeguarding legislation.

3. In their response, DFFH also listed various initiatives which are funded by the Victorian Government, and which are aimed at preventing and responding to elder abuse. I do not view any of these initiatives as a substitute for the above recommendations, which have been made and supported by the ALRC, the OPA and the Disability Royal Commission over the course of several years. At-risk adults, particularly those who live in their own homes, continue to experience abuse and neglect at the hands of people known to them, and the service sector is not equipped to respond to this risk.

4. Finally, DFFH referred to the new Social Services Regulator as a new initiative to reduce the risk to vulnerable adults with care and support needs, however this body only covers state-funded disability services. In this case, YTR was not receiving state-funded disability services, so the Social Services Regulator is unlikely to have made a difference here.

I convey my sincere condolences to YTR'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:

PLK, Senior Next of Kin

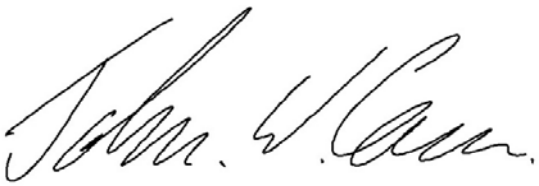
Department of Families, Fairness and Housing

Eastern Health

Office of the Public Advocate

Sergeant Angie Clark, Coronial Investigator

Signature:



Judge John Cain
State Coroner
Date: 30 July 2025

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.