IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 001168

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge Liberty Sanger, State Coroner
Deceased:	Judith Margaret Kerr
Date of birth:	17 November 1943
Date of death:	1 March 2022
Cause of death:	1(a) Multiple organ failure 1(b) Sepsis and renal failure 1(c) Bronchopneumonia and rhabdomyolysis in a woman with covid infection
Place of death:	Sunshine Hospital Furlong Road St Albans Victoria 3021
Keywords:	Adult safeguarding; natural causes; sepsis; multiple organ failure; bronchopneumonia

INTRODUCTION

1. On 1 March 2022, Judith Margaret Kerr was 78 years old when she died at Sunshine Hospital. At the time of her death, Judith lived at Darley, Victoria with three of her four adult children.

Background

2. Judith had four children, Andrew, David, James and Cameron. Andrew, David and James lived with Judith prior to her death. James has a disability and following his mother's passing, moved into NDIS-supported care. Judith reportedly did not have contact with Cameron for several years prior to her death.

3. The father of Judith's children passed away in 1982. Her long-term partner, Charlie, died in about 2012.

4. Judith previously worked at a biscuit factory in Bacchus Marsh. It is not known when she stopped working there. After Charlie passed, she reportedly became introverted and withdrew from social activities. According to Andrew and David, Judith's daily activities included watching television and sleeping.

5. Judith's medical history included hypertension, depression, cognitive impairment and left frontal meningioma. Medical records suggest that she may have also suffered from anxiety. She did not engage with a general practitioner (**GP**) for five to ten years prior to her death.

6. At the time of the fatal incident, Andrew was not employed. He reportedly had no hobbies or external interests. David worked at an apple orchard in Bacchus Marsh and was the sole income earner for himself, Judith, Andrew and James.

THE CORONIAL INVESTIGATION

7. Judith'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 Sergeant Daniel Huisintveld to be the Coronial Investigator for the investigation of Judith'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. State Coroner, Judge John Cain (as his Honour then was) originally held carriage of this matter, prior to his retirement in August 2025. I assumed carriage of this investigation on 1 September 2025.

12. This finding draws on the totality of the coronial investigation into the death of Judith Margaret Kerr 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

13. On 1 March 2022, Judith Margaret Kerr, born 17 November 1943, was visually identified by her son, David Kerr.

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

Medical cause of death

15. Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 4 March 2022 and provided a written report of his findings dated 7 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.

16. The post-mortem examination confirmed bilateral pneumonia (which was suspected in life). There was no evidence of meningitis/encephalitis.

17. Examination of the post-mortem CT scan showed a left lower lobe pneumonia. There was no acute intracranial haemorrhage. There was a right pneumothorax and a T11 wedge/crush fracture.

18. Microbiological examination showed the presence of *Candida parapsilosis* in blood from a left lung swab. Testing from a nasopharyngeal swab was positive for COVID-19, suggestive of the omicron variant. Brain tissue was negative for viruses.

19. The deceased weighed 36kg and was about 150cm tall at the time of the post-mortem examination.

20. Dr Burke stated that it "*would seem reasonable to suggest the probability of Judith Kerr surviving would have been increased if she had been presented to medical attention at an earlier time.*"

21. Toxicological analysis of ante-mortem samples[2] identified the presence of bromhexine.[3]

22. Dr Burke provided an opinion that the medical cause of death was *1(a) Multiple organ failure* secondary to *1(b) Sepsis and renal failure* due to *1(c) Bronchopneumonia and rhabdomyolysis in a woman with covid infection.*

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

Circumstances in which the death occurred

24. At an unknown time on 11 February 2022, Judith was at her home in Darley when she experienced an unwitnessed fall. David left the family home that evening and stayed in the Geelong area. He regularly stayed in Geelong on weekends.

25. Andrew heard Judith calling out for help and he located her lying on the floor. He assisted Judith to get into bed. He attempted to give her medication and some water, but she was unable or unwilling to consume either. Andrew did not advise what medication he tried to provide;

[2] Collected at 10.10pm on 22 February 2022.
[3] Bromhexine is a mucolytic agent.

however, he described it as an "*orange tablet*". Investigating police noted that mirtazapine comes in the form of an orange-coloured tablet, and Judith was prescribed this medication.

26. Andrew reported that he did not check on his mother again until 15 February 2022. When he checked on her, he observed she was having difficulty breathing. At 12.11pm, Andrew called David about their mother's difficulty breathing.

27. David called Triple Zero and requested an ambulance for Judith at 12.12pm. A Triple Zero call-taker subsequently called Andrew to obtain more information. Andrew explained that Judith had a fall and injured her back, she had difficulty speaking, she was clammy, her mouth was shaking and she looked orange. He reported that she had been in that state over the weekend, since she suffered the fall. He noted that she had not consumed any food or fluids and had not taken her medications since the fall as she was unable to swallow the tablets.

28. Ambulance Victoria paramedics arrived at the scene at 12.24pm. One of the paramedics noted that upon entry to the house, she was immediately overwhelmed with a pungent smell, which she could smell through her P2 mask. The paramedics noted that the smell became stronger when they entered Judith's bedroom. The paramedics identified that the smell appeared to be emanating from Judith, who was covered with dried urine and faeces.

29. The paramedics described Judith's room as very cluttered with numerous belongings and rubbish throughout the room. The carpet was stained and there was minimal access to the bed. Judith was lying flat on her back on a single mattress that was visibly stained and had an offensive smell. The paramedics observed faeces and urine that was "*leaking down the mattress*".

30. Around Judith's mouth, the paramedics observed dried orange and brown stains. The paramedics thought she might have vomited, which caused the orange stain around her mouth. Her body was under a doona, however her right leg was hanging off the edge of the bed. It appeared swollen and oedematous. The paramedics noted Judith's breathing was "*gurgling*" and opined that she had likely aspirated on vomit.

31. Andrew repeatedly left the bedroom while paramedics assessed his mother. The paramedics repeatedly had to call him back into the room in order to answer questions about Judith's condition and history. Andrew reported that Judith suffered a fall four days' earlier during which she injured her back and hit her head. Andrew reported that he tried to administer

Judith's medications a few days' earlier, however she was unable to swallow them, so he left her in the bed.

32. After assessing Judith, the paramedics determined she required urgent transport to hospital. Once they removed the doona that covered her body, they observed further urine and faeces staining covering her clothes.

33. While one of the paramedics commenced treatment, the other asked Andrew for information about Judith's medication history, allergies, date of birth and any other details. Andrew collected Judith's medications and provided them, however, was unable to provide any other information. He advised paramedics that his brother was Judith's power of attorney but claimed that he did not have his brother's contact details.

34. While enroute to the hospital, the paramedics met a Mobile Intensive Care Ambulance (**MICA**) paramedic, who was able to assist with treatment. They arrived at Sunshine Hospital at 1.26pm. The paramedics reported their concerns of potential neglect/elder abuse to both hospital staff and their own safeguarding managers at Ambulance Victoria.

35. Judith underwent COVID-19 testing, which was positive. Investigations revealed she had developed COVID-19 pneumonia, which was complicated by anaemia, persistent hypoxia in the context of respiratory muscle weakness secondary to critical illness polyneuropathy and myopathy. She experienced increased oxygen requirements and delirium throughout her admission. Judith was also found to have aspiration pneumonia, sepsis of unknown origin (presumably chest) and clinicians had concerns for her reduced level of consciousness.

36. Staff treated Judith with intravenous antibiotics and supported her with high flow oxygen. Clinicians considered transporting her to the radiology department for an MRI or a CT scan, however given her poor condition, this was determined to be very high risk. Despite treatment, Judith's condition did not improve, and she passed away on 1 March 2022.

POLICE INVESTIGATION

37. Due to the concerns raised by paramedics and hospital staff, police commenced a criminal investigation in relation to Judith's death.

Field interviews

38. On 4 March 2022, police attended the family home in Darley and spoke to David. He reported that Judith's fall reportedly occurred when she fell backwards, after assuming a chair was

behind her. David reported that his mother received Meals on Wheels deliveries every second day and that a carer came twice per week to give her showers. David reported that he did not have any concerns for his mother's hygiene and a carer attended twice weekly to shower her. He was unable to name the service but believed it was through the local council.

39. David explained that his brother, Andrew, looked after their mother. He noted that Andrew did not work and therefore was home all the time, so he was able to care for Judith. He also reported that Andrew was capable of caring for Judith.

40. That same day, police spoke to Andrew. He reported that Judith had a fall and was in bed for four days. He was home when the fall occurred but did not witness it. He reported that he tried to give her a tablet, but she could not take it because she was unable to swallow it. He explained that the orange stains around her mouth were from the tablet. He did not try to give her water but reiterated that he tried to give her a tablet.

41. Andrew advised that he did not hold any concerns for Judith at the time, until she had difficulties breathing. When he observed her breathing difficulties, he called his brother, who called the ambulance.

Formal interviews

42. On 25 April 2024, David participated in a formal police interview. In David's version of events, he stated that when he returned home from a weekend away (15 February 2022), his mother was unable to get out of bed.

43. David explained that Judith stopped looking after herself when her partner died, some 10 years earlier. From this time, she "*went downhill*" and "*stopped caring about her appearance*". She previously left the house to walk down the main street, however "*she stopped doing that as well*".

44. David reported that towards the end of her life, Judith did not eat or drink much. He noted that "*she either didn't want it or couldn't drink it*". David agreed that this raised concerns, when asked by police.

45. When police asked about what support services the family were engaged with or if they ever asked for help, David advised that he "*thought [he] could do it on [his] own*". David was unable to explain his mother's diagnoses and reported that he had never been told how to care for his mother. He also admitted that he never asked for help.

46. That same day, Andrew participated in a formal police interview. In his interview, Andrew reported that he did not see his mother fall, but he helped her back into bed and gave her an orange tablet.

47. Andrew reported that it was his responsibility to give Judith her regular medications, because David worked long hours. He explained that he would give her the tablets, and Judith would put them in her mouth and would take them with water.

48. When police asked whether Andrew thought he should have called for help earlier, he stated that he called his brother, who called the ambulance, however this was four days after the fall. Andrew reported that after he helped Judith back into bed, he did not see her for the four days that followed. He noted that she "*slept all the time, stayed in that room all the time, she didn't move out the room, so [he] thought she'd be all right*".

49. Andrew admitted that carers attended the house to assist Judith with showering, however when this ceased, he put her in the shower on the shower chair that David purchased from the chemist.

50. When asked whether Andrew considered himself a 'carer' for Judith, Andrew replied "*not really*". He noted that other carers attended to help and that he believed his role was "*just to take care of her, just look, look in on her occasionally*". As part of those responsibilities, Andrew reported that it was his job to take her to the toilet, give her food, water and medication. Over the weekend prior to her hospital admission, Andrew admitted that he had not done so.

51. Following an exhaustive investigation by police, no criminal charges were laid against David or Andrew.

FURTHER INVESTIGATIONS AND CPU REVIEW

52. As Judith's death occurred in circumstances where she may have experienced neglect, this case was referred to the Coroner's Prevention Unit (**CPU**).[4] The CPU were asked to examine

[4] 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.

the circumstances of Judith's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[5]

53. I make observations concerning service engagement with Judith and her family 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 Judith's death.

54. 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*".[6] I make observations about services that had contact with Judith to assist in identifying any areas of practice improvement and to ensure that any future prevention opportunities are appropriately identified and addressed.

Medical treatment and services involved in the year prior to death

55. As noted above, Judith did not consult with a GP for five to ten years prior to her death. However, about one year prior to her death in February 2021, she was admitted to hospital. On 4 February 2021, David called Triple Zero to advise that his mother had been unable to get out of bed for two weeks. Members of the Royal Flying Doctor Service (**RFDS**) attended the home and observed:

    a) Judith was lying flat on a mattress with no bed covers, in a very dirty room, and was covered in urine and faeces.

    b) Judith was covered in bruises and looked emaciated.

    c) Judith stated that she was unable to cook meals and was unable to move from bed.

    d) Judith was unsure how she got the bruises and when she stopped being able to get out of bed.

    e) Judith reported she had not eaten a meal in weeks.

    f) There was no food in the house and the house was dirty.

[5] 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.

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

56. Judith was admitted to Ballarat Base Hospital (**BBH**) for about four months. During this time, Judith reported being bed-bound for two weeks and having minimal oral intake during this time. She also reported that she suffered a fall about three weeks prior to the hospital admission.

57. Hospital records from this period reflect that Judith required help with all activities of daily living. Her mobility was impaired and clinicians documented that she was cognitively impaired. She scored 21/30 on a Mini-Mental State Examination.[7]

58. Clinicians diagnosed Judith with malnutrition; however, she denied that her sons were neglecting her. Despite her assertions, clinicians recorded their impression that Judith had been subject to elder abuse and neglect.

59. David told hospital staff that his mother's care needs had increased over the previous three to four years, and she required support with activities of daily living including dressing and going to the toilet. David indicated he was not comfortable assisting her with these tasks. He confirmed that he would like a formal service referral to assist Judith with personal care upon her discharge from hospital. Judith consistently told staff that she wanted to return home upon her discharge and that she was happy to receive in-home care services.

60. A social worker from BBH worked with David to clean up the family home, which was reported to be in a "*squalid*" condition. The house was cleared of clutter and was cleaned to enable care providers to attend and assist Judith. Judith received assistance from various allied health professionals while at BBH and was able to walk with supervision using a four-wheel walker upon her discharge.

61. While admitted to BBH, staff referred her to the Grampians Aged Care Assessment Service (**ACAS**) for a Transition Care Program (**TCP**) assessment. TCP is a specialist residential aged care program which provides "*restorative support*" to older people leaving hospital.[8]

62. On 11 March 2021, the ACAS assessment team completed an assessment with Judith in hospital. The assessment recorded cognitive impairment and neglect amongst the reasons for the assessment and noted that Judith was still "*below premorbid level of function*". The assessment documented that Judith's home was "*squalid*" at the time of her admission and that Judith had lost 20kg in the three months prior to her admission. Judith had no teeth and

[7] A score below 24 can indicate a cognitive impairment.
[8] Department of Health, Transition Care Program (11 February 2026, Web Page) < Transition Care Program>.

was not wearing dentures. Judith reportedly indicated an interest in participating in social activities.

63. ACAS redacted the name of Judith's carer in the records they sent to the Court, however noted that the carer was "*unable to maintain care needs and will require formal support*". The assessment described Judith as a "*frail thin lady*" with a "*very flat affect*". Judith reportedly "*appeared to understand the assessment process and signed her own application for care*".

64. The ACAS assessment found that Judith required long-term support with transport, shopping, meal preparation, housework, medication, managing finances, walking, bathing/showering, toileting, dressing and at least short-term assistance with eating. Medications had to be provided in pureed fruit due to Judith's swallowing difficulties. Judith also required prompting to eat. She was assessed at high-risk of falls. When she was assessed, she was prescribed several medications including a multi-vitamin, thiamine, oxycodone, paracetamol, cocalciferol, ferrous fumarate, ascorbic acid, ondansetron, Mylanta and mirtazapine.

65. The assessment recorded no memory concerns, however documented that it was unclear whether Judith had impaired judgement. Judith required assistance to make decisions about her "*living activities and arrangements*" and reported occasional loneliness and social isolation.

66. ACAS determined that Judith was eligible for the TCP for up to 12 weeks. The assessment noted that the TCP would help optimise Judith's functioning and would allow time for in-home services to be organised.

67. The ACAS records that were provided to the Court include an 'Accommodation and Safety Arrangements' screening tool. The stated purpose of this tool was to "*screen for consumer's accommodation risk of homelessness and their safety needs, including family violence and personal emergency planning*". The form included questions about family violence although does not ask about neglect. The form was not completed for Judith.

68. ACAS completed a support plan for Judith which outlined several areas of support that she required. The support plan was approved on 12 March 2021. Judith was discharged to Ballan Health TCP on 25 March 2021. The Court requested Judith's records from this episode of care; however, they had been archived and the archive company were unable to locate them.

69. On 16 June 2021, ACAS reviewed Judith's support plan and confirmed that she required ongoing support from the Commonwealth Home Support Program. Her support plan remained

largely unchanged from the March 2021 plan. It recommended various forms of support including personal care, transport, respite, cleaning, medication administration, shopping social support (in-home visits; accompanied outings), financial and legal advocacy and various allied health services.

70. Ballan TCP referred Judith to the Moorabool Shire Council (**MSC**) for Meals on Wheels deliveries and twice-weekly support with showering. This was due to commence the week after her discharge from BBH on 16 June 2021. MSC were aware of the circumstances of Judith's hospital admission as part of the referral.

71. MSC developed a care plan for Judith on 10 August 2021. This included meal deliveries five times per week and personal care assistance every Tuesday and Thursday.

72. On 28 September 2021, David and Judith signed an 'authority to act as an advocate' form with MSC. This confirmed that Judith consented to David representing her interests with MSC. It also confirmed that David would ensure that he acted in Judith's best interests, amongst other matters.

73. Between October and December 2021, Judith received twice-weekly in-home support with personal care. Her carers observed that she mobilised slowly with a walking frame. Without the walking frame, she was unsteady on her feet. Judith reportedly presented in clean clothing, although she needed help with getting dressed. It appeared that she had often slept in the clothes she was wearing when the carer attended in the morning. Carers noted that the house appeared very dirty and cluttered, and the shower was covered in black mould which appeared resistant to attempts to clean it.

74. One carer referred to Judith as "*a little slow minded*" while another opined "*although Judith's home wasn't tidy, her presentation never had [them] concerned about her care*".

75. On 16 December 2021, a carer completed a MSC 'support loop feedback form' which listed various concerns, including:

    a) The house was "*extremely unkempt*".

    b) There was mould on the roof and parts of the walls.

    c) The floors were "*extremely filthy*".

76. The carer recorded their "*suggested action*" as an assessment review.

77. On 17 December 2021, an MSC Team Leader spoke to another carer who reported concerns about Judith's health. In relation to the house, the carer noted that she had "*not seen anything like it*" and noted that there were "*boxes of cans and cigarettes inside near the front entry*". The Team Leader consulted with the 'Coordinator Community Support Services' (**CCSS**) on how to mitigate the risk to staff providing care to Judith. The Team Leader also queried whether they needed to seek consent to request a review of Judith's needs, in order to ascertain whether she required further support with cleaning. They noted that they did not have an emergency contact listed for Judith, although they were aware that she had one son who lived with a disability. Other MSC records suggest that MSC did not identify that David lived with Judith, nor that he signed an 'authority to act as an advocate' form some months earlier.

78. The CCSS advised the Team Leader to contact Judith to obtain consent to request support with removing mould via the Office of Housing (**OoH**) in Ballarat. The CCSS advised that Judith's services should be suspended until the mould issue could be rectified, given the occupational health and safety risk it posed to their staff.

79. Additionally on 17 December 2021, the Team Leader contacted Judith and obtained her consent to contact the OoH on her behalf. MSC records reflect:

    a) Judith was "*very slow to process the conversation*" and was fearful about losing her housing due to the state of the property.

    b) Judith asked "*who will do my shower*" when she was advised that in-home services would be suspended until the mould was removed.

    c) Judith required convincing not to cancel her personal care. The Team Leader told Judith, "*she was referred for support with her PC [personal care] because it was an identified need that if she didn't have anyone else to help her, withdrawing her request for PC permanently might not be in her long-term best interests*".

80. The Team Leader emailed and called the OoH that day. According to a statement from the Manager of Client Support and Housing Services (**Manager – CSHS**) in the Central Highlands Area, a contractor attended Judith's property on 23 December 2021 and completed the mould remediation works.

81. MSC suspended Judith's personal care services on 17 December 2021, noting that they would remain suspended until the mould issue was rectified. There was no record of any assessment by MSC in relation to the risk posed by leaving Judith without care. There was no record of a

reassessment of her needs, as per the carer's suggestion, and no documented consideration of residential respite care while Judith's home was cleaned.

82. On or about 20 December 2021, the Manager – CSHS noted that the OoH contacted MSC "*to confirm that priority works had been raised to treat the mould*". There was no other contact between the OoH and MSC after this time. The Manager – CSHS noted that tenants usually make contact with their service providers themselves, which is outside the standard remit of housing staff to organise services.

83. An MSC carer mistakenly attended Judith's home on 6 January 2022. Judith "*opened the front door a crack*" and advised that she thought her personal care services were restarting the following week. She also noted that she needed to clean the house. The carer offered to support her with personal care that day, however Judith declined and said the shower was blocked. The carer advised MSC that based on what she could see past the door, "*there may be safety issues*" in the house. Judith advised the carer that she would be ready for services to resume the following week.

84. According to MSC, on 7 February 2022, the MSC Team Leader emailed the OoH seeking an update on the mould in Judith's bathroom. The email noted "*[t]here is some urgency to this matter as Mrs Kerr has not received personal care for showering that she was referred for. The lapsed time frame is now 7 weeks*". The Team Leader sent another email on 11 February 2022, noting that they had been awaiting an update since first raising the issue with the OoH. They further documented that they had not heard from Judith "*who is fearful and lacks confidence and skills at navigating service systems*". The Team Leader stated that they did not hear back from the OoH prior to Judith being admitted to hospital on 15 February 2022.

85. There are no records to suggest that MSC contacted Judith again after suspending her care in December 2021, nor that they contacted David as her advocate.

Procedural fairness responses

86. As a matter of procedural fairness, the Court wrote to MSC, Andrew and David and offered them an opportunity to respond to proposed adverse comments.

Moorabool Shire Council

87. MSC advised that they did not wish to provide a response to the Court's correspondence.

Andrew and David

88. Andrew did not respond to the Court's correspondence.

89. David responded to advise that Judith "*was in respite in Ballan after she was discharged. [David and Andrew] also had meals on wheels for her and we had someone come shower her twice a week*". David provided photos of a Mecwacare business card, a letter from MSC confirming meals on wheels deliveries and correspondence from Ballan District Health and Care referring to COVID-19 lockdown restrictions in Victoria. David did not otherwise respond to concerns about the squalid conditions in which Judith was living.

Systemic issues – adult safeguarding

90. This case sadly involves the death of a vulnerable adult who had complex needs for care and support. Her needs for care and support may have prevented her from independently accessing the support she required. The most substantive issue in this case appears to relate to Victoria's lack of a comprehensive framework for safeguarding at-risk adults from abuse, neglect and exploitation.[9] This gap in the Victorian service sector left concerned professionals who engaged with Judith and her sons proximate to the fatal incident without a clear referral pathway to address these concerns. Below is an explanation of adult safeguarding, and its relevance to the circumstances surrounding Judith's death.

Definition

91. Broadly, adult safeguarding means protecting the rights of adults to live in safety, free from abuse and neglect.[10] 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.[11] At-risk adults are defined as people aged 18-years-old and over, who:

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

b) are being abused or neglected, or are at risk of abuse or neglect; and

[9] OPA, *Line of Sight: Refocussing Victoria's Adult Safeguarding Laws and Practices* (Review, 18 August 2022) 13 < Line_of_Sight (11).pdf>.

[10] 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)>.

[11] 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)>.

[12] 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)>.

c) are unable to protect themselves from the abuse or neglect because of their care and support needs.[13]

92. Adult safeguarding is important because people with a disability are more likely to experience violence, abuse, and neglect than people without a disability,[14] often from people on whom they depend for care and support.[15] 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%,[16] with those experiencing poor physical or psychological health and higher levels of social isolation more likely to experience abuse.[17]

93. 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.[18] A specialised response to reports of abuse and neglect of at-risk adults is therefore required.

94. Adult safeguarding can 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) proactively making enquiries to establish whether any action needs to be taken to prevent abuse or neglect, and if so, by whom

c) 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

d) facilitating decision-making support for at-risk adults

[13] 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).

[14] 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 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.

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

[16] 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)>.

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

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

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

f) reporting the abuse to the police

g) applying for an intervention order in relation to the person allegedly causing harm to the at-risk adult.[19]

How adult safeguarding could have assisted Judith

95. Judith would have likely met the criteria for an adult safeguarding response given:

a) She had needs for care and support related to her physical and cognitive impairments.

b) She was at risk of neglect.

c) Her needs for care and support may have prevented her from accessing the support required to address this risk.

96. If an adult safeguarding mechanism existed at the time of Judith's February 2021 hospital admission, Judith may have received:

a) Provision of an accessible service.

b) Thorough investigation and decisions about whether Judith had experienced, or was at risk of, neglect, as hospital staff suspected in February 2021.

c) Completing or facilitating a robust assessment of the risks associated with the alleged neglect, including:

i. David being listed as Judith's advocate with her care agency upon her discharge from hospital in mid-2021.

ii. The apparent lack of personal care that Judith received in between carer visits, and the lack of support provided to her to keep her home in a safe condition.

d) Facilitating an assessment of Judith's capacity to make decisions about her care and the need for guardianship, noting that her sons appeared to be unable to provide her with an appropriate level of care. Judith's care agency similarly commented on her

[19] UK Department of Health, *Care and support statutory guidance*, (5 October 2023) s 14.10, 14.58 < Care and support statutory guidance - GOV.UK (www.gov.uk)>; Australian Law Reform Commission (ALRC), *Elder Abuse – A National Legal Response* (Final Report, May 2017), 402-3.

"*potentially poor decision-making*" and "*limited capacity to navigate service systems and assert herself with confidence*" shortly before her death.

e) Convening a multi-agency meeting to implement a safety plan. This could have included:

   i. Ensuring Judith's needs were met following her discharge from hospital.

   ii. Allocating responsibilities for monitoring Judith's wellbeing and ensuring ongoing monitoring and care, particularly noting it was Judith's wish to have in-home care services in place.

   iii. A plan to ensure ongoing collaboration and communication between services and Judith, to monitor concerns and to refer back to the safeguarding agency as needed.

Previous adult safeguarding cases and discussion

97. Judith's case is not the first case before this Court where an adult safeguarding mechanism/response may have been beneficial. Former State Coroner, Judge Cain, extensively canvassed the issue of adult safeguarding in several findings handed down in 2025, including the deaths of CFT[20], William Heddergott[21], MHT[22], YTR[23], and DRF[24].

98. In Judge Cain's finding into the death of CFT, his Honour recommended (amongst other matters):

> 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.*

[20] Finding into death without inquest – CFT (COR 2020 4205).
[21] Finding into death without inquest – William Heddergott (COR 2020 6253).
[22] Finding into death without inquest – MHT (COR 2022 4511).
[23] Finding into death without inquest – YTR (COR 2020 6157).
[24] Finding into death without inquest – DRF (COR 2022 0022).

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.*[25]

99. In response to his Honour's recommendations in CFT, the Department of Families, Fairness and Housing (**DFFH**) advised that it had taken all the recommendations into consideration. It further noted that the Victorian Government is working with the Disability Reform Ministerial Council to consider reform options in response to the Disability Royal Commission (**DRC**), which also recommended the introduction of adult safeguarding legislation.

100. DFFH's response also listed various initiatives which are funded by the Victorian Government, which are aimed at preventing and responding to elder abuse. Judge Cain stated that he did not view these initiatives as a substitute for the recommendations made in CFT and noted that these recommendations have been made and supported by the ALRC, the OPA and the DRC over the course of several years. His Honour noted that at-risk adults 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.

101. Finally, DFFH referenced the new Social Services Regulator as an initiative to reduce the risk to vulnerable adults with care and support needs, however this body does not have a role in regulating services provided under the *Aged Care Act 2024* (Cth), nor does it appear to have a role in investigating allegations of neglect perpetrated by family members against at-risk adults. The Social Services Regulator is therefore unlikely to have made any difference in Judith's case.

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

102. I remain concerned that that without a comprehensive adult safeguarding framework in Victoria, vulnerable adults such as Judith (and their carers/families/professionals) have no centralised avenue to seek advice or raise concerns. In my recent finding into the death of JZA, I reiterated Judge Cain's recommendations 4 to 10.[26]

103. The Department of Justice and Community Safety (**DJCS**) responded to the recommendations in JZA. Other than to advise that my adult safeguarding recommendations in JZA would require funding via future budget processes, DJCS did not further address the recommendations (nor the preceding findings).

104. DFFH also responded to my recommendations in JZA by reiterating the response[27] it provided to Judge Cain's finding into the death of CFT. Since DFFH's response to CFT, it further advised that the Victorian Government introduced the *Social Services Regulation Amendment (Child Safety, Complaints and Workers Regulation) Bill 2025* into Parliament. The Bill sought to increase protections for children and people with disability and to merge the functions of the Victorian Disability Worker Commission and Disability Services Commissioner with the Social Services Regulator, simplifying disability regulation and creating a 'one stop shop' for users of state-funded disability services.

105. I acknowledge these changes appear to be promising and positive, however as noted above, they do not address concerns for vulnerable adults who use federally funded disability services (i.e., the NDIS) or those who do not receive any state-funded disability services. The purpose of the safeguarding mechanism is to ensure that *all* vulnerable adults, regardless of which services they engage with (if any) are protected from harm and exploitation. Of note, the recently published Victorian Government response to the DRC recommendation that states and territories should introduce legislation to establish nationally consistent adult safeguarding functions, expresses similar sentiments, noting that the Social Services Regulator does not consist of the same functions as an adult safeguarding service of the kind recommended by the ALRC, OPA, DRC. The Victorian Government response states that this DRC recommendation is 'subject to further consideration'[28].

106. Since my finding into the death of JZA was published, the Commonwealth Government published the National Plan to End the Abuse and Mistreatment of Older People 2026-2036

[26] Finding into death without inquest – JZA, 17-18.
[27] DFFH's response to recommendations, 2 June 2025, https://www.coronerscourt.vic.gov.au/sites/default/files/2025-07/2020%204205%20Response%20to%20recommendations%20from%20DDFH_CFT.pdf.
[28] Victorian Government, Response to DRC, 243.

(**'the National Plan'**). One focus of the National Plan is to "*clarify the avenues for reporting abuse and mistreatment within each jurisdiction', given the importance of clear avenues for reporting concerns about abuse and mistreatment of older people*".[29] I note that the OPA undertook a review of the current safeguarding supports available in Victoria, including avenues for reporting abuse, before recommending the introduction of Victorian adult safeguarding legislation in 2022.[30]

107. Of relevance to the above listed adult safeguarding recommendations, the National Plan includes the following priority actions under focus area two ('Improve Laws and systems to promote and protect the rights of older people'):

> *2.4 Adopt recommendations of the Disability Royal Commission relevant to ending the abuse and mistreatment of older people, in accordance with Government responses in each jurisdiction*
>
> *2.5 Strengthen safeguarding frameworks and clarify pathways for abuse and mistreatment to be reported and addressed. This includes further education and training on reporting obligations for relevant sectors*[31]

108. The Victorian Government has also published its response to the recommendations of the DRC. Recommendation 11.1 of the DRC recommended that states and territories should each introduce legislation to establish nationally consistent adult safeguarding functions. The Victorian Government advised that this recommendation is 'subject to further consideration'.[32]

109. The Victorian Government's response to the DRC's recommendations also echoed sentiments that I have previously expressed in findings. These comments were supported by findings of former State Coroner, Judge John Cain, namely, that the Social Services Regulator does not include the same functions as an adult safeguarding service as recommended by the ALRC, OPA and DRC. This is notable, given that DFFH previously referenced the Social Services Regulator as a solution, when responding to coroners' recommendations about the need for an adult safeguarding mechanism.

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[29] Australian Government, National Plan to End the Abuse and Mistreatment of Older People 2026-2036 (16 March 2026) 67.
[30] OPA, *Line of Sight: Refocussing Victoria's Adult Safeguarding Laws and Practices* (Review, 18 August 2022) 15.
[31] Australian Government, National Plan to End the Abuse and Mistreatment of Older People 2026-2036 (16 March 2026) 71.
[32] Victorian Government, Response to DRC, 243.

110. In my recent finding into the death of JNY,[33] I reiterated my recommendations in JZA, which reiterated his Honour's recommendations in CFT. The Department of Justice and Community Safety (**DJCS**) responded to Recommendation 1 in JNY.

111. DJCS acknowledged my recommendation to make appropriate funding available to the OPA. The purpose of the funding is to ensure that all of the VAGO's recommendations can be implemented. DJCS noted that all of VAGO's recommendations were accepted or accepted in principle by the OPA and DJCS, and implementation is underway.

112. DFFH is yet to respond to my recommendations in JNY. While the DFFH's response is still pending, I will direct a copy of this finding be provided to DJCS, DFFH, the Minister for Disability and the Victorian Government, for consideration.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Judith Margaret Kerr, born 17 November 1943;

    b) the death occurred on 1 March 2022 at Sunshine Hospital Furlong Road St Albans Victoria 3021, from multiple organ failure secondary to sepsis and renal failure due to bronchopneumonia and rhabdomyolysis in a woman with covid infection; and

    c) the death occurred in the circumstances described above.

I convey my sincere condolences to Judith's family for their loss.

[33] Finding into death without inquest – JNY (COR 2023 3518).

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:

David Kerr, Senior Next of Kin

Department of Families, Fairness and Housing

Department of Justice and Community Safety

Department of Premier and Cabinet

The Hon. Lizzie Blandthorn, Minister for Disability

Detective Sergeant Daniel Huisintveld, Coronial Investigator

Signature:

Judge Liberty Sanger, State Coroner

Date: 26 August 2026

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.