IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

**COR 2022 004511**

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

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

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| Findings of: | Judge John Cain, State Coroner |
| Deceased: | MHT |
| Date of birth: | [redacted] |
| Date of death: | 9 August 2022 |
| Cause of death: | 1(a) Complications of blunt force trauma in a man with cardiac amyloidosis and atherosclerotic cardiovascular disease |
| Place of death: | University Hospital Geelong, 272-322 Ryrie Street, Geelong, Victoria, 3220 |
| Keywords: | Family violence; dementia; adult safeguarding |

## INTRODUCTION

1. On 9 August 2022, MHT was 86 years old when he passed away at University Hospital Geelong (**UHG**) from injuries sustained in an assault by his adult son RFT. At the time of his death, MHT lived in a regional Victorian town.

2. MHT was born in [redacted] and fled to [redacted] in about 1939 to escape religious persecution. He experienced significant trauma during World War II and was observed to display signs of post-traumatic stress disorder (**PTSD**). After World War II, MHT moved to Australia with his family, where he met his wife, CDE, and they married soon after.

3. MHT and CDE had four children together – MHT, ASD, UYT and TRE. Their children alleged that MHT was violent towards them and their mother, including physical and sexual violence and controlling behaviour. This alleged violence was mostly never reported to police.

4. There was only one reported incident of family violence on 20 March 2019. On this occasion, MHT allegedly punched RFT twice to the face, then threatened to retrieve his gun and shoot RFT. It was also alleged that MHT threatened RFT and charged at him on a previous occasion. Police attended and issued Family Violence Safety Notices (**FVSNs**) against MHT in protection of RFT and UYT. These were converted to Family Violence Intervention Orders (**FVIOs**).

5. In 2019, MHT was diagnosed with Alzheimer's disease and vascular dementia. He declined the assistance of care services and CDE became his sole carer. The FVIOs were withdrawn on 5 August 2019 due to MHT's dementia diagnosis.

6. On 2 August 2021, MHT called emergency services and alleged that RFT had assaulted him. RFT intercepted the call, and police noted that he prevented his father from speaking. Police did not attend the residence on this occasion and did not submit a family violence report.

7. MHT's use of violence increased with his cognitive decline. UYT described having to place himself between his mother and MHT as he became physically violent towards her. His family noted that he did not acknowledge his diagnoses and told CDE that he would "*kill himself if they ever put him in a nursing home or got anyone in the house*".

## THE CORONIAL INVESTIGATION

8. MHT'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.

9. 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.

10. 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.

11. Victoria Police assigned Detective Senior Constable (**DSC**) Alexander Gemin and later, Detective Sergeant Gemma Etherington to be the Coronial Investigators for the investigation of MHT's death. The Coronial Investigators 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.

12. This finding draws on the totality of the coronial investigation into the death of MHT 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 9 August 2022, MHT, born [redacted], was visually identified by his granddaughter, BGV.

[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.

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

**Medical cause of death**

15. Forensic Pathologist Dr Joanne Ho, from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 10 August 2022 and provided a written report of her findings dated February 2023. Dr Ho provided supplementary reports on 11 May 2023 and 9 April 2024.

16. The post-mortem examination revealed extensive blunt force injuries comprising subdural haemorrhage, subarachnoid haemorrhage, nasal fracture, multiple bruises to the face, right frontoparietal region, right temporal muscle, left forearm, right forearm, left leg, right axilla, left pectoral region and scapula. Dr Ho explained that blunt force injuries are the result of the impact against or with a hard or unyielding surface/object.

17. There were also fractures to the left superior horn of the thyroid cartilage and right greater horn of the hyoid. This can occur in instances of blunt force trauma to the neck but can also be seen in instances of neck compression. There are no pathognomonic features to distinguish between the two.

18. The deceased also had significant natural disease, in particular, cardiac amyloidosis and severe double vessel coronary artery atherosclerosis. Cardiovascular amyloidosis is a condition where a substance called amyloid builds up in your organs. There are several types of amyloidosis including familial, senile systemic, secondary and haemodialysis associated. In this case, it was likely to be senile systemic amyloidosis (**SSA**) which affects people over the age of 80 years and is derived from normal transthyretin and can involve the atria, aorta or the entire heart. It can result in congestive heart failure (with a mainly restrictive infiltrative pattern), atrial fibrillation and conduction system disturbances.

19. Coronary artery atherosclerosis occurs when there is a build-up of cholesterol and other material in the blood vessels that supply oxygen and other nutrients to the heart. This accumulation of material narrows the vessels is associated with sudden cardiac death. The mechanism of death in such cases is an arrhythmia triggered by acute myocardial ischemia. Risk factors for coronary atherosclerosis include increasing age, smoking, hypertension, family history, diabetes mellitus, obesity, male gender and other factors such as hyperlipidaemia (high cholesterol). Dr Ho concluded that while there was significant natural disease, the amount and significance of the blunt force injuries could not be disregarded as the cause of death.

20. Dr Linda Iles performed a neuropathological examination on the brain which showed an evolving middle cerebral artery territory infarct with an organising thrombus proximal left middle cerebral artery. An infarct is an area of necrosis that typically results from the obstruction of the circulation, in this case, a thrombus within the proximal left middle cerebral artery. The loss of blood flow to the area can cause tissue death and lead to serious and potentially permanent brain injury. Given there was no dissection of the carotid or cerebral arteries and in the setting of recent trauma, where there is a known associated increased risk of stroke due to the procoagulant state and immobility, the parietal stroke was best deemed a complication of his blunt force trauma.

21. The accumulation of haemorrhage from the injuries (subdural haemorrhage, subarachnoid haemorrhage and multiple bruises and lacerations) in an individual with significant underlying cardiac disease is substantial and has likely contributed to his death. Furthermore, the SDH and SAH may also have secondary effects of cerebral oedema and dysfunction in the setting of the middle cerebral infarct.

22. Toxicological analysis of ante-mortem samples identified the presence of ondansetron.

23. Dr Ho provided an opinion that the medical cause of death was *1(a) complications of blunt force trauma in a man with cardiac amyloidosis and atherosclerotic cardiovascular disease.*

*First supplementary report – 11 May 2023 – Dr Ho*

24. On 11 May 2023, Dr Ho produced her first supplementary statement. DSC Gemin requested that she review images of the alleged weapon and confirm whether this alleged weapon was involved in the assault. Dr Ho explained that due to the time between the alleged incident and the post-mortem examination, no accurate statement could be made with respect to the injuries sustained and the alleged weapon. She further noted that no accurate statement could be made with respect to the degree of force required to inflict those injuries. Dr Ho stated that the cause of death remained unchanged.

*Second supplementary report – 9 April 2024 – Dr Ho*

25. Dr Ho was asked by DSC Gemin to review a second opinion report by Professor Johan Duflou (**Prof Duflou**), that was obtained by the defence, on behalf of RFT.

26. Dr Ho noted the opinion of Prof Duflou and made the following comments:

a) Prof Duflou opined that the cause of death was *1(a) Left middle cerebral artery territory infarct* secondary to *1(b) Thrombotic occlusion of left middle cerebral artery* with contributing factors of *2 Blunt force injurie to the body, atherosclerotic cardiovascular disease, cardiac amyloidosis, neurodegenerative changes in the brain including cerebrovascular disease, cerebral amyloid angiopathy and Alzheimer type lesions*). Dr Ho noted that this cause of death was not dissimilar to the cause of death she provided (as above).

b) Dr Ho accepted Prof Duflou's concluding statements in relation to the physical injuries, namely. That the majority of the cutaneous injuries, laryngeal injuries and possibly the intracranial pathology (presumed subarachnoid haemorrhage, subdural haemorrhage and left middle cerebral artery territory infarct) were largely contributed to be the actions of another.

c) Dr Ho noted that ultimately, Prof Duflou's conclusions were not dissimilar to the conclusions she reached in her own report, that is, that the death occurred in the setting of a blunt force injury, with a middle cerebral artery territory stroke, in a man with multiple cardiac and cerebral comorbidities.

d) Prof Duflou noted that:

> *The primary cause of death of a stroke (left middle cerebral artery territory infarct), which in turn was due to a thrombus within the left middle cerebral artery. It is possible that the deceased's cutaneous and soft tissue injuries, the laryngeal injuries, the bleeding over the surface of the brain (subdural and subarachnoid haemorrhages), his neurodegenerative condition including cerebrovascular disease with prior strokes, cerebral amyloid angiopathy, and neurodegenerative changes (Alzheimer-type changes), generalised atherosclerotic cardiovascular disease, and cardiac amyloidosis may have contributed to his death*.

e) Dr Ho explained that this opinion was not entirely dissimilar to the commentary in her own report, where she noted the interplay of injury and natural disease as being important. However, she noted that whilst the left middle cerebral artery territory infarct was ultimately the reason for his palliation, emphasis must be placed on the described assault and its temporal relationship to the deceased's death. The combination of injuries (subdural haemorrhage, subarachnoid haemorrhage, fractures

and soft tissue trauma) in an individual with significant underlying natural disease is substantial, places immense physiological stress on the body and has likely contributed to the death. Therefore, Dr Ho opined that the combination of findings has likely resulted in the deceased's death.

f) Dr Ho explained that the main point of contention between her opinion and that of Prof Duflou was in relation to the causative event of the thrombus formation. Prof Duflou discussed that the thrombus was "*presumably either thrombotic or thrombo-embolic in cause*", either from severe atheroma of the internal carotid artery or from the thrombo-embolic causes originating from the cavities of the heart, especially in the setting of cardiac amyloidosis. He also noted that the deceased had a number of risk factors for a stroke.

g) Dr Ho stated that while she agreed with Prof Duflou's reasoning in a general sense, she noted that the post-mortem examination did not reveal severe atheroma of the internal carotid arteries. There was also no mural thrombus within the heart. While she accepted that thrombo-embolic events are a complication of cardiac amyloidosis, the mechanisms of thromboembolism appears to be multifactorial with the deposition of amyloid in the heart muscle causing impaired wall movement or causing a hypercoagulable state due to damage to the renal system through proteinuria, infiltration of the spleen causing thrombocytosis, or direct effect on the coagulation cascade with increased blood viscosity or procoagulant activity due to circulating monoclonal components that all increase the risk of thromboembolism. The autopsy did not show amyloidosis within the sections of kidneys or spleen, and he had normal renal function on biochemistry performed 8 August 2022.

h) As highlighted by Prof Duflou in his report, the deceased at multiple risk factors for stroke including advanced age, male gender, hypertension, atherosclerosis, amyloid heart disease, and abnormal glucose tolerance ('pre-diabetes'). In his opinion, neither a single predisposing cause nor multiple predisposing causes can be confidently stated to be the cause of the stroke in this case. The deceased was a previous smoker and previously consumed heavy amounts of alcohol.

i) Dr Ho agreed with Prof Duflou's comment that the deceased had many predisposing risk factors for stroke and that no specific cause for the thrombus was determined and that while the link she proposed in her report is possible, it cannot be made with any

degree of certainty. However, Dr Ho noted that the deceased was at heightened risk of a stroke due to his risk factors but further increased from his procoagulant state as a result from trauma.

j) Whilst immobility can worsen a hypercoagulable state (tendency to clot) by slowing down blood flow (stasis of blood), it traditionally is associated with venous thrombosis (clots in the veins), as mentioned in Prof Duflou's report. Venous thrombosis was not seen in this case.

27. Dr Ho noted that her cause of death as described above remained unchanged, following the review of Prof Duflou's report. She noted the main contention was in relation to the causative nature of the thrombus in the proximal left middle cerebral artery, and in her opinion, this could be attributed to a post-trauma complication in a man already at high risk for stroke. She reiterated that there was a temporal relationship between the alleged assault and the deceased's death.

*First supplementary report – 16 April 2024 – Dr Iles*

28. Dr Iles was asked by the Office of Public Prosecutions to review Prof Duflou's report and to comment on specific matters.

*Left middle cerebral artery thrombus*

29. She noted that in relation to the origin of the left middle cerebral artery thrombus, it was either cardioembolic (originating from the heart) or related to atherosclerotic disease (hardening of the arteries due to atheromatous plaque), with the latter being more common.

30. Dr Iles commented that the cardioembolic nature of the thrombus seen in this case was considered most unlikely. Despite incidental cardiac amyloidosis being identified at autopsy, autopsy examination did not demonstrate any evidence of mural thrombus, and the deceased was recorded as being in sinus rhythm between the time of his admission to hospital and the time he developed the stroke symptoms, i.e., there was no period of atrial fibrillation or other dysrhythmia that would put the deceased at risk of such an event.

31. In the setting of atherosclerotic disease, stroke may occur as a result of atheroembolism or as a result of thrombosis developing at a site of underlying arterial atherosclerotic plaque. The histological features of the thrombus observed here were considered most in keeping with in

situ thrombosis. The plaque showed features of instability, characterised by focal inflammation and microscopic foci of haemorrhage.

32. Dr Iles noted that there are three main factors that underpin the development of arterial thrombosis (Virchow's triad). These are related to abnormal/reduced flow (no hypotensive episode noted in this case), abnormalities of the blood vessel wall (atherosclerotic plaque noted), and a predisposition to increased blood coagulation (hypercoagulability).

33. Dr Iles agreed with Dr Ho and Prof Duflou that the deceased had a number of longstanding underlying risk factors for stroke, and neuropathological examination showed evidence of previous, predominantly small vessel, cerebral ischaemic events. Superimposed on the deceased's pre-existing vulnerabilities to stroke, the deceased had sustained a number of soft tissue blunt force injuries resulting in bruising and bleeding. These types of soft tissue injuries promote a hypercoagulable state by the release of tissue factor that promotes haemostasis. She agreed with Prof Duflou that prothrombotic states occur after injuries have been sustained, and this more commonly results in venous thromboembolism rather than arterial thrombosis. However, this is still an additional risk factor for arterial thrombosis. She noted that the deceased developed symptoms of middle cerebral artery stroke about or within 12 hours following soft tissue trauma.

34. Dr Iles agreed with Prof Duflou that the presence of immobility in this instance was immaterial to the development of the deceased's middle cerebral artery stroke.

*Intracranial carotid artery examination*

35. Dr Iles noted the autopsy performed by Dr Ho which did not document significant atherosclerotic disease within the carotid arteries in the neck. There was, however, significant atherosclerotic disease within the internal carotid and vertebral arteries proximal to the middle cerebral artery. Prof Duflou indicated that there was no mention of examination of the deceased's intracranial carotid vessels by the pathologist. Dr Iles noted that this was not quite correct as she performed an examination of the intracranial carotid arteries attached to the brain. However, she noted there was no documented examination of the petrous of intracavernous segments of the internal carotid arteries.

*Traumatic axonal injury*

36. Dr Iles noted that Prof Duflou suggested that in the absence of significant brain swelling, and an absence of intraparenchymal macroscopic injury would make traumatic axonal injury

relatively unlikely. Dr Iles stated that this was incorrect as those factors need not be present in the setting of traumatic axonal injury, particularly traumatic axonal injury, which is focal or multifocal. Nevertheless, Dr Iles stated this was of little consequence in this case.

*Conclusion about cause of death*

37. I accept and adopt the cause of death as opined by Dr Ho. While there is some discrepancy about the cause of the deceased's left middle cerebral artery thrombus, I accept Dr Ho's advice that there is a temporal connection between the assault and the deceased's passing.

**Circumstances in which the death occurred**

38. On 5 July 2022, CDE was hospitalised after suffering a stroke, leaving MHR at home alone without care. His family voiced concerns to services that MHT would be left alone during CDE's hospitalisation, noting the property was large and had a dam and a quarry on it. In their statements to police, the family noted that while UYT was residing at the family home with MHT at the time, he was unable to provide the required care due to work commitments. This meant that MHT was left unsupervised for long periods of time.

39. In an effort to arrange care for MHT, his granddaughter, BGV first contacted Barwon Health for assistance, where CDE was receiving care. She was advised that they were unable to assist as MHT was not a patient of the hospital and she was referred to speak with the Carer Gateway, a service that provides practical and emotional support to carers.

40. BGV also viewed the Victorian Civil and Administrative Tribunal (**VCAT**) website which advised she would need to contact the Office of the Public Advocate (**OPA**) in order to fast track a guardianship application. In her statement to the Court, BGV advised that between 11 and 18 July 2022, she placed seven calls to the OPA and was eventually advised to send the guardianship application to VCAT "*which [was] just a standard process, nothing fast tracked*".

41. To have the guardianship order approved, BGV was also required to submit supporting evidence of MHT's diagnosis, which she attempted to obtain from July 2022 onwards, without success. BGV also contacted the Carer Gateway, Dementia Support Australia and My Aged Care during this time but was advised that these services were unable to provide an assessment or support without a guardianship order or MHT's approval.

42. BGV lodged her application to VCAT on 27 July 2022 for guardianship and administration of MHT. In her application, BGV noted that MHT had been diagnosed with dementia, did not have care supports in place and that he had an inability to care for himself, noting that he only ate ice cream and fruit, and did not shower. BGV submitted a medical report to VCAT in support of the application and a hearing was scheduled for 26 August 2022.

43. MHT's children and BGV continued their attempts to coordinate some form of care for MHT during this time. On 28 July 2022, MHT allegedly attempted to assault ASD while she was caring for him. ASD called the local police station who advised her that they would not attend the address as they needed to contact MHT's health practitioner for an assessment. The family then contacted 000 and ASD advised that she had left her wallet at the house and was fearful to return. Police attended the address and spoke to ASD and BGV who advised:

    a) MHT was allegedly violent towards ASD and that she did not feel safe

    b) No one was willing to care for MHT and there were no guardianship orders in place

    c) There were no services able to assist

    d) The family members were at risk of violence

    e) MHT was unable to care for himself and was living in unsanitary conditions.

44. Police confirmed that UYT was content to remain at home with MHT, that MHT would not be left home alone overnight, or the next day and they recommended that the family contact healthcare services for further assistance, noting that this was not a police matter.

45. On 1 August 2022, the family met with MHT's general practitioner (**GP**), who agreed to complete the relevant section on the VCAT application and advised the family to contact emergency services if they held concerns for MHT's safety. Following this advice, the family decided to contact emergency services. Paramedics and police attended the address and advised the family that MHT did not meet the criteria for apprehension under the *Mental Health Act 2014* (Vic) and referred the family back to MHT's GP for support.

46. Later that day, the family contacted Carer Gateway and reported feeling overwhelmed by the situation and were frightened for MHT's wellbeing and for their own safety in his presence due to a history of family violence. Carer Gateway contacted emergency services on the family's behalf and requested a welfare check on MHT as he was home alone. Carer Gateway

later advised BGV that police had not attended, and that they would be ceasing their support as they did not have MHT's consent to remain involved.

47. On the morning of 6 August 2022, CDE passed away following a period of hospitalisation due to the stroke she suffered one month prior. After viewing CDE's body at the hospital, MHT, RFT and UYT returned to MHT's home, where RFT and UYT commenced drinking alcohol.

48. At some point that evening, MHT left the house to tend to his geese. He later left the property and attended a neighbour's house where he requested that they call police. He reported that he needed help because "*they're trying to kill me*", he noted his wife passed away earlier that day and "*they*" accused him of killing her. MHT's neighbours contacted the local police station and spoke to a member who advised the neighbour that MHT had dementia. The member asked the neighbour if they could attend the family home and "*see what was going on*".

49. The neighbour attended MHT's home as instructed and observed that both UYT and RFT appeared intoxicated. They told the neighbour that MHT had dementia and could be violent, but did not appear interested in retrieving MHT from the neighbour's home. The neighbour returned home and called police again.

50. The same police member attended the neighbour's home where they located MHT with UYT and the neighbour. The member escorted MHT home in the company of UYT and MHT appeared to willingly leave with same.

51. At about 8.00pm, RFT physically attacked his father, stating "*you killed my mother*". UYT witnessed the incident and called BGV to notify her. BGV instructed UYT to contact 000, which he did.

52. Paramedics transported MHT to UHG where he was observed to have multiple head and chest injuries and superficial injuries to his hands. MHT underwent a CT scan which showed an acute right subdural haemorrhage, nasal fracture and a possible displaced left mandible fracture. UHG clinicians discussed MHT's results with clinicians at the Royal Melbourne Hospital who recommended conservative management.

53. A repeat CT scan demonstrated a subarachnoid haemorrhage over the right parietal lobe, bilateral subdural haematomas and likely evolving left parietal infarct. He experienced a Medical Emergency Team (**MET**) call on the evening of 7 August 2022 for agitation and

delirium which settled with sedatives. A third CT scan on 8 August 2022 demonstrated an increase in size of the parietal infarct and a decision was made to transition MHT to palliative care. MHT passed away on the evening of 9 August 2022.

54. RFT was arrested and interviewed by police. He was originally charged with murder, however later pleaded guilty to intentionally causing serious injury. He was sentenced to four years' imprisonment, with a non-parole period of two years and two months.

## FURTHER INVESTIGATIONS AND CPU REVIEW

55. As MHT's death occurred in circumstances of family violence, I requested that the Coroner's Prevention Unit (**CPU**)[2] examine the circumstances of MHT's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**)[3].

56. I make observations concerning service engagement with MHT and his family as they arise from the coronial investigation into his 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 MHT's death.

57. 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 MHT and his family to assist in identifying any areas of practice improvement and to ensure that any future prevention opportunities are appropriately identified and addressed.

### Victoria Police

58. Following MHT's passing, Victoria Police conducted a Family Violence Service Delivery Report (**FV-SDR**) in relation to the police contact on 2 August 2021. The FV-SDR did not consider any episodes of police contact in 2022. I note that the FV-SDR is a desktop review

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[2] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[3] The VSRFVD provides assistance to Victorian Coroners to examine the circumstances in which family violence deaths occur. In addition the VSRFVD collects and analyses information on family violence-related deaths. Together this information assists with the identification of systemic prevention-focused recommendations aimed at reducing the incidence of family violence in the Victorian Community.

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

completed in the absence of the time pressures and competing priorities facing frontline members.

59. The FV-SDR noted that on 2 August 2021, police should have submitted a family violence report in relation to the violence allegedly perpetrated by RFT. I agree with this conclusion.

60. However, I am concerned that Victoria Police did not consider its 2022 contact with MHT's family. In particular, I note Victoria Police's response to the threats reported by MHT on 6 August 2022. It does not appear that the attending member made substantial inquiries with MHT and his family regarding the threats of violence. This is concerning, given MHR's vulnerability as an elderly person with reduced cognitive capacity and the known history of family violence.

61. I note that MHT's dementia diagnosis may have caused difficulty in determining the authenticity of the threats or the risk posed to MHT. Nevertheless, I am of the view that additional efforts should have been made to ask MHT, RFT and UYT about the events that occurred.

62. Even if the attending police probed further, I cannot determine now that it would have prevented the fatal incident or MHT's passing. I also note that the options available to BGV Police may have been limited in circumstances where MHT was highly reliant upon the care provided by his sons. If police used their powers to exclude one or both of his sons from the family home, MHT would have been left home alone with no support. The circumstances of this case highlight the challenges associated with the current services and responses available for adults with complex care and support needs, such as MHT.

63. In response to the concerns identified above, Victoria Police advised that it did not wish to make a further comment in relation to same.

**Support for people with care needs and their families**

64. As noted by BGV, the family "*felt helpless and couldn't get the support we required [for MHT]. I was screaming for support, and was doing all the right things and contacting all the right people and all of the services I had been referred to – I work in the industry, I know all the right things to say, and I still couldn't get any community support for my grandfather*".

65. In an effort to seek assistance, MHT's family asked Victoria Police and other support services for help in arranging care for MHT, however they were repeatedly advised that this support

was either not in scope or MHT's consent (or power of attorney) was required before care could be arranged.

66. For unknown reasons, MHT's family were either unable or were not directed to access a fast-tracked VCAT hearing and support services seemed unsure of how to respond to the family's urgent need for a guardianship order and in-home care. This is symptomatic of a fragmented system that is unable to provide agile responses to adults with care and support needs.

67. In her statement to the Court, BGV noted that "*the system doesn't allow for rapid services to be organised in this type of situation*" and there is "*no efficient mechanism in place to prioritise matters based on the degree of urgency, nor a mechanism for waiving the consent requirement in the interim, whilst the necessary arrangements and orders are put in place*". As a result, BGV and her family found themselves "*on a 'merry go around'*", noting that "*agencies do not communicate well with each other, each passing the need for action to the next*".

68. I note that the gap in the Victorian service sector is not unique to MHT's family. I noted similar concerns in my Finding into the death of CFT who had complex care and support needs.[5] CFT had contact with various support services, however, the fragmented nature of the system meant that the services did not interact well with one another, and there was no 'central' or 'main' service in control of CFT's care needs.

69. In August 2022, the Office of the Public Advocate (**OPA**) completed a review of Victoria's existing legislation relating to adult safeguarding and support for at-risk adults to identify gaps in the state's safeguarding provisions. The subsequent report, *Line of Sight: Refocussing Victoria's adult safeguarding laws and practices* (Line of Sight), describes Victoria's adult safeguarding provisions as "*a patchwork of agencies with specific roles, functions and powers, largely focused on the regulation of specific services or providers, or Victorians who have a decision-making disability*" which is "*complex and difficult to navigate*".[6] There are several organisations which each play a limited role in adult safeguarding in Victoria including Seniors Rights Victoria, Elder Abuse Helpline, hospitals, the OPA, the NDIS Quality and Safeguards Commission, Aged Care Quality and Safety Commission, and Victoria Police.[7] Despite this, there are circumstances in which at-risk adults who are experiencing or are at

[5] Finding into death without inquest – CFT (COR 2020 4205).
[6] OPA, *Line of Sight: Refocussing Victoria's Adult Safeguarding Laws and Practices* (Review, 18 August 2022) 13.
[7] Ibid 47.

risk of experiencing abuse, neglect or exploitation are likely to fall through the cracks of Victoria's safeguarding system.[8]

70. The fragmented Victorian safeguarding system imposes a significant barrier to at-risk adults and their families in accessing support as it relies on "*individuals to seek out information, communicate and advocate for their needs, make informed decisions, and navigate within and across systems, to deliver services and supports effectively.*"[9] This complex system also makes it "*very difficult for third parties who are concerned about an at-risk adult experiencing abuse to know where to go for help*" and contributes to the under-reporting of violence, abuse, neglect and exploitation of at-risk adults.[10]

71. In the present case, an adult safeguarding framework may have assisted MHT's family in navigating and accessing the required support for MHT prior to and after CDE's hospitalisation. A safeguarding mechanism may have assisted in the present case as follows:

    a) Concerns were noted for MHT's self-care and hygiene in the years prior to his death while he was cared for by his elderly wife. Concerns were also noted that MHT was allegedly abusive towards CDE and that her physical safety was at risk. An adult safeguarding service may have provided an option for concerned family members who wished to seek intervention.

    b) Following CDE's hospitalisation, family members sought assistance to arrange care and support for MHT and noted that they were unable to care for him due to his perpetration of violence and their fear for their safety. If a safeguarding service was available, MHT's family members, support services and/or Victoria Police could have accessed this service to help identify options for care and respite.

    c) Following reports that MHT allegedly made threats against ASD on 28 July 2022 and that there was a history of family violence, Victoria Police could have liaised with a safeguarding agency to assess the risk posed by MHT to his family and provide emergency care.

    d) Similarly, following MHT's allegations that his son was violent towards him on 2 August 2021 and 6 August 2022, Victoria Police could have used a safeguarding

[8] Ibid 48
[9] Australian Government, *Safety Targeted Action Plan* (Plan, December 2021) 2.
[10] *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* (Final Report, September 2023) Executive Summary and Recommendations, 171.

service as an option to assess MHT's safety in the home and the risk of family violence. Without this option, it was difficult for police to exclude family members from the address (by way of FVIO), as this would have left MHT alone and without care.

72. In my Finding into the death of CFT, I made ten recommendations about the establishment of an adult safeguarding agency. In response, the Department of Families, Fairness and Housing (**DFFH**) responded to advise that it has taken all of 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, which also recommended the introduction of adult safeguarding legislation.

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

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

## FINDINGS AND CONCLUSION

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

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

    b) the death occurred on 9 August 2022 at University Hospital Geelong, 272-322 Ryrie Street, Geelong, Victoria, 3220, from *1(a) complications of blunt force trauma in a man with cardiac amyloidosis and atherosclerotic cardiovascular disease*; 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.

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

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

    5. *In framing legislation, the Victorian Government review the circumstances of 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.*

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

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

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:

**UYT, Senior Next of Kin**

**BGV**

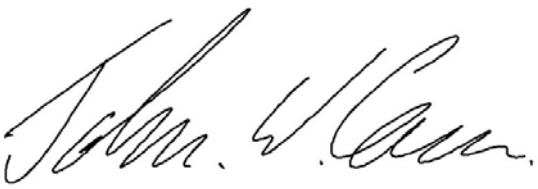
**Barwon Health**

**Department of Families, Fairness and Housing**

**Office of the Public Advocate**

**Detective Sergeant Gemma Etherington, Coronial Investigator**

Signature:




Judge John Cain
State Coroner
Date: 30 July 2025

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.