



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 004946

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:	JZA
Date of birth:	[REDACTED]
Date of death:	29 August 2022
Cause of death:	1(a) combined effects of acute pneumonia, pancreatitis, urinary tract infection, and osteomyelitis complicating decubitus ulcers in the setting of a prolonged lie in a woman with multiple comorbidities
Place of death:	The Alfred Hospital 55 Commercial Road Melbourne Victoria 3004
Keywords:	Adult safeguarding, alcohol dependence, neglect, older persons, at-risk adult

INTRODUCTION

1. On 29 August 2022, JZA was 65 years old when she passed away at the Alfred Hospital. At the time of her death, JZA lived with her husband, BWE, in an outer suburb of Melbourne.
2. JZA was born in a regional area of Victoria and was the middle child to parents ETN and GRT. She had an older brother, NGF, and a younger brother, WER. JZA was described as a “wonderful” person who “*proved her way*” in the world. She loved living on a farm as a child, tending to animals and enjoying the countryside.
3. JZA married her first husband when she was 18 years old, however he struggled with alcoholism and was reportedly abusive towards her. JZA reportedly also began consuming excessive quantities of alcohol during this time.
4. After separating from her first husband, JZA commenced a relationship with KHJ in the 1980s. They shared one child together, PKI, born in 1991. The pair separated in about 1993, however they maintained an amicable relationship despite the separation.
5. In about 1992, JZA experienced three admissions to a rehabilitation facility due to her alcoholism. Her family noted that she was able to maintain abstinence briefly after discharge, however ultimately relapsed over time. Her family also noted that she had a demanding and stressful career at the time, and believed she was using alcohol to de-stress. JZA disclosed to WER that she had been abused by a family friend as a child and used alcohol as a coping mechanism.
6. JZA commenced a relationship with BWE in about 2002 and they married in about 2015. JZA’s son, PKI, lived with JZA and BWE throughout most of his adolescent years, as their home was close to his school.

Medical history

7. JZA’s health began to decline from about 2008, however deteriorated further from about 2016. In 2008, JZA was diagnosed with glaucoma, cardiac issues and haemochromatosis. In 2014, JZA was diagnosed with tonsil cancer and commenced chemotherapy. She told her family at the time that the chemotherapy was very challenging for her and if the cancer returned in the future, she would not undertake chemotherapy again.
8. In 2016, JZA’s parents both passed away within a week of one another, and one of her brothers suffered a heart attack. JZA struggled with the death of her parents and her family opined that

she “*lost the will to live*” around this time. JZA started spending a significant amount of time in bed from about 2016. Due to her increasing health problems, she became heavily reliant upon other people for her care needs.

9. KHJ visited JZA while BWE was in hospital in about 2016 and became concerned that she had lost weight and was not consuming enough food. KHJ contacted WER and reported his concerns, resulting in JZA being transported to hospital. Following her hospital admission, JZA continued to drink alcohol to excess and consumed very little food. In his statement to the Court, WER explained that at the time he “*decided [he] wasn’t going to intervene anymore as [he] could tell she didn’t want any help, and it appeared she didn’t want he be here anymore*”.
10. BWE underwent a double lung transplant in 2019 due to an emphysema diagnosis. At about the same time, JZA underwent hip replacement surgery. She was largely bedridden following the surgery and continued to consume a significant quantity of alcohol.
11. In early-2021, JZA was hospitalised due to sepsis and was discharged home after declining in-home care services. BWE stated that after this hospitalisation, JZA developed a persistent cough, however she did not want to seek medical treatment as she believed her cancer had returned.

THE CORONIAL INVESTIGATION

12. JZA’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.
13. 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.
14. 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.

15. Victoria Police assigned Acting Sergeant Slagian Radoievici to be the Coronial Investigator for the investigation of JZA'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.
16. 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.
17. This finding draws on the totality of the coronial investigation into the death of JZA 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

18. On 30 August 2025, JZA born [REDACTED], was visually identified by her husband, BWE.
19. Identity is not in dispute and requires no further investigation.

Medical cause of death

20. Forensic Pathologist Dr Chong Zhou from the Victorian Institute of Forensic Medicine (VIFM) conducted an autopsy on 2 September 2022 and provided a written report of her findings dated 7 November 2022.
21. Dr Zhou explained that the cause of death was due to the combined effects of multiple potentially treatable infections/inflammatory processes (i.e., pneumonia, pancreatitis, urinary tract infection) and multiple potentially preventable severe decubitus ulcers (pressure sores) complicated by osteomyelitis (infection/inflammation of bone) which developed in the setting of a prolonged lie and on a background of multiple significant comorbidities (i.e.,

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.

malnutrition, ischaemic heart disease, pulmonary emphysema, end-stage kidneys and a history of chronic excessive alcohol consumption).

22. Dr Zhou explained that pneumonia is an inflammatory and infective condition of the lungs. In this case, it was likely caused by *Pseudomonas aeruginosa* and *Morganella morganii ssp. siboni* which were cultured from a right main bronchus swab. The deceased's risk factors for the development of pneumonia include emphysema, malnutrition, immobility in the setting of a prolonged lie, altered conscious state, and a history of smoking and chronic excessive alcohol consumption. If left untreated, pneumonia can lead to sepsis (dysregulated systemic response to infection), respiratory failure, and death.
23. Pancreatitis is an inflammatory condition of the pancreas, which is a gland in the upper abdomen that produces digestive enzymes and hormones essential to the regulation of blood sugar levels. The deceased's history of chronic excessive alcohol consumption is a risk factor for the development of pancreatitis. In this case, pancreatitis was complicated by the development of an abscess or pseudocyst which had ruptured into the abdomen causing peritonitis (inflammation of the membrane lining the abdominal wall and organs). If left untreated, pancreatitis can cause sepsis, severe metabolic abnormalities, fluid shifts with dehydration and hypovolaemic shock (reduced circulating blood volume leading to circulatory collapse), renal failure, acute respiratory distress syndrome, and cardiac arrhythmias. Any one or a combination of these conditions can result in death.
24. The deceased had a severe urinary tract infection (UTI) with *Escherichia coli* and *Proteus vulgaris* cultured from the urine. This was associated with severe cystitis (inflammation of the bladder) including some chronic changes indicating that the UTI had been untreated, inadequately treated and/or was recurrent for some time. If left untreated, severe UTIs can cause sepsis and acute renal failure leading to death.
25. There were multiple deep areas of decubitus ulceration (pressure sores) which were complicated by rhabdomyolysis (breakdown of skeletal muscle) and osteomyelitis (infection/inflammation of bone). A swab from the sacral ulcer showed mixed growth of *Escherichia coli*, *Proteus vulgaris* and *Enterococcus faecalis*.
26. Decubitus ulcers are lesions of degenerating skin and underlying tissues caused by impaired blood supply and tissue malnutrition owing to prolonged pressure. In this case, it has occurred secondary to a prolonged lie. If left untreated, osteomyelitis complicating decubitus ulcers can lead to sepsis and death. Predisposing factors for decubitus ulcers include immobility,

inadequate hygiene, urinary/faecal incontinence, and malnutrition. Malnutrition and a history of chronic excessive alcohol consumption can lead to an impaired immune system which can accelerate skin breakdown and predispose to secondary infections.

27. Microbiology on a blood culture specimen showed mixed growth of *Pseudomonas aeruginosa*, *Escherichia coli*, and *Proteus vulgaris*, which is supportive of bacteraemia and sepsis from combined lung, urine and decubitus ulcer origin.
28. The deceased had significant background comorbidities including malnutrition, ischaemic heart disease (**IHD**), pulmonary emphysema, end-stage kidneys and a history of chronic excessive alcohol consumption. Dr Zhou noted:
 - a) Chronically reduced oral intake and malnutrition can lead to dehydration, electrolyte imbalances, compromised immune function, and an increased risk of infections. At the time of the post-mortem examination, the deceased weighed 39kg and was 165cm tall (BMI of 14.3 kg/m²).
 - b) IHD is characterised by an imbalance between myocardial oxygen supply and demand and has arisen due to coronary artery disease. IHD predisposes the development of fatal cardiac arrhythmias (abnormal heart rhythms), particularly in the setting of circulatory compromise secondary to dehydration and sepsis, complicating multiple severe infections.
 - c) Emphysema refers to irreversible permanent enlargement of the air sacs within the lungs which is typically caused by long-term smoking. Individuals with emphysema have reduced respiratory reserve and are at increased risk for developing pneumonia.
 - d) The deceased had end-stage kidneys which were likely due to the combined effects of chronic hypertension and chronic pyelonephritis.
 - e) The deceased had a history of chronic excessive alcohol consumption, and the post-mortem examination showed sequelae of chronic alcohol misuse. Individuals who chronically consume alcohol in excessive amounts are at an increased risk of sudden death from alcohol withdrawal syndrome, seizures, and cardiac arrhythmias (abnormal heart rhythms). It is also a risk factor for the development of malnutrition and infections.

29. Review of ante-mortem blood test results taken at the Alfred Hospital on 29 August 2022 at 2.15am showed acute renal failure (which likely developed in the setting of combined septic and hypovolaemic shock), metabolic acidosis, and hypoxaemia (reduced oxygenation of the blood).
30. There was no evidence of recurrent tonsillar squamous cell carcinoma.
31. Toxicological analysis of post-mortem samples identified the presence of pholcodine². Ethanol was not detected.
32. In summary, Dr Zhou stated that while the deceased had significant background comorbidities, her death was hastened by multiple severe, potentially preventable and potentially treatable conditions that have developed in the setting of a prolonged lie and failure to seek medical attention.
33. Dr Zhou provided an opinion that the medical cause of death was 1(a) Combined effects of acute pneumonia, pancreatitis, urinary tract infection, and osteomyelitis complicating decubitus ulcers in the setting of a prolonged lie in a woman with multiple comorbidities.
34. I accept Dr Zhou's opinion as to the medical cause of death.

Circumstances in which the death occurred

35. In the eight to nine months prior to her passing, JZA's health deteriorated significantly. BWE reported that he and JZA's family and friends all witnessed this deterioration, however JZA refused to see a doctor or attend a hospital. She was bedridden and relied on BWE to help her with all her activities of daily living. As she did not attend her doctor, she also stopped taking her previously prescribed medications.
36. About three weeks prior to her passing, JZA fell out of her bed. BWE told police that he wanted to call KHJ or WER, however JZA refused. BWE tried to lift JZA back into bed, however, was not physically strong enough to do so. He continued to assist her on the floor by bringing her food and assisting with her hygiene needs to the best of his ability. He ensured she remained warm by placing blankets and doonas on her. He provided soft foods including ice cream, Sustagen, eggs and mashed avocado.
37. When police asked BWE whether he considered calling an ambulance against JZA's wishes, BWE explained that JZA was "*very stubborn*" and that she would have "*cracked it*" if he

² Pholcodine is a semisynthetic opioid derivative indicated for cough.

called an ambulance. He further explained that he did not “*want to suffer the consequences*” of going against JZA’s wishes. He also stated that even if an ambulance was called, JZA would not have consented to being transported to hospital.

38. On the evening of 28 August 2022, BWE observed that JZA’s breathing had changed. He explained that her breathing appeared quicker than it was the day before and told JZA that he was going to call an ambulance. JZA did not respond when BWE told her that he was calling an ambulance.
39. Ambulance Victoria (AV) paramedics attended the home and observed that JZA was malodorous and was covered in faeces, dirt and vomit. Paramedics documented blood, faeces and fluid on the floor, and that JZA had vomited blood at some point over the previous three weeks, as it had dried on her shirt and damaged the skin of her right upper arm and shoulder. Paramedics noted JZA had numerous pressure sores and there was insect activity inside the house.
40. Paramedics documented their opinion that BWE appeared to have “*little to no insight*” into how unwell his wife was. He appeared to focus on his inability to move her due to his double lung transplant and JZA’s consistent refusal of help (until that night because she was unconscious).
41. Paramedics transported JZA to the Alfred Hospital, arriving in the early hours of 29 August 2022. Upon arrival, staff documented that JZA had unrecordable blood pressure, she was covered in faeces, dirt and vomit, there were pressure sores on her arms and most of her back with some necrotic areas and skin breakdown in the groin. She was also significantly cachectic. Staff noted she had insects in her hair and was extremely malodorous.
42. The clinical impression was of “[*n*]eglect, malnutrition and long lie”, and that JZA was actively dying. Emergency department clinicians discussed her case with intensive care clinicians, and the consensus was that JZA’s condition was irreversible, irrespective of medical management. Clinicians initiated comfort care measures and JZA passed away at 9.10am that morning.

FURTHER INVESTIGATIONS AND CPU REVIEW

43. As JZA's death occurred in circumstances where she may have experienced neglect in the lead-up to her passing, the Coroner's Prevention Unit (CPU)³ examined the circumstances of JZA's death as part of the Victorian Systemic Review of Family Violence Deaths (VSRFVD)⁴.
44. I make observations concerning service engagement with JZA 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 JZA's death.
45. 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*".⁵ I make observations about services that had contact with JZA to assist in identifying any areas of practice improvement and to ensure that any future prevention opportunities are appropriately identified and addressed.

Care provided to JZA

46. BWE was JZA's sole carer, despite having his own health conditions, including undergoing a double lung transplant in 2019. Evidence available in the coronial brief suggests that BWE may have also struggled with alcohol misuse.
47. Statements provided to the Court suggest that JZA's family members may have held concerns regarding BWE's capacity to care for JZA and her refusal to receive care. WER stated that he did not believe BWE "*had the strength to look after JZA especially in the circumstances*". He explained that he "*was told that JZA had fallen out of bed and [he] wondered why [BWE] wouldn't help her up but [he] realised now it was probably because of her dignity and being too proud. She didn't want attention drawn to her as that probably would have resulted in her back in hospital which she didn't want*". KHJ similarly commented that BWE "*was doing the*

³ 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.

⁴ 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.

⁵ *Adameczak v Alsco Pty Ltd (No 4)* [2019] FCCA 7, [80].

best he could to care for [JZA] but she [was] very stubborn and was the more controlling one in the relationship.

48. Given JZA was bedridden, it appears that she was reliant upon BWE to purchase alcohol for her. KHJ stated that he believed BWE purchased alcohol for her “*to appease her but not to harm her*”.

Previous treatment at Alfred Health

2021 admission - JZA

49. On 18 February 2021, JZA was admitted to the Alfred Hospital Intensive Care Unit (ICU) due to urosepsis and shock in the setting of functional decline. During this admission, staff documented:
- a) JZA had not left the house since December 2020 and was found on a single mattress, with faeces on the floor.
 - b) JZA was incontinent and malnourished.
 - c) JZA self-ceased her medications in 2020 and was not engaged with her general practitioner (GP).
 - d) JZA had chronic alcohol use and potentially an underlying cognitive impairment.
 - e) JZA had limited mobility.
 - f) BWE appeared to be experiencing carer stress. He was JZA’s sole carer and there were no formal supports in the home.
 - g) JZA had reduced insight into her incontinence and the “*impact on carer burden*”.
 - h) JZA told staff that BWE could be “*mean and grouchy*”.
50. During her admission, JZA engaged with a physiotherapist, occupational therapist and dietician. Her mobility and dietary intake showed some improvement at the time of her discharge.
51. Staff spoke to BWE who advised that he was “*unable to care for [JZA] at home at [current level of functioning]...given his own health issues he [was] unable to care for pad changes*

and full attendance” to JZA. He noted that he might be able to care for her with significant additional supports.

52. During her admission, staff strongly encouraged JZA to accept in-home supports or an admission to a rehabilitation facility. JZA told staff that she had previously been sexually harassed while in a facility and was also a private person. These issues were identified as barriers to receiving ongoing support. Staff worked with JZA and BWE to address her concerns, however JZA ultimately declined in-home care and rehabilitation. Nevertheless, she agreed to regular visits from an outreach physiotherapist.
53. Towards the end of JZA’s admission, on 30 March 2021, a hospital physiotherapist and occupational therapist met with BWE. During this conversation, BWE told the clinicians that he wished JZA was ambulating further and more independently before being discharged, however he was happy for her to be discharged into his care.
54. JZA was referred to the outreach physiotherapy team for ongoing support, however she was out of the service area, so a new referral was sent to Monash Health on 13 April 2021. Monash Health attempted to contact JZA on 12 May 2021 and left a voicemail with referral details. Monash Health spoke to JZA later that day and she declined services as “*it has taken so long*” and noted that she was “*doing well anyway*”. The referral was closed, and no further contact occurred.

2019 admission – BWE

55. While he was an inpatient at Alfred Health during November and December 2019, BWE raised concerns that he would be unable to provide care to JZA due to his own health issues. A social worker met with BWE and discussed options for ongoing support, with a plan to revisit these options at a later date.
56. The social worker met with BWE again in January 2020 and he advised that his health had improved, JZA had become more independent, and she was now able to help around the house. BWE explained that “*everything is working out better now*” and the couple decided not to proceed with a carers assessment as they did not need support.

██████████ Medical Centre

57. JZA was last reviewed by a GP at ██████████ Medical Centre in October 2020. Earlier that year, on 7 February 2020, WER contacted the clinic and advised that he was concerned about

JZA. He reported that she had not showered or moved from her bed for three months and her mental health had deteriorated. The clinic directed ETN to contact emergency services so that JZA could be transported to hospital. The clinic tried to contact JZA in May 2020, however received no response.

National Home Doctor Service

58. JZA was reviewed by the National Home Doctor Service (NHDS) on 22 May 2021. This was the last time that JZA was seen by a medical professional prior to her hospitalisation on 28 August 2022. During this consultation, JZA advised that she had throat cancer, was unable to tolerate solid foods and had been vomiting. She also reported difficulty sleeping but did not have diarrhea or abdominal pain.
59. The NHDS reviewed JZA and observed that she looked tired and cachectic. Her blood pressure and temperature were normal, her abdomen was soft, and she was not dehydrated. She was prescribed with an anti-emetic medication and temazepam and was advised to attend her regular GP or local emergency department for further treatment if her symptoms continued.

Systemic issues

Support for people with care needs and their families

60. During JZA's 2021 admission to Alfred Health, BWE was documented as taking sole responsibility for JZA's care. He assisted her with toileting, showering, ambulation and dressing. Given her level of functioning, clinicians strongly encouraged the use of in-home supports, however JZA declined. BWE advised staff on several occasions that he would be unable to care for her if she was immobile, particularly given his own health conditions. Staff also documented concerns for carer stress/burden. Following some improvements in JZA's mobilisation and her persistent refusal of in-home care, BWE agreed to provide ongoing care to JZA on the condition that she received outreach physiotherapy to continue her rehabilitation and improve her mobility. When JZA later declined this service, the couple received no further support.
61. Despite BWE's best intentions to care for JZA, without an adult safeguarding framework, family members and health professionals did not have a course of action available when they had concerns for JZA's care. JZA's case demonstrates the issues associated with Victoria's

lack of a comprehensive framework for safeguarding at-risk adults from abuse, neglect and exploitation.

Adult safeguarding

62. Broadly, adult safeguarding means protecting the rights of adults to live in safety, free from abuse and neglect.⁶ In the United Kingdom, adult safeguarding involves the investigation of, and coordination of responses to, suspected abuse and neglect (including self-neglect) of ‘at-risk’ adults.⁷ At-risk adults are defined as people aged 18-years-old or over, who:
- a) Have care and support needs;⁸ and
 - b) Are being abused or neglected, or are at risk of abuse or neglect; and
 - c) Are unable to protect themselves from the abuse or neglect because of their care and support needs.⁹
63. Adult safeguarding is important because people with a disability are more likely to experience violence, abuse, and neglect than people without a disability. Adult safeguarding can also play an important role in intervening when third parties hold concerns about an informal carer’s capacity to meet the care and support needs of a family member.¹⁰
64. Managing wellbeing becomes even more complex when a person with care and support needs refuses intervention and carers have their own care and support needs that may make their caring role challenging. Therefore, a specialised response to reports of abuse, neglect and self-neglect of at-risk adults is required. Adult safeguarding can include actions such as:

⁶ UK Department of Health, Care and support statutory guidance, (5 October 2023) s 14.7 <https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1>

⁷ Australian Law Reform Commission (ALRC), Elder Abuse – A National Legal Response (Final Report, May 2017), 376 https://www.alrc.gov.au/wp-content/uploads/2019/08/elder_abuse_131_final_report_31_may_2017.pdf.

⁸ 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 <https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1>

⁹ 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).

¹⁰ 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

- 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 same, including in relation to safety planning.
- d) Facilitating decision-making support for at-risk adults.
- e) Cooperating with other agencies, including care providers, legal and medical services, to promote the safety of the at-risk adult.
- f) Reporting the abuse to police.
- g) Applying for an intervention order in relation to the person allegedly causing harm to the at-risk adult.¹¹

Victoria's adult safeguarding

65. 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*".¹² There are several organisations which each play a limited role in adult safeguarding in Victoria, including Seniors Rights Victoria, Elder Abuse Helpline, the OPA, the NDIS Quality and Safeguards Commission, the Aged Care Quality and Safety Commission and Victoria Police.¹³ Notwithstanding this, there are circumstances in which at-risk adults who are experiencing

¹¹ UK Department of Health, *Care and support statutory guidance*, (5 October 2023) s 14.10, 14.58 <[Care and support statutory guidance - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/publications/care-and-support-statutory-guidance)>; Australian Law Reform Commission (ALRC), *Elder Abuse – A National Legal Response* (Final Report, May 2017), 402-3.

¹² OPA, *Line of Sight: Refocussing Victoria's Adult Safeguarding Laws and Practices* (Review, 18 August 2022) 13.

¹³ Ibid, 47.

abuse, neglect or exploitation or are at risk of same are likely to fall through the cracks of Victoria's safeguarding system.¹⁴

How adult safeguarding may have assisted

66. In the present case, JZA would have likely met the criteria for an adult safeguarding response given that she had needs for care and support in relation to her activities of daily living and health, and due to BWE's own health issues preventing him from being able to provide the standard of care JZA required. In some jurisdictions, safeguarding responses can be initiated when there are concerns for neglect or self-neglect. As noted above, JZA presented to Alfred Health in February 2021 with numerous signs of neglect and staff held concerns for BWE's capacity to care for her. Without a safeguarding framework in place, these concerns were not comprehensively investigated and a thorough plan to address them was not implemented. At best, staff could only encourage JZA to receive in-home support services.
67. WER's attempts to assist JZA were also disrupted by her refusal of further intervention. Consequently, WER had no further avenues to intervene or seek help.
68. Adult safeguarding responses often consider whether an at-risk adult has mental capacity to make specific decisions with respect to their care and support needs and can facilitate decision-making support. Following JZA's fall (three weeks prior to her death) and given her significant health issues, it is not clear whether JZA had capacity or maintained the capacity to make decisions relating to her care and support needs. If a safeguarding framework had been in place at the time of her fall, BWE and family members may have had an additional avenue through which to seek help or facilitate intervention.

Other recent safeguarding cases

69. Former State Coroner, Judge Cain, extensively canvassed the issue of adult safeguarding in several findings handed down this year (2025) including the deaths of CFT¹⁵, William Heddergott¹⁶, MHT¹⁷, YTR¹⁸, and DRF¹⁹.
70. In Judge Cain's finding into the death of CFT, his Honour recommended:

¹⁴ Ibid, 48.

¹⁵ [Finding into death without inquest – CFT \(COR 2020 4205\).](#)

¹⁶ [Finding into death without inquest – William Heddergott \(COR 2020 6253\).](#)

¹⁷ [Finding into death without inquest – MHT \(COR 2022 4511\).](#)

¹⁸ [Finding into death without inquest – YTR \(COR 2020 6157\).](#)

¹⁹ [Finding into death without inquest – DRF \(COR 2022 0022\).](#)

1. *That the Office of the Public Advocate whenever they become aware of any allegations of neglect or abuse of a represented persons where a guardianship and administrative order is made by VCAT conduct a thorough investigation. This investigation could be carried out by the Office of the Public Advocate or another agency at their request. The outcome of the investigation should inform the guardian advocate's decision-making, where appropriate.*
2. *When implementing the VAGO recommendation that the Office of the Public Advocate "review and update its guidance about allocating orders and balancing the risk of harm when making decisions", the Office of the Public Advocate should review their training, policies, procedures and guidelines to ensure guardian advocates have the guidance and skills necessary to appropriately assess the risks of harm to represented people which may emanate from neglect and unmet care needs.*
3. *That the Victorian Government make available appropriate funding to the Office of the Public Advocate to enable it to implement all of the recommendations from the VAGO report.*
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.²⁰*

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

71. In response to his Honour's recommendations in CFT, the Department of Families, Fairness and Housing (**DFFH**) responded to advise that it had 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.
72. 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 Disability Royal Commission 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.
73. Finally, DFFH referenced 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 the present case, JZA was not receiving any state-funded services, so the Social Services Regulator is unlikely to have made any difference in her case.
74. I remain concerned that without a comprehensive adult safeguarding framework in Victoria, vulnerable adults such as JZA (and their carers/families/professionals) have no centralised avenue to seek advice or raise concerns. I therefore intend to reiterate Judge Cain's recommendations, in particular, recommendations 4 to 10.

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 JZA, born [REDACTED]
 - b) the death occurred on 29 August 2022 at The Alfred Hospital, 55 Commercial Road Melbourne Victoria 3004, from combined effects of acute pneumonia, pancreatitis, urinary tract infection, and osteomyelitis complicating decubitus ulcers in the setting of a prolonged lie in a woman with multiple comorbidities; and
 - c) the death occurred in the circumstances described above.

RECOMMENDATIONS

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

- i. That the **Victorian Government** make available appropriate funding to the Office of the Public Advocate to enable it to implement all of the recommendations from the VAGO report.
- ii. 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.
- iii. In framing legislation, the **Victorian Government** review the circumstances of JZA's passing and similar cases together with the safeguarding recommendations of the ALRC, the OPA and the DRC.
- iv. That any new adult safeguarding agency be adequately funded by the **Victorian Government** to function in an effective manner.
- v. 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.
- vi. 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.
- vii. 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.
- viii. 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 JZA's family for their loss.

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

I direct that a copy of this finding be provided to the following:

BWE, Senior Next of Kin

Alfred Health

Department of Families, Fairness and Housing

Department of Premier and Cabinet

Acting Sergeant Slagian Radoievici, Coronial Investigator

Signature:



Judge Liberty Sanger, State Coroner

Date: 18 November 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.
