IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 000022

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:	DRF
Date of birth:	[redacted]
Date of death:	2 January 2022
Cause of death:	1(a) Acute intracranial haemorrhage
Place of death:	The Alfred 55 Commercial Road, Melbourne, Victoria, 3004
Keywords:	Family violence; adult safeguarding, elder abuse; disability

INTRODUCTION

1. On 2 January 2022, DRF was 95 years old when she passed away at the Alfred Hospital. DRF is survived by her two sons, UJN and QAZ.

Background

2. DRF was born in Greece on [redacted], married NBV and had her two children. UJN was born in 1956, and QAZ was born two years later. The family of four moved to Australia in 1969. NBV tragically took his own life in 1981.

3. UJN lived with his wife and three children at DRF's home in Prahran until 2012, when he separated from his wife. UJN went on to live with his mother at her home until DRF's death. Also living at the address was UJN's adult son, BHU.

4. QAZ maintained contact with his mother through UJN, who occasionally transported DRF to QAZ's home. This contact reduced in the two years prior to the fatal incident due to the COVID-19 pandemic and associated lockdowns. The relationship between UJN and QAZ was reportedly turbulent at times.

5. DRF began to show signs of dementia in 2020. Her general practitioner (**GP**) conducted a mini-mental state examination (**MMSE**) in December 2020 which reflected that DRF had a mild cognitive impairment. The GP reported that DRF displayed "*increased confusion and wandering*" in the months prior to the fatal incident. This assessment appeared to be based on information provided by UJN, who attended GP appointments with his mother. At the time of her passing, DRF had other care and support needs. Due to her age and frailty, she required a walker or walking stick to mobilise and QAZ reported that she had a history of falls. Her hearing was impaired to the extent that she could not use the telephone. She was prescribed several medications, including a low-dose opioid for chronic sciatic pain.

6. In the years prior to the fatal incident, UJN was DRF's primary carer. According to QAZ, UJN administered DRF's medications and facilitated contact between her and QAZ. UJN often took DRF to the GP for appointments.

THE CORONIAL INVESTIGATION

7. DRF'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.

8. 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.

9. 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.

10. Victoria Police assigned Detective Senior Constable Brett Dickson to be the Coronial Investigator for the investigation of DRF's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

11. This finding draws on the totality of the coronial investigation into the death of DRF 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

12. On 2 January 2022, DRF, born [redacted], was visually identified by her son, UJN.

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

Medical cause of death

14. Forensic Pathologist Dr Brian Beer, from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 4 January 2022 and provided a written report of his findings dated 13 May 2022.

[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.

15. Dr Beer noted significant pathology of a large predominantly left-sided subdural haemorrhage and bilateral inferior base of brain frontal and temporal subdural haemorrhage, together with left-sided subarachnoid haemorrhage. There was subsequent brain mass effect and brain herniation. There were no features of organisation of the subdural haemorrhage histologically and this is consistent with a relatively acute event prior to death in the order of hours to days, rather than weeks. There was no evidence of skull fractures and no significant scalp or temporalis muscle injury.

16. Dr Beer explained that subdural haemorrhage occurs when the bridging veins between the brain and the dura are torn due to blunt force trauma to the head. In the present case, there was a frontal scalp contusion, bilateral periorbital contusions, and subarachnoid haemorrhage which were all supportive of a traumatic aetiology for the injuries seen. Dr Beer noted that there are several other factors to consider with regard to the cause/extent of the haemorrhage. There was amyloid angiopathy which increases the risk of bleeding, but the pattern in the present case was typically of a discrete intra-cerebral bleed, and the overall pattern seen was of trauma and was not in keeping with a spontaneous haemorrhage from amyloid angiopathy. The deceased was taking warfarin, which increases the risk of haemorrhage even with a relatively minor trauma.

17. There had been a right-sided traumatic impact to the abdomen with acute bruising to the right abdominal wall and retroperitoneal zone, and a much less well-defined area of bruising to the right lateral chest rib zone.

18. There was moderately extensive bruising to both arms and to a much lesser extent, the head, legs and torso. As noted, the deceased was taking warfarin and was elderly, so some of the bruising can be explained by those factors. Bruising can occur with relatively minor trauma in elderly people on anticoagulant medication.

19. There was autopsy evidence for multiple traumatic events with no history provided as to how these may have occurred, notably any witnessed falls. One possible explanation for these injuries is of an elderly and frail woman who is anticoagulated, having repeated unwitnessed accidental falls. Third-party involvement in these injuries could not be excluded.

20. There was also natural disease observed, consistent with age, and a COVID-19 organising pneumonia. However, the intracranial haemorrhage was sufficient to have caused death.

21. Toxicological analysis of post-mortem samples identified the presence of oxycodone, irbesartan, warfarin, domperidone and paracetamol, all within therapeutic levels.

22. Dr Beer provided an opinion that the medical cause of death was *1(a) acute intracranial haemorrhage.*

23. I accept Dr Beer's opinion as to the medical cause of death.

Circumstances in which the death occurred

24. After the incident on 21 December 2021 (see below), QAZ alleged that UJN did not permit him to see their mother, and he was not able to speak to her over the phone due to her hearing impairment. On 22 December 2021, UJN took his mother to her GP and reported that she was increasingly confused and was wandering more.

25. On the evening of 1 January 2022, UJN called 000 and reported that his mother had been sleeping for most of the afternoon and he was unable to rouse her. He later reported that she had been "*agitated and screaming for help*" overnight. Paramedics attended and transported DRF to the Alfred Hospital where she was found to have a large subdural haematoma. Her condition was deemed inoperable, and she passed away at 5.21am on 2 January 2022.

FURTHER INVESTIGATIONS AND CPU REVIEW

26. As DRF's death occurred in circumstances where there was a reported history of family violence, I requested that the Coroner's Prevention Unit (**CPU**)[2] examine the circumstances of her death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[3]

27. I make observations concerning service engagement with DRF 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 DRF's death.

[2] The CPU was established in 2008 to strengthen the coroners' prevention role and assist in formulating recommendations following a death. The CPU is comprised of health professionals and personnel with experience in a range of areas including medicine, nursing, mental health, public health, family violence and other generalist non-clinical matters. The unit may review the medical care and treatment in cases referred by the coroner, as well as assist with research related to public health and safety.

[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.

28. 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] I make observations about services that had contact with DRF to assist in identifying any areas of practice improvement and to ensure that any future prevention opportunities are appropriately identified and addressed.

29. I also note that UJN has never been charged or convicted with any offence in relation to DRF and I make no comment as to the validity of the claims against him. The allegations are noted here purely to illustrate the challenges associated with responding to complex complaints of family violence and/or elder abuse. Prior to my finalisation of this matter, the Court wrote to UJN to provide him with an opportunity to respond to the allegations. The Court sent both a letter via registered post and an email, neither of which received a response.

Review of Victoria Police contact and family violence history

26 September 2021

30. On 26 September 2021, a third-party contacted Crime Stoppers and reported that neighbours had heard an elderly woman being "*emotionally abused*" by her adult son at DRF's address for at least a year, including yelling, swearing, name-calling, and threats of violence. They reported hearing such abuse at 11.00am on the day of the report, including a threat to kill. The report stated, "*it is quite clear that the lady is afraid*" and noted that she usually did not "*say much*" in response to the abuse, but on this occasion had calmly stated that if it did not stop that she would call the police.

31. Crime Stoppers notified police of the report, and they attended DRF's address on the same day, however no one answered the door. Police conducted checks and correctly identified all the inhabitants of the house, and attempted to call UJN, but he did not answer.

32. On 27 September 2021, a Sergeant at the Prahran Family Violence Investigation Unit (**FVIU**) recorded a plan for police to follow up with a welfare check on DRF "*to determine if any FV is occurring, if further supports are required for parties*". Nothing further occurred and no welfare check was conducted.

33. I note that police did not complete a family violence report (**FVR L17**) on this occasion. Section 3.5 of the Victoria Police Manual (**VPM**) at the relevant time stated:

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

Members investigating an incident where family violence has occurred, must:

- *Complete an FVR (L17) for every reported incident of family violence, regardless of who made the report…*

34. In their submissions to the Court, Victoria Police noted that an L17 is "*required where family violence has occurred. For the incident on 26 September 2021 members were responding to a Crime Stoppers report of a loud verbal dispute occurring between [DRF] and her son, [UJN]. They first needed to ascertain whether family violence had occurred before completing an L17*".

35. I accept that technically police had not confirmed whether a family violence event occurred. However, police did not speak to any of DRF and UJN's neighbours to assist with this determination. The person who made the Crimestoppers report provided contact details, however these were found to be incorrect. Based on the Crimestoppers report, it is apparent that the person reporting the alleged abuse was a neighbour or someone who lived nearby (within earshot). They also noted "*A person said that they have heard this kind of abuse for the entire year that they have lived here*".

36. It is not clear why attending police did not speak to DRF's neighbours, to ascertain if they recalled any historical incidents, or if they heard the alleged incident earlier that day. I cannot now determine why police did not make these enquiries, and obtaining statements from the relevant members three and a half years after the incident would be of limited forensic value. Nevertheless, this appears to be a departure from the VPMG FV that states when attending a family violence incident, members should "*investigate all offences by gathering background information…and statements from all available witnesses*".[5]

37. In its statement to the Court, Victoria Police conceded that "*best practice would include attempting to speak to neighbours whilst investigating the report (if time and resources allowed)*".

38. It is also unclear why police did not follow up with DRF or perform a welfare check as suggested by the Prahran FVIU. In circumstances where police were unable to speak to DRF or UJN, and the Crimestoppers reporter had serious concerns for DRF's welfare, it would have been prudent to conduct a welfare check in my view.

[5] VPMG FV, 3.

39. I cannot determine that these departures from policy were causative of or contributory to DRF's death, nor that speaking to neighbours and/or performing a welfare check would have prevented DRF's death. However, I am of the view that this represents a missed opportunity for police to obtain more information about the relationship between DRF and UJN and consider whether any further action was required.

40. In its response to the Court, Victoria Police stated that there is no prescriptive structure or procedure for a welfare check, as the range of circumstances that may be encountered by police members when conducting a welfare check are very broad. It submitted that a miscommunication between frontline members at the FVIU may have contributed to the situation in which no follow-up occurred.

16 December 2021

41. On 16 December 2021, a neighbour called Victoria Police and reported that UJN was allegedly "*yelling and screaming*" at DRF, including "*threats to kill*". Two police officers attended the address and UJN denied threatening DRF. He explained that he yelled at DRF because she was deaf, and he had a loud voice. He also noted that DRF had dementia and explained that she had previously demonstrated signs of paranoia and confusion.

42. Police separately spoke to BHU during their attendance. BHU stated that "*he had heard the dispute today however says it is a regular occurrence as she is partially deaf and has dementia*". BHU stated that he did not hear his father threaten DRF.

43. During this contact, DRF exited the home and sat on the front porch where police were speaking with UJN. Police observed that she did not have any visible injuries. UJN entered the house twice during the police attendance, leaving DRF alone with one or both of the members very briefly each time. The first time a member asked DRF if she was okay, she responded "*Ah, no good*" and then explained that she could not speak English. The member responded, "*Yeah I know, that's okay*".

44. The second time DRF was alone with police she attempted to communicate with them, gesturing to the house and saying, "*two boys*", but the rest of her sentence is inaudible. During a private conversation between the members, one suggested that they use Google translate to communicate with DRF, however the other declined, stating "*she seems to be okay…She's got dementia and stuff, you try and talk to her she probably won't know what's going on. It's all good*".

45. Police concluded that this was a "*non violent, non abusive*" verbal dispute and labelled UJN as the respondent and DRF as the affected family member (**AFM**). Police completed a Family Violence Report (**L17**), however as the L17 risk rating was low, family violence support referrals were not generated for DRF or UJN.

46. There appear to be several issues of non-compliance with respect to this contact. DRF told the officers that she did not speak English and when one of the members suggested that they should use Google translate, the more senior member declined. The Family Violence VPM in place at the time specified:

- *Where any party does not speak English as their first language…members must seek an interpreter from an approved interpreter service as soon as possible to ensure they can tell their story.*
- *The language needs of the AFM and respondent are to be considered separately and children must not be used as interpreters.*
- *Members may only use neighbours or other persons present (with the exception of respondents family members, friends and children) in an emergency situation. An accredited interpreter must be used as soon as practicable.*
- *When using onsite interpreters, members should take all reasonable steps to ensure that the interpreter is not associated with the AFM or their immediate cultural community.*

47. I am of the view that members should have obtained the services of an interpreter to assist with speaking to DRF. In its statement to the Court, Victoria Police conceded that there was a failure to comply with policy in relation to obtaining an interpreter.

48. I also note that members did not speak to DRF privately, and UJN was present or nearby for all of their interactions with her. According to the VPMG FV, members should "*separate the parties and speak to them privately to ascertain what has occurred*".[6] The members also did not call the complainant (the neighbour), despite having their contact details, or ask any of the other neighbours if they had heard anything.

49. These deviations from Victoria Police policy and procedure meant that when police completed the FVR L17, they were not working with a complete picture of the incident or DRF and UJN's relationship. Different information may have prompted a higher risk rating, which may

[6] VPMG FV, 26 February 2021, 3.

have triggered further actions such as formal family violence referrals. I note, however, that specialist referrals are unlikely to have had a preventative impact in this case due to the barriers DRF faced when accessing support independently.

50. Ultimately, I cannot conclude that these deviations, if rectified, would have prevented DRF's death, nor that they were causative or contributory to her passing. Nevertheless, they represent missed opportunities to engage with DRF in a culturally safe manner and potentially obtain further details about DRF and UJN's relationship.

21 December 2021

51. On 21 December 2021, a member of the public located DRF in a distressed state outside a pub nearby her Prahran home. The member of the public arranged for a Greek-speaking friend, XSW to attend and translate for DRF, then contacted Victoria Police. He reported to police that DRF "*was distressed thinking that her son is going to beat her up she [sic] goes home*" and that "*she keeps saying that M [UJN] is threatening to beat her up*".

52. Upon police arrival, they first spoke with XSW who explained that DRF was afraid of her son and had become "*petrified*" during a discussion with him about her wish to leave part of her home to her other son. Police separately spoke to the passer-by, who reiterated that DRF told him that her son was threatening to kill her. The more senior of the two police officers had his body worn camera (**BWC**) activated during these two conversations, however he walked towards DRF so the rest of the conversation between the passer-by and the junior officer was not captured on BWC.

53. The senior officer sat down with DRF and reviewed the LEAP record of police contact between DRF and UJN on 16 December 2021. Shortly thereafter, UJN arrived at the pub, searching for his mother. UJN remained within a few metres of DRF for the remainder of her contact with police. During this time, UJN approached the table where the police officer and DRF were seated and informed the officer that DRF "*makes things up*" because she had dementia.

54. The officer spoke to DRF, using XSW as a translator. After UJN's arrival, XSW noted that DRF was "*changing her story*" and advised that DRF was now describing UJN as "*really nice*". However, DRF did disclose that she was petrified that UJN would get "*more angry*" if she left part of her home to her other son, QAZ. When asked whether she was worried that

UJN might hurt her, DRF stated "*I'm scared*". DRF started to make further comments, however the police officer walked away before XSW could translate.

55. The two officers consulted with one another. The senior officer stated that the police call out one week prior was "*just loud voices heard, nothing threatening*". He then contacted a supervisor by phone but muted his BWC and did not unmute it until he had returned to DRF and spoke to her for a further 20 minutes. During that time, the officer made notes including "*scared of the way he talks to her*" and then appears to contact QAZ by phone. In his statement, the junior officer explained that the senior officer told him that QAZ was happy to collect DRF and take her to his house for the night. This is not referenced in QAZ's statement and DRF did not stay with QAZ that evening.

56. When the senior officer unmuted his BWC, he advised UJN that QAZ would be attending the pub to make sure things were "*all good*" and stated, "*We're not saying that anything's happened, but your mum's quite worried that there will be some kind of verbal argument…we're just trying to keep everyone calm, not stressed out*".

57. As the police prepared to leave, XSW said "*she won't let me go now, I don't know what to do*", however police continued to leave. The senior officer stated "*I know but, public place. I'll speak to the staff. If anything changes they can call us and we can just come back and deal with it from there…I think she's just worried about getting back home and having the argument*". As the officers left the pub, a staff member approached and asked to speak to them, however the senior officer turned off his BWC, so the content of their conversation is unknown.

58. The senior officer's statement on the brief reflects that DRF denied that UJN had yelled at or physically hurt her and was simply worried about having a "*difficult conversation*" with UJN about the will. Due to the BWC being muted, this cannot be confirmed. In his statement, the junior member noted that the senior member told him "*that the conversation with DRF had been difficult because he had to go through [the passer-by's friend] as a translator, but that she appeared afraid, and had left the house that afternoon because she was afraid of her son UJN and thought that he might kill her and that there was a dispute over inheritance*".

59. The junior officer did not activate his BWC, however his statement reflects that he spoke to UJN who denied arguing with his mother about his inheritance, said that DRF "*had severe dementia and was becoming paranoid and acting out by leaving their home on her own*". UJN

was reportedly "*upset with police being involved and the lady translating for police and the process in general*" and was "*dismissive of people believing his mother's concerns*".

60. Police left the scene before QAZ arrived. They completed a FVR L17 which labelled UJN as the respondent and DRF as the AFM and noted that no criminal offences would be investigated. The FVR L17 stated that DRF had left the house because she was concerned that UJN was "*going to argue with her*", and that she told a passer-by that she was "*afraid to go home*". The L17 does not include a reference to DRF's disclosure to XSW/the passer-by that she was afraid that UJN would "*beat her up*" or kill her. The L17 did not include an accurate summary of the recent concerns raised with police about UJN's alleged behaviour and only stated that there had been one previous recorded incident with no criminal offences, which appeared to be "*just loud parties due to the AFM's hard hearing*". The FVR L17 triggered referrals to family violence services for both DRF and UJN.

61. QAZ alleged that after this incident, he and UJN had a verbal argument outside DRF's home and UJN punched him in the face. DRF reportedly tried to intervene during the argument and fell over in the process, however no one sought medical intervention for DRF, with UJN and BHU taking DRF inside.

62. After the incident, QAZ noted that he called the senior officer and discussed what he could do to help his mother. The officer reportedly informed him that "*police would most likely remove the perpetrator from the home address*" if he pursued the matter further. QAZ explained that he decided not to take the issue any further because he believed DRF would have been placed in a nursing home or a care facility if UJN were excluded from the house. The Victoria Police records provided to the Court do not include any record of this conversation by the senior officer.

63. I note that members did not use an approved interpreter in this situation, as with the incident on 16 December 2021. Although XSW was utilised as a friend of the passer-by who first located DRF, the junior member opined that this significantly impeded communication between DRF and police. Additionally, UJN was noted to be within a few metres of DRF during the majority of her contact with police, as was the case on 16 December 2021. This may have impacted DRF's ability to freely tell police what was occurring at home.

64. I also note that only one of the two attending members activated their BWC, so only some of the conversations with the parties and witnesses were captured on BWC. When the senior member made a call to his supervisor to discuss the case, he muted the BWC, however did

not unmute the BWC when the call ended. Pursuant to 3.7 of the VPM – BWC in place at the time, "*Members should only mute a recording when…making or receiving a telephone call when not directly communicating with a subject*".[7]

65. It is understandable that members may forget that their BWC is still muted after taking a phone call. I note that the issue of activating and using BWC has been a feature in other coronial inquests. In the Inquest into the passing of Stanley Turvey, the predominant issue was in relation to the use of BWC for Special Operations Group members, while in the Inquest into the death of Gabriel Messo, the primary issue related to the activation of BWC when police draw their firearms. The present case differs from both the Messo and Turvey inquests, in that police did not draw or use their firearms during their interactions with DRF, however the missing BWC footage and missing audio has nevertheless hindered my ability to determine precisely what occurred in the present case.

66. I am of the view that forgetting to unmute the BWC was accidental in nature and is not representative of a conscious decision by the member to obscure the conversation. The BWC unit used by Victoria Police has a function LED that flashes blue while it is muted. However, it does not have an audible alert to advise the user that the device is muted. When in normal recording mode, the BWC beeps twice at the start of a recording and every two minutes. I acknowledge that Victoria Police does not manufacture, nor control the features provided by the BWC units. However, in circumstances where the device is already configured to give audible alerts during routine recording, it appears reasonable that the unit could be modified to provide a different alert tone while the device is muted, for example a triple tone or a longer single tone. This would serve as an additional reminder for police to unmute the device. I therefore intend to make a recommendation to that effect.

67. In circumstances where it is not possible to modify the BWC units, then an alternative solution may be appropriate. For example, if BWC guidance was changed to state that BWC should not be muted during phone calls or other forms of contact with other police members, including supervisors, while responding to an incident that has required BWC activation. When BWC is used in court proceedings, then Victoria Police could apply the necessary redactions to the audio, prior to releasing the footage to a legal practitioner or interested party. This would ensure the audio is available for use if required, and otherwise sensitive or private

[7] VPM – Body Worn Cameras, 1 June 2022, 5.

sections of audio could be redacted prior to its release for legal or other proceedings. I therefore intend to make a recommendation to that effect.

68. I also note there are discrepancies in the statements provided by the two attending members. The senior member stated that when asked if UJN had perpetrated family violence against her, DRF denied the allegation. However, the junior member stated that after speaking with DRF, the senior member reported that she appeared afraid, had left the house as she feared that UJN might kill her and that there had been a dispute over inheritance earlier that day. Similarly, the junior member's statement indicates that QAZ would take DRF to her home for the night, however QAZ does not reference this in his statement, and she did not stay with him that evening. I also note that police left the scene prior to QAZ's arrival. The advice provided to QAZ regarding risk management options was somewhat inaccurate, as the member reportedly only advised QAZ about UJN's removal via an FVIO, and did not discuss the option of an FVIO with limited conditions.

69. Finally, I note that the FVR L17, which doubled as the referral to support services, did not contain information about the prior two police contacts with DRF and UJN, including allegations that UJN was abusing DRF and reports of threats to kill.

70. Ultimately, I cannot conclude that the police response on 21 December 2021 was causative of or contributory to DRF's death, nor that a different response would have prevented her passing. However, the deviations from Victoria Police policy and procedure are regrettable as they represent missed opportunities to obtain more information about DRF and UJN's relationship and potentially intervene prior to the fatal incident.

71. Victoria Police already have guidance in place on best practice when responding to allegations of abuse against older people. This includes information on the vulnerabilities of older people, including dependence on perpetrators for care and support, reluctance to report adult children to police, and types of abuse commonly perpetrated against older people, such as financial abuse including pressuring older people to change their wills.

72. Victoria Police conceded that its interactions with DRF and her family included instances when best practice was not employed. It further noted that it is committed to improvement and that issues involving non-compliance have been investigated by the Professional Standards Command (**PSC**) and recommendations have been made. The PSC investigation resulted in workplace guidance and opportunities for training.

73. Victoria Police submitted that it has enhanced the organisational understanding and focus on elder abuse in recent years. There have been several enhancements to improve members' understanding of what elder abuse is; education to ensure members can identify elder abuse; and support victims. In recent years, Victoria Police has:

    a) Created a learning hub quick guide about elder abuse and financial abuse.

    b) Published internal elder abuse, seniors factsheets, and myth buster factsheet about dementia.

    c) Published internally on the intranet a Financial Elder Abuse page with additional resources, case studies and educational links for members and employees.

74. Despite Victoria Police's ongoing commitment to improving responses to family violence and elder abuse, this case illustrates that responding to abuse of people with needs for care and support is complex and often necessitates a level of specialisation beyond that of Victoria Police. I am of the view that the establishment of adult safeguarding legislation and a robust adult safeguarding agency which police can consult with and work alongside, will improve Victoria Police responses to allegations of abuse of at-risk adults. Adult safeguarding is discussed further below.

75. After the incident, the FVR L17 was reviewed by a Divisional Deputy Family Violence Liaison Officer (**FVLO**) who requested further information about whether the investigating member had considered the possibility of elder abuse and asked that they confirm whether appropriate referrals had been made "*to support AFM's health conditions*". An undated response confirmed that The Orange Door had referred DRF to Better Place services for support. It also stated that there was "*no indication of abuse at time of incident*" including in the conversation that police had with QAZ. It does not appear that Victoria Police took any further action in relation to this incident.

76. The Orange Door consulted with Better Place and sent them the referral. The referral was not sent until 11 February 2022, about six weeks after the fatal incident. The referral was allocated to a Better Place staff member who attempted to contact DRF on 25 February 2022. They noted that the phone number provided by The Orange Door was disconnected and closed the referral that same day.

Adult safeguarding

77. It appears that the most substantive issue in this case relates to Victoria's lack of a comprehensive framework for safeguarding at-risk adults from abuse, neglect and exploitation. Below is an explanation of safeguarding, and its relevance to the circumstances of DRF's death. While DRF may not have been able to contact a safeguarding agency herself, police, QAZ, or other parties may have been able to make a referral to the agency when they noted concerns for her welfare.

78. The issue of adult safeguarding was extensively discussed in my recent finding into the death of CFT[8], and appears to be a relevant issue in the present case. In DRF's case, neighbours, locals and at least one Victoria Police member who were concerned about DRF's welfare did not have a clear referral pathway to raise concerns about UJN's alleged behaviour or escalate their concerns.

79. Broadly, adult safeguarding means protecting the rights of adults to live in safety, free from abuse and neglect.[9] In the United Kingdom (**UK**), adult safeguarding involves the investigation of, and co-ordination of responses to, suspected abuse and neglect of 'at-risk' adults.[10] At-risk adults are defined as people aged 18-years-old and over, who:

    a) have care and support needs;[11] 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.[12]

80. Adult safeguarding is important because people with a disability are more likely to experience violence, abuse, and neglect than people without a disability,[13] often from people on whom

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8 Finding into death without inquest – CFT (COR 2020 4205).

9 UK Department of Health, *Care and support statutory guidance*, (5 October 2023) s 14.7 < Care and support statutory guidance - GOV.UK (www.gov.uk)>.

10 Australian Law Reform Commission (ALRC), *Elder Abuse – A National Legal Response* (Final Report, May 2017), 376 <elder_abuse_131_final_report_31_may_2017.pdf (alrc.gov.au)>.

11 In the UK these needs may relate to a physical or mental impairment or illness, including conditions such as physical, mental, sensory, learning or cognitive disabilities or illnesses, and brain injuries. This list is not exhaustive, and the criteria for accessing a safeguarding response is broader than that for accessing publicly funded care and support services - UK Department of Health, *Care and support statutory guidance*, (5 October 2023) s 6.104 and s 14.5 < Care and support statutory guidance - GOV.UK (www.gov.uk)>.

12 Australian Law Reform Commission (ALRC), *Elder Abuse – A National Legal Response* (Final Report, May 2017), 387; OPA, *Line of Sight: Refocussing Victoria's Adult Safeguarding Laws and Practices* (Review, 18 August 2022) 7; Care Act 2014, s 42 (1); Care Act 2014 (UK), s 42 (1).

13 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*

they depend for care and support.[14] 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%,[15] with those experiencing poor physical or psychological health and higher levels of social isolation more likely to experience abuse.[16]

81. 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 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.[17] A specialised response to reports of abuse and neglect of at-risk adults is therefore required.

82. In this case, DRF would have likely met the criteria for an adult safeguarding response, given that:

    a) She had needs for care and support related to hearing, mobility, and mild cognitive impairments.

    b) She was allegedly experiencing abuse perpetrated by her son who was also her primary carer.

    c) Her needs for care and support likely prevented her from protecting herself from the alleged abuse.

83. Furthermore, it is possible that none of the agencies currently involved in adult safeguarding in Victoria would have been equipped to adequately respond to the alleged abuse for the following reasons:

    a) The alleged abuse was perpetrated in private accommodation where abuse of people with a disability is significantly under-reported, and which is not subject to the oversight of the Office of the Public Advocate (**OPA**) through Victoria's Community Visitors Program.

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.

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

[15] Australian Institute of Family Studies, National Elder Abuse Prevalence Study: Final Report (July 2021), 53 <National Elder Abuse Prevalence Study: Final Report (aifs.gov.au)>.

[16] Australian Institute of Family Studies, National Elder Abuse Prevalence Study: Final Report (July 2021), 68.

[17] ALRC, *Elder Abuse – A National Legal Response* (Final Report, May 2017), 379; DRC vol 11, 25.

b) Although DRF may have required support with decision-making due to her mild cognitive impairment, the extent of this need may not have met the threshold for an investigation by the OPA under their limited role in adult safeguarding. The OPA has powers to advocate for the human rights and interests of people with a disability, however this is not required, nor is the OPA funded to provide this advocacy, following reports of abuse and neglect of at-risk adults.

c) As in this case, Victoria Police responses to allegations of abuse against at-risk adults, particularly in the absence of clear criminality, are generally limited to offering referrals to other agencies.[18] In this case, the offer of an FVIO was not necessarily appropriate, given that the alleged perpetrator of the abuse was also DRF's carer.

d) Specialist family violence services do not have a statutory safeguarding function, nor the associated powers required to carry one out. In this case, DRF was referred to The Orange Door, and from there to Better Place. Better Place provides elder abuse specialist services which may have benefitted DRF. However, Better Place do not have the necessary resources to provide comprehensive and time sensitive adult safeguarding services. Of note, the Victorian Government defunded 70% of Better Place's elder abuse specialist positions in August 2023, reducing the number of practitioners in the state from 15 to five. The Better Place website indicates that only 30% of The Orange Door locations are currently able to refer clients to specialist elder abuse services and wait lists for support are several weeks long. Further, Better Place services are not underpinned by safeguarding legislation, and therefore do not have the powers necessary to comprehensively investigate and respond to allegations of abuse of older adults. In DRF's case, The Orange Door and police were not compelled to make a timely referral to Better Place, and Better Place were not empowered or obliged by legislation to respond in a timely way to concerns for DRF, nor to attend her address when they were unable to contact her by phone.

84. As in the matter of CFT, I am of the view that DRF's case is another example of a situation where an adult safeguarding agency could have been beneficial. QAZ, neighbours or police who held concerns for DRF could have raised these with the agency and received guidance and advice. If DRF's situation met the requisite threshold for a safeguarding response, the agency could have taken the lead as the coordinator. This also provides a simpler and more

[18] OPA, *Line of Sight: Refocussing Victoria's Adult Safeguarding Laws and Practices* (Review, 18 August 2022) 69.

streamlined response and eliminates confusion in situations where multiple parties are involved.

85. An adult safeguarding response which involved actions commonly taken in other jurisdictions could have benefited DRF by:

    a) Providing an accessible service within a prescribed timeframe.

    b) Speaking directly and sensitively with DRF about her alleged experiences to assess risk, including via outreach if necessary.

    c) Considering DRF's mental capacity to make decisions relating to the safeguarding process, advocating for her right to make decisions free from abuse and coercion, and considering protective interventions such as appointing an independent advocate, or making applications for guardian and/or administration orders.

    d) Implementing a specialised safety plan, which could include assistive technologies relevant to DRF's care needs, engaging the support of other family members, and otherwise broadening her informal support network.

    e) Supporting DRF to consider formal aged care arrangements to supplement or replace the care provided by UJN and providing advocacy in relation to setting these services up in a timely way.

FINDINGS AND CONCLUSION

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

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

    b) the death occurred on 2 January 2022 at The Alfred 55 Commercial Road, Melbourne, Victoria, 3004, from *1(a) acute intracranial haemorrhage*; 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 the 10 recommendations made in my Finding into the death of CFT:

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.*

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.*

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.*[19]

RECOMMENDATIONS

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

(i) That **Victoria Police** consider the possibility of modifying their body worn camera (**BWC**) units in collaboration with the relevant manufacturer(s) to emit an audible alert tone that reminds officers that their unit is muted.

(ii) Or, in the alternative, that **Victoria Police** amend section 3.7 of the Victoria Police Manual – Body worn cameras to state that members must not mute body worn cameras during phone calls or other forms of contact with other police members, including supervisors, while responding to an incident that has required BWC activation.

I convey my sincere condolences to DRF'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:

UJN, Senior Next of Kin

Alfred Health

Office of the Public Advocate

Victoria Police (C/o – Hall and Wilcox)

Detective Senior Constable Brett Dickson, Coronial Investigator

[19] Finding into death without inquest – CFT (COR 2020 4205), 20-21.

Signature:

Judge John Cain
State Coroner
Date: 3 June 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.