IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 003101

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:	TBL
Date of birth:	[redacted]
Date of death:	8 June 2023
Cause of death:	1(a) Multisystem failure in the setting of hyponatraemia secondary to chronic malnutrition in a woman with multiple medical comorbidities
Place of death:	Austin Hospital 145 Studley Road Heidelberg Victoria 3084
Keywords:	Adult safeguarding; care and support needs; mental ill-health; malnutrition

INTRODUCTION

1. On 8 June 2023, TBL was 81 years old when she passed away at the Austin Hospital, Heidelberg. At the time of her death, TBL lived in a suburb of Melbourne with her husband, CAQ and adult son, MRD.

2. Not much is known about TBL's history, although she was born overseas and did not primarily speak English. TBL and her husband shared two sons, MRD, and GYT. GYT tragically passed away years prior in a motor vehicle incident.

Medical history

3. TBL had a significant medical history which included chronic schizophrenia, heart failure, hypertension, previous caecal carcinoma (2006), lymphoedema and extrapyramidal side effects secondary to long-term antipsychotic use.

4. Consultant Psychiatrist, Dr Arthur Kokkinias, treated TBL from 2004 until 2022. While he initially trialled various psychotropic medications, he found that TBL responded best to risperidone.

5. By 2013, Dr Kokkinias suspected that TBL was experiencing a comorbid dementing illness, based on cognitive testing, however TBL refused to undergo any brain imaging. He commenced TBL on donepezil, alongside her risperidone, amisulpride, benztropine and diazepam (as needed).

6. TBL's psychotic symptoms were exacerbated in 2015, following the tragic passing of her son. Dr Kokkinias noted that in 2016, TBL's extrapyramidal side effects were worsening, so he reduced her dose of risperidone. TBL's general practitioner (**GP**), Dr Anna Arsenakis, referred her to a cardiologist in late-2017, for investigation of her lower-limb oedema.

7. In 2018, CAQ underwent surgery, which meant that TBL was unable to remain at home on her own. Dr Kokkinias arranged an admission for TBL to The Melbourne Clinic while her husband was unable to care for her, partly so that she could be cared for, and partly to optimise her medications. By the end of 2018, Dr Kokkinias observed that TBL's physical health had deteriorated, as she was more lethargic and tired, short of breath and developed fluid overload and pneumonia, requiring a hospital admission.

8. Both Dr Kokkinias and Dr Arsenakis noted that MRD first became involved in his mother's care in about 2019, when CAQ was no longer able to care for her due to his own medical

issues. At the time, MRD told Dr Kokkinias that he was staying with his parents on weekends and observed his mother had experienced a significant deterioration in physical and mental health. Dr Arsenakis noted that both MRD and his father were very caring, attentive and accommodating of TBL's needs. Dr Kokkinias similarly noted that MRD appeared to be "*very caring and concerned about his mother's overall wellbeing*".

9. TBL was not compliant with treatment and was very averse to most medication, in particular new medication and any investigations that were more complex than a blood test. She told Dr Arsenakis on numerous occasions that God had advised her not to take certain medications.

10. TBL was re-admitted to The Melbourne Clinic in 2019, while her husband was hospitalised again. She was treated for a urinary tract infection, and she was commenced on a different antipsychotic (olanzapine) to reduce the severity of her extra-pyramidal side effects. Unfortunately, upon her discharge, TBL refused to take the olanzapine and only took risperidone.

11. Both Dr Kokkinias and Dr Arsenakis noted that TBL advised them that she was fasting, for religious reasons, and refused some of her medications (in particular, the ones to treat her cardiac conditions). Dr Arsenakis noted that, within her faith, fasting can take place at various times of the year. Dr Arsenakis noted that some patients take fasting to "*extreme levels*" by fasting for a few set days in the week, and several months per year, leading to iron, calcium and vitamin deficiencies. She opined that TBL's fasting appeared to be a combination of her religious beliefs and "*commands*" from God, the latter being related to her psychiatric condition. Dr Arsenakis explained that she regularly reminded TBL of the need to consume adequate nutrients and to take her prescribed medications.

12. In mid-2019, MRD completed paperwork with his mother's treating clinicians to assume the role of Medical Power of Attorney (**MPOA**). MRD was also living with his parents on a full-time basis at this point.

13. In about August 2019, MRD advised Dr Kokkinias that he wanted to assist his mother with an improved diet, which would exclude all processed foods. He also noted that he wanted to reduce his mother's antipsychotic medications, noting the significant extra-pyramidal side effects she was experiencing. Dr Kokkinias agreed to reduce TBL's medications. In correspondence from Dr Kokkinias to Dr Arsenakis, he wrote:

...MRD directing her towards a change in diet which perhaps reflects more his own ideas and principals but is very well-meaning. He was insistent that her vegan diet was improving her psychosis at the onset of admission and certainly what I did note was that when TBL came to hospital that she had far improved fluid balance, which can be largely attributed I think to the diligence of her son.

14. Dr Kokkinias noted that a gradual reduction of TBL's risperidone from 6mg daily to 4mg daily, then eventually 2mg daily, appeared to improve her extra-pyramidal side effects, without a deterioration of her mental health.

15. By the end of 2020, TBL's blood tests showed normal vitamin B12 and iron levels, however she was vitamin D deficient and required more calcium in her diet. Dr Arsenakis also recommended a bone density scan, however TBL refused. By this time, TBL had ceased most of her medications, and while Dr Arsenakis had lengthy conversations with her and her son, she was adamant about not taking these medications.

16. By early-2021, Dr Kokkinias reduced TBL's risperidone dose to 1mg daily, and this appeared to be well-tolerated. TBL was initially unwilling to trial another antipsychotic; however, Dr Kokkinias was eventually able to convince her to trial lurasidone 40mg daily and accordingly reduced her risperidone to 0.5mg daily. By mid-2021, Dr Kokkinias reduced the risperidone further to 0.5mg every other day, without a deterioration in TBL's mental state. Her extra-pyramidal side effects had also improved significantly, following a reduction in her risperidone dose.

17. Dr Kokkinias' last appointment with TBL occurred on 11 March 2022, in the presence of MRD. TBL reported intermittent headaches, which were resolved with the use of paracetamol. She continued to experience psychotic symptoms including auditory hallucinations, however Dr Kokkinias noted that she was "*not significantly worse overall*". At that time, her mood was not depressed, and she denied suicidal thoughts or plans. Dr Kokkinias noted that TBL did not appear malnourished during this appointment, and he did not hold any concerns for MRD's ability to care for her.

18. Dr Arsenakis recalled her final face-to-face appointment with TBL was on 25 March 2022. She noted that TBL had lost some weight, however she was still in a healthy weight range at the time, with a BMI of 26.6 (noting TBL's BMI was previously elevated). TBL was no longer taking her blood thinning medication. She weighed 56.7kg at this appointment.

19. Dr Arsenakis' final telehealth appointment was on 5 April 2022. During this appointment, Dr Arsenakis noted TBL's improved vitamin D levels, which was positive. However, she was unable to convince MRD about his mother's need to take blood thinning medication. She recalled a lengthy discussion about TBL's atrial fibrillation, and the risk of stroke if she did not take her prescribed medication. MRD advised that blood thinning medication caused his mother to be dizzy, aggravated, have swollen legs and explained his belief that she was at "*greater risk taking it as it had lots of side effects*". Dr Arsenakis noted that despite the potential side effects, she felt that the benefits of the medication outweighed the risks. Dr Arsenakis stated:

> *[MRD] could not understand this [and] was advising me he had done his research [and] he had medical power of attorney. I could sense he was getting aggravated with my recommendation [and] lacked the intelligence [and] background to understand the meaning of evidence based research, [and] the benefit versus risk equation. He had made up his mind that a lot of the medications were causing his mother's conditions [and] this was re-inforced [sic] by her improved state at the time. I also got the sense, that unfortunately he was doing a lot of research on the internet [and] getting swayed by information that was not always evidence based or accurate [and] this is always a problem as patients cannot filter through the volumes of information [and] consider what is evidence based. I do not feel he meant any harm to his mother [and] she was very unlikely to take the medication anyway, it could not be forced on her even if we medically saw it as the best option for her health.*

20. TBL and her son did not present to Dr Arsenakis or Dr Kokkianis again after these appointments. The only medical appointments she attended after this time were with podiatrists, on 29 July 2022, 4 October 2022 and 20 December 2022. She did not fill any prescriptions for any Pharmaceutical Benefits Scheme (**PBS**) subsidised medication in the 12 months prior to her death.

21. Records from TBL's podiatry appointments are limited to issues with her feet and do not capture any other details about her general presentation, weight loss or other issues.

THE CORONIAL INVESTIGATION

22. TBL'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.

23. 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.

24. 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.

25. Victoria Police assigned Detective Senior Constable Jarrad Brookman to be the Coronial Investigator for the investigation of TBL'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.

26. 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.

27. This finding draws on the totality of the coronial investigation into the death of TBL 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

28. On 9 June 2023, TBL, born [redacted], was visually identified by her son, MRD.

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

[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.

Medical cause of death

30. Senior Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine conducted an examination on 15 June 2023 and provided a written report of his findings dated 5 October 2023.

31. The post-mortem external examination revealed findings consistent with the reported history.

32. Review of the post-mortem CT scan showed cerebral atrophy, calcific coronary artery disease, mitral valve annulus calcification, bilateral pleural effusions and patchy bilateral pulmonary consolidation.

33. The deceased's family expressed a strong preference for no internal examination to be performed; hence a full autopsy was not conducted.

34. Toxicological analysis of post-mortem samples identified the presence of ondansetron.[2] There were no suitable ante-mortem samples available for analysis.

35. Dr Lynch provided an opinion that the medical cause of death was 1(a) Multisystem failure in the setting of hyponatraemia secondary to chronic malnutrition in a woman with multiple medical comorbidities. Dr Lynch opined that the death was due to natural causes.

36. I accept Dr Lynch's opinion as to the medical cause of death.

Circumstances in which the death occurred

37. At 8.00am on 1 June 2023, MRD located his mother in bed, unable to move, speak, eat or drink. It is unclear what MRD did from 8.00am when he observed his mother, until 7.24pm, when he called Triple Zero and requested an ambulance.

38. Ambulance Victoria (**AV**) paramedics attended TBL's home, arriving at 7.38pm. MRD guided the paramedics to his mother's room, and noted that his mother had a history of schizophrenia, heart failure and oedema. He explained that TBL had been experiencing a significant functional and cognitive decline over the previous two days and that she was unable to leave her bed, was not speaking or responding as normal. He further noted TBL refused to eat, and that she retched when he tried to get her to drink water.

[2] Ondansetron is indicated for post-operative nausea and vomiting from cancer chemotherapy.

39. MRD further explained to the paramedics that he had been carrying his mother to the bathroom as needed, and that her general health had been deteriorating over a period of several months, during which time she experienced multiple falls. MRD noted that his mother was no longer taking any prescribed medications, however, was unable to say how long this had been occurring. He noted that TBL had not seen a GP in more than 12 months.

40. The paramedics completed an assessment of TBL and noted she was conscious and non-verbal, however appeared to be making eye contact with them and occasionally nodded in response to a question. She did not appear to be in significant distress and was cooperative with paramedics. Her right hand appeared swollen, however MRD stated he was unaware of any injury to that area. When paramedics exposed TBL's lower legs to assess them, they observed extensive bruising to both legs from the ankles to just above the knees.

41. While extracting TBL from her bed and preparing to transport her to hospital, the paramedics asked MRD if his mother had been vaccinated for COVID-19. MRD reportedly told the paramedics that he did not want his mother vaccinated, that she was not permitted to receive any vaccinations and that he did not want her transported to hospital if she was going to be vaccinated there. He reportedly demanded that paramedics and hospital staff not perform any medical treatment without his consent. Paramedics continued with the planned transportation, and she arrived at the Austin Hospital at about 9.15pm.

42. In the emergency department (**ED**), MRD provided collateral information, as TBL was unable to communicate verbally. He explained:

    a) Since 8.00am, TBL was non-verbal, unable to communicate and possibly experienced an episode of aspiration.

    b) TBL was unable to eat or drink due to an inability to swallow.

    c) TBL experienced a significant decline over the preceding one to two days with increasing difficulty speaking and communicating with others.

    d) TBL nevertheless appeared to understand what was happening and was able to obey commands.

    e) TBL experienced a general functional decline over the preceding three months, with increasing falls, averaging about one fall per month. Her falls were not accompanied by head strike.

f) TBL's last fall occurred about one month earlier and involved a fall onto carpet with extensive bruising to lower limbs.

43. ED clinicians documented that TBL appeared comfortable and her eyes opened to voice. She was cachectic (weakness and wasting of the body) and had pitting oedema to her knees. TBL weighed 37.2kg at the time of her admission, representing a loss nearly 20kg over the previous 12 months. Prior to her acute deterioration in the previous day or two, she was on a strict diet consisting solely of steamed vegetables and fruit.

44. Clinicians spoke to MRD, noted TBL's significant deterioration from her baseline and opined that she was approaching the end of her life and may pass within hours or days. clinicians noted that she would not benefit from further fluids (which would cause peripheral/pulmonary oedema) or glucose (which would drop salt levels). Clinicians documented that while MRD appeared to understand their advice, he still "*believe[d] patient will improve, reports patient has appeared worse and improved*". MRD agreed for his mother to receive comfort-based measures only.

45. On 3 June 2023, TBL was reviewed by a speech pathologist, due to her issues with communication and speech. The speech pathologist attempted to complete a swallow assessment, which involves providing food and drinks of various consistencies to the patient and observing for signs of swallowing impairment. However, before they were able to commence this assessment, MRD "*verbally intervened due to the preservatives in the food/fluids [they] planned to provide*". The speech pathologist provided education to MRD about the rationale for the test, and he reluctantly agreed to proceed with limited amounts of food and fluid trials.

46. From the speech pathologist's limited bedside assessment, they determined that TBL was experiencing moderate oropharyngeal dysphagia, characterised by reduced strength in the oral structures required for swallowing. The speech pathologist recommended TBL commence a pureed diet and mildly thickened fluids to minimise the risk of food/fluids entering her airway. They also recommended following safe swallowing strategies, for example, only providing food/fluids via teaspoon while sitting upright/alert with a slow rate and constant supervision.

47. MRD advised that he did not want his mother to receive food or fluids from the hospital due to the preservatives in them and requested to bring food in from home instead. The speech pathologist provided verbal education to MRD and explained how to prepare a pureed diet and mildly thickened fluids for his mother, however noted that they were unaware of how to

thicken fluids without using ingredients with preservatives. The speech pathologist noted that MRD appeared to be engaged and responsive during this education and asked appropriate questions.

48. Additionally on 3 June 2023, TBL was reviewed by a hospital social worker (**SW**) due to her complex social situation and concerns about her presentation. The SW was unable to speak to TBL directly, however gathered collateral information from MRD. MRD reported that prior to this hospital admission, his mother was still able to mobilise short distances inside, prepare her own meals, wash dishes and clean bathrooms daily. MRD reported that he would assist his mother as required, however noted that his mother liked routine and wanted to be independent with her activities of daily living.

49. MRD explained that his mother's last hospital admission was a "*turning point – noting that she had almost died during the admission*" and stated his belief that her health issues were not being effectively managed with her (then) existing medications and lifestyle choices. Consequently, MRD reported he "*took over*" TBL's health and diet, leading to TBL weaning off all medication. MRD reported that his mother's changes to diet and cessation of medication improved her health and ability to function. He denied that his mother was malnourished and stated that she was functioning relatively normally prior to the most recent period of decline. He noted his main concern was his mother's dehydration and low vitamin levels.

50. The SW documented that MRD presented as concerned and worried about his mother and the treating team's assessment that she was critically unwell. MRD expressed concerns that his mother's treating team did not understand him or his concerns, and that he knew "*his Mum best and how she will react to things (i.e., food, medications)*". MRD asked the SW to explain the broader context that he provided to TBL's treating team so that they would better understand his concerns.

51. The SW documented her concerns that TBL had a significantly minimal oral intake and no medications for at least two years, at MRD's direction. She further noted that MRD appeared to have reduced his mother's access to her previous doctors (GP, psychiatrist). The SW did not believe that MRD was intentionally neglecting or abusing his mother as he appeared to firmly believe that his actions and changes had improved her health and life. Nevertheless, the SW documented concerns that MRD was demonstrating elements of coercive control over his mother and was very involved in the treatment she was receiving at hospital. The SW noted

that TBL's untreated medical and metal health conditions were likely impacting her thinking and actions.

52. TBL was also referred to a dietician, for concerns regarding her low weight during her admission. The dietician completed a nutritional assessment and diagnosed TBL with severe malnutrition, based on losing 58% of her bodyweight over the previous four years (89kg in 2019 to 37.2kg in June 2023).

53. On 5 June 2023, the dietician spoke to MRD who reported his mother's diet over the preceding four years was largely fruit and vegetables with some legumes. He reported only selecting organic food that was free from additives, excluded meat (except fish), dairy, many grains and starchy foods (other than occasional potatoes). MRD also reported his mother was experiencing 10 to 12 loose bowel motions per day, and that this had been occurring for many months.

54. The dietician discussed food options MRD could bring from home that would meet the requirements outlined by the speech pathologist (pureed food), in particular, higher protein and energy options. He agreed to trial scrambled eggs, yoghurt and Sustagen energy drinks.

55. On 7 June 2023, the dietician returned to review TBL and the nursing staff caring for her reported that MRD continued to decline hospital meals and refused Sustagen as he believed it caused his mother to have a headache. The dietician noted TBL's oral intake continued to be very poor due to her ongoing drowsiness and low blood glucose levels. She ceased the Sustagen trial and suggested a trial of Resource Ultra, as an alternative high protein nutritional supplement drink, if TBL's alertness improved.

56. Unfortunately, TBL's condition continued to deteriorate over the following hours, and she passed away at 9.00pm on 8 June 2023.

FURTHER INVESTIGATIONS AND CPU REVIEW

57. As TBL's death occurred in circumstances where concerns were raised about the care being provided to her at home, in the lead-up to her passing, this case was referred to the Coroner's Prevention Unit (**CPU**)[3] to be reviewed as part of the Victorian Systemic Review of Family

[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.

Violence Deaths (**VSRFVD**).[4] The Health and Medical Investigations Team (**HMIT**) of the CPU also reviewed the medical treatment TBL received at the Austin Hospital, proximate to her passing.

58. I make observations concerning service engagement with TBL 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 TBL's death.

59. 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 TBL and her family to assist in identifying any areas of practice improvement and to ensure that any future prevention opportunities are appropriately identified and addressed.

60. As noted above, TBL did not consult with her GP or psychiatrist for more than 12 months prior to her passing. She consulted with her podiatrist three times in the 12 months prior to her death, as well as some other support services. These are discussed in more detail below.

Victoria Police investigation

61. Due to the circumstances of TBL's hospital admission and subsequent passing, Victoria Police investigated her death. The Homicide Squad became involved on 4 July 2023 and executed a search warrant at TBL's home on 7 July 2023. Investigators also arrested MRD for manslaughter by criminal negligence and transported him to a nearby Police Station to complete an interview. MRD provided a 'no comment' interview and was released pending further investigation.

62. Police investigated MRD's mobile phone and located a text message conversation with a friend who I will refer to as 'AB'. On 19 May 2023, the following text message exchange occurred:

63. At 8.28am, AB sent to MRD:

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

If she continues to not be herself. Please take her to the doctors. She might have a UTI. Urine infection?

64. At 8.31am, MRD sent to AB:

Thanks [AB]

I will.

She's slot [sic] better and focused this morning.

Headache and dizziness has subsided.

Thanks again.

If you can do it again if you think so.

Thank you.

Much appreciated.

65. At 10.03am, AB sent to MRD:

Have you got any holy water at home?

Give mum to take 3 sips and cross her foreheads [sic] 3 times with αγιασμό [sanctification].

66. On 25 May 2023, at 10.35am, AB sent to MRD:

Please take her blood pressure, oxygen levels and her temperature and let me know.

67. On 27 May 2023, at 10.22am, MRD sent to AB:

PS

She is much better today.

I think – I'm pretty sure its her hydration I need to stay on top of.

Have spent the last 2 days – like clockwork – keeping her hydrated and she's come around.

Anyway I'll let you know what her readings are.

Thanks for everything [AB].

68. On 28 May 2023, at 10.22am, MRD sent to AB:

Morning [AB]

Oxi is 99-98

BP – 100/80

69. On 19 July 2023, police attended TBL's home and spoke to CAQ, in the presence of an interpreter and an independent third person. Police asked CAQ to participate in a video-recorded statement, however he declined.

70. On 26 July 2023, police attended AB's home and enquired about her relationship with MRD. AB refused to provide a formal statement, however informed police that her husband was friends with MRD. She reported that she had never met TBL or her husband, but denied that TBL was neglected, noting that MRD "*committed all these years to his mum*".

71. Ultimately, Victoria Police did not charge MRD with any offences in relation to his mother's death.

CPU review

72. As noted above, the HMIT reviewed TBL's care and treatment at the Austin Hospital. Specifically, they were requested to consider whether the hospital had to be bound by MRD's directions regarding nutrition as MPOA.

73. The HMIT noted that upon admission on 1 June 2023, TBL was considered to be extremely unwell, at high risk of refeeding syndrome and likely to be actively dying. Subsequently, clinicians commenced intravenous glucose and electrolytes, with a focus on attempting to re-establishing oral feeding.

74. By 5 June 2023, it appears TBL was not considered in a terminal phase any longer, as her goals of care were adjusted to 'C', meaning palliative rather than terminal care. While staff considered oral feeding in the notes, to respect MRD's wishes, she was marked nil by mouth. Unfortunately, TBL deteriorated shortly thereafter and passed away on 9 June 2023.

75. HMIT noted that despite the presence of a MPOA, a hospital can apply to the Victorian Civil and Administrative Tribunal (**VCAT**), who *can* override a previously appointed MPOA and appointing another person (or the Office of the Public Advocate (**OPA**)). There are pathways for urgent escalation to the OPA for an urgent hearing and in a hospital setting, this is usually coordinated by the social worker on the advice of the treating medical team. The HMIT explained that this step was not clinically indicated in TBL's case given her very brief admission and her clinical instability. On 7 June 2023, the social worker documented that TBL was likely to pass away in hospital and the role of access to food would not have changed the outcome at that point in time.

Let's Get Care

76. Let's Get Care (**LGC**) is an approved Home Care Package (**HCP**) provider. LGC delivers services through telehealth, self-managed care model, designed to give HCP recipients autonomy and flexibility to manager their in-home care, according to their individual needs, goals and preferences.

77. TBL commenced services with LGC on 26 July 2019. Care plans completed in July 2019, January 2020, July 2021 and October 2022 consistently identified that TBL demonstrated reluctance to engage with formal support services through her HCP. This reluctance was attributed to her diagnosis of schizophrenia.

78. During TBL's engagement with LGC, she was reimbursed for the purchase of continence aids and compression stockings in January 2021. No other services were engaged, and no other requests for reimbursement were submitted. LGC advised the Court that pursuant to her support plan, TBL was assessed as requiring the following supports, however these were not provided by or requested from LGC, as follows:

    a) Personal care – CAQ reported that he provided personal care to his wife.

    b) Home maintenance – MRD provided assistance with gardening and general maintenance around the house.

    c) Medication management – TBL required some assistance with her medication, however CAQ dispensed her medications when required, otherwise she took her medication independently.

d) Allied health – TBL was assessed as needing physiotherapy, podiatry, psychiatry and cardiology services, however no allied health services were accessed through the HCP.

e) Aids and equipment – TBL was assessed as needing mobility aids and equipment, and a referral to an occupational therapist was recommended, however neither were accessed through her HCP.

f) Social support – Due to TBL's medical condition, she had limited social interaction and did not engage in social activities outside the home. TBL read magazines as a coping mechanism.

g) Continence aids – as noted, some reimbursement for continence aids was provided, with MRD responsible for purchasing them.

h) Transport needs – MRD provided transport for his mother.

i) Respite/care support – although carer strain was acknowledged, no formal respite care was accessed via TBL's HCP.

j) Meal preparation – MRD provided informal support for meal preparation, as TBL was able to assist in the kitchen.

Assessments by LGC; contact with TBL

79. LGC advised that they completed the following assessments of TBL during the period she was engaged with their service:

a) 26 July 2019 – client assessment, care plan, emergency plan and internal assessment conducted as part of onboarding a new client.

b) 11 January 2020 – client care plan update.

c) 26 July 2020 – client assessment, care plan, emergency plan and internal assessment as part of the annual review process.

d) 20 July 2021 – client reassessment, care plan and internal assessment as part of the annual review process.

80. LGC noted that they attempted to obtain details of TBL's treating clinicians via MRD to support LGC in obtaining her health summaries, however MRD did not respond to any of the

(four) requests. LGC was consequently unable to obtain additional information from TBL's treating team.

81. LGC noted that they engaged with TBL directly on two occasions:

    a) 21 April 2020 – call to discuss COVID-19 action plan.

    b) 5 November 2020 – call to discuss COVID-19 action plan.

82. All other communication occurred via MRD.

Concerns observed regarding TBL; how concerns are escalated

83. LGC stated that it did not identify or note any concerns for TBL's safety or wellbeing while she was their customer. LGC similarly did not identify or note any concerns for the care provided by MRD.

84. If LGC staff identify an immediate risk of harm, including acute deterioration or elder abuse, they are required to escalate these concerns to their direct manager and emergency services to ensure customer safety.

85. Where elder abuse is suspected, disclosed or witnessed by a carer, LGC advises that staff are instructed to take immediate action to prioritise the client's safety. For clients who retain capacity to make informed decisions about their living arrangements, LGC provides appropriate supports and referrals to the client directly. If LGC suspects an appointed decision maker, representative, or legal guardian is suspected of being abusive, neglectful or failing to act in the client's best interests, and the client does not have the capacity to make decisions independently, LGC staff are instructed to escalate the matter to the Victorian Civil and Administrative Tribunal (or the equivalent interstate tribunal) and relevant authorities.

86. LGC noted that its staff receive various training and education in the following areas:

    a) Assessment and care planning

    b) Recognising changes in client needs

    c) Respectful and dignified accommodation of behaviours – mental health

    d) Communication

    e) Duty of care

f) Culturally inclusive support

g) Dementia and how to respond to dementia behaviours

87. I have not identified any concerns with respect to TBL's engagement with LGC. Sadly, despite being eligible for more support options, TBL and/or MRD either did not want to engage with those support options or did not understand what was available.

Fairfield Podiatry

88. According to the TBL's Medicare records, she attended Fairfield Podiatry three times in 2022 – 29 July, 4 October and 20 December 2022. The records from Fairfield Podiatry are limited and there is no record of the 20 December 2022 visit.

89. On 22 February 2022, the podiatrist documented:

> *Red o/chaux [onychauxis][6] and HK/anhid [hyperkeratosis/anhidrosis][7] skin*
>
> *Enuc HDs B/F [enucleated heloma drum][8]*
>
> *RV [review] 10/52 [in 10 weeks]. Rec RV 6/52 [receive review in 6 weeks].*

90. The record of the 4 October 2022 appointment was almost identical. There were no references to TBL's low weight or presentation.

GP – Dr Anna Arsenakis

91. As part of the investigation, the Court obtained a statement from Dr Arsenakis and a copy of TBL's medical records. Dr Arsenakis provided a detailed statement, outlining her treatment of TBL over several years.

92. Dr Arsenakis noted that while MRD appeared to be relying on non-evidence-based information from the internet in relation to his mother's diet and medication management, he did not intend to harm his mother.

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[6] Onychauxis is a nail disorder that causes the nail to grow unusually thick.
[7] Hyperkeratosis is the thickening of the outer layer of the skin, also known as a callus. Anhidrosis refers to dry feet.
[8] Enucleated heloma durum refers to the removal of the centre of a hard corn.

93. I have not identified any concerns with respect to Dr Arsenakis' treatment of TBL. She appropriately communicated with TBL in her native language and obtained collateral information from MRD where appropriate.

Psychiatrist – Dr Arthur Kokkinias

94. As part of the investigation, the Court obtained a statement from Dr Kokkinias and a copy of TBL's medical records.

95. Dr Kokkinias similarly engaged with TBL in her native language, as she was not fluent in English. He also obtained collateral information from MRD as required.

96. I have not identified any concerns with respect to Dr Kokkinias' treatment of TBL.

Systemic issues

97. From a review of the limited services involved with TBL, it appears that she was largely reticent to engage with support services. Prior to MRD's appointment as MPOA, this reticence appeared to be driven by TBL's mental health conditions. From mid-2019 until the time of her death, this reticence appeared to be driven by MRD, and his desire to wean his mother off all medication and commence a strict diet.

98. If any of the services involved with TBL became concerned about MRD's care of her, there are currently only limited options for escalation.

Adult safeguarding explanation

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

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

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

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

[11] In the UK these needs may relate to a physical or mental impairment or illness, including conditions such as physical, mental, sensory, learning or cognitive disabilities or illnesses, and brain injuries. This list is not exhaustive, and the criteria for accessing a safeguarding response is broader than that for accessing publicly funded care and support

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

c) are unable to protect themselves from the abuse or neglect because of their care and support needs.[12]

100. Adult safeguarding is important because people with a disability are more likely to experience violence, abuse, and neglect than people without a disability,[13] often from people on whom they depend for care and support.[14] Further, the 2021 *National Elder Abuse Prevalence Study* found that older people living in community dwellings in Australia experience abuse at a rate of 14.8%,[15] with those experiencing poor physical or psychological health and higher levels of social isolation more likely to experience abuse.[16]

101. People with needs for care and support face added barriers to accessing and engaging with support when they are experiencing abuse and neglect. These include inability to independently seek out support services, and challenges associated with reporting and addressing abuse perpetrated by people they are dependent on for care and support.[17] A specialised response to reports of abuse and neglect of at-risk adults is therefore required.

102. 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

services - UK Department of Health, *Care and support statutory guidance*, (5 October 2023) s 6.104 and s 14.5 < Care and support statutory guidance - GOV.UK (www.gov.uk)>.

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

[13] Australian Government, *Australia's Disability Strategy 2021-2031* (Strategy, December 2021) 14; Centre of Research Excellence in Disability and Health, *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability Research Report: Nature and Extent of Violence, Abuse, Neglect and Exploitation Against People with Disability in Australia* (Report, March 2021) 9; *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* (Final Report, September 2023) vol 11, 171.

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

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

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

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

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

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[18].

Victoria's adult safeguarding provisions

103. 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'.[19]

104. 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.[20] Despite this, there are circumstances in which at-risk adults who are experiencing or at risk of experiencing abuse, neglect or exploitation are likely to fall through the cracks of Victoria's safeguarding system.[21]

105. The fragmented Victorian safeguarding system imposes a significant barrier to at-risk adults 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,

[18] 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.
[19] OPA, *Line of Sight: Refocussing Victoria's Adult Safeguarding Laws and Practices* (Review, 18 August 2022) 13.
[20] Ibid 47.
[21] Ibid 48

to deliver services and supports effectively.'[22] 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.[23]

106. Since 2017 the Australian Law Reform Commission (**ALRC**), the OPA and the Disability Royal Commission (**DRC**) have recommended the introduction of Victorian adult safeguarding legislation to establish adult safeguarding functions including assessment, investigation, and co-ordination of responses to allegations of abuse of at-risk adults.[24]

Adult safeguarding in relation to TBL and MRD

107. TBL may have met the criteria for an adult safeguarding response, given that she had complex needs for care and support relating to her mental health, and she was highly reliant upon her son for transportation, access to healthcare and to purchase food and supplies. These complex care and support needs may have prevented her from accessing the support she required to address this risk.

108. While TBL's home was clean and tidy, police noted concerns about the strict diet that MRD was encouraging his mother to adhere to, as well as his desire to wean her off all medication. MRD reported that she experienced regular falls at home, however it does not appear that he sought medical attention for her.

109. Safeguarding responses can be initiated when there are concerns for neglect or self-neglect. The available evidence suggests that TBL relied heavily on her son for several years prior to her passing, however he does not appear to have been able to meet these needs.

110. If an adult safeguarding agency/mechanism were available, any of TBL's medical practitioners and/or LGC could have made a report about her. An adult safeguarding mechanism may have been able to investigate TBL's complex needs for support and risk of neglect and could coordinate with services to assess risk and implement multi-disciplinary risk management strategies.

[22] Australian Government, *Safety Targeted Action Plan* (Plan, December 2021) 2.
[23] *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* (Final Report, September 2023) Executive Summary and Recommendations, 171.
[24] ALRC, Elder Abuse – A National Legal Response (Final Report, May 2017), 377; OPA, Line of Sight: Refocussing Victoria's Adult Safeguarding Laws and Practices (Review, 18 August 2022) 15; Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (Final Report, September 2023) vol 11, 11, 47.

111. Once she was admitted to hospital, clinicians could have also drawn on a safeguarding mechanism to raise concerns for the in-home care TBL was receiving. Such a mechanism could have assisted clinicians in determining the applicability of MRD's MPOA, given TBL's circumstances and significant malnutrition.

Previous adult safeguarding cases and discussion

112. TBL'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[25], William Heddergott[26], MHT[27], YTR[28], and DRF[29].

113. 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.*
> 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.*

[25] Finding into death without inquest – CFT (COR 2020 4205).
[26] Finding into death without inquest – William Heddergott (COR 2020 6253).
[27] Finding into death without inquest – MHT (COR 2022 4511).
[28] Finding into death without inquest – YTR (COR 2020 6157).
[29] Finding into death without inquest – DRF (COR 2022 0022).

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.[30]

114. 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, which also recommended the introduction of adult safeguarding legislation.

115. 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.

116. 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 only covers state-funded disability services. In the present case, TBL was not receiving any state-funded disability services, so the Social Services Regulator is unlikely to have made any difference in her case.

117. I remain concerned that that without a comprehensive adult safeguarding framework in Victoria, vulnerable adults such as TBL (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.[31]

118. The Department of Justice and Community Safety (**DJCS**) responded to the recommendations in JZA. DJCS advised that it supported the work of the OPA, in particular, that it supported the Victorian Auditor-General's Office (**VAGO**) report, *Guardianship and Decision-Making for Vulnerable Adults*, which was tabled in May 2024. The VAGO report made 10 recommendations to the OPA and three recommendations to the OPA and DJCS jointly. The recommendations included improving the OPA's documentation, how it engages with clients, its training and guidance for staff, how it collects and uses data, and its planning and oversight.

[30] Finding into death without inquest – CFT (COR 2020 4205), 20-21.
[31] Finding into death without inquest – JZA, 17-18.

These recommendations have been accepted or accepted in principle, and implementation is underway.

119. DJCS advised that it supports the work of the OPA through its funding of OPA's guardianship, investigation and Independent Third Person programs. It also advised that implementation of some of the recommendations from the VAGO report directed at the OPA were over and above the existing levels of funding, support for my recommendation in JZA would be subject to further funding considerations by government during future budget processes.

120. I accept and acknowledge that DJCS supports the work of the OPA, in particular, to implement the recommendations of the VAGO report. However, the VAGO report did *not* include a recommendation to introduce adult safeguarding legislation and functions. In JZA, I recommended the introduction of adult safeguarding legislation and associated functions, reiterating the recommendations made by former State Coroner, Judge Cain. Other than to advise that my recommendations in JZA would require funding via future budget processes, DJCS did not specifically address the recommendations in JZA (and the findings that came before it).

121. DFFH also responded to my recommendations in JZA by reiterating the response[32] 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.

122. 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, such as TBL. The purpose of the safeguarding mechanism is to ensure that *all* vulnerable adults, regardless of which disability services they engage with (if any) are protected from harm and exploitation.

[32] 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.

123. In my recent finding into the death of Mr JNY,[33] I reiterated my recommendations in JZA, which reiterated his Honour's recommendations in CFT. As a response has not been received to my recommendations in Mr JNY, I will direct a copy of this finding be provided to DJCS, DFFH, the Minister for Disability and the Victorian Government, for consideration.

Procedural fairness response

124. As a matter of procedural fairness, the Court wrote to MRD, to provide him with an opportunity to respond to the concerns raised about the care of his mother. Through his solicitor, MRD indicated that he did not wish to file a response.

FINDINGS AND CONCLUSION

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

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

b) the death occurred on 8 June 2023 at Austin Hospital 145 Studley Road Heidelberg Victoria 3084, from multisystem failure in the setting of hyponatraemia secondary to chronic malnutrition in a woman with multiple medical comorbidities; and

c) the death occurred in the circumstances described above.

I convey my sincere condolences to TBL'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:

CAQ, Senior Next of Kin

Austin Health

Australian Unity

Department of Families, Fairness and Housing

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

Department of Justice and Community Safety

Department of Premier and Cabinet

The Hon. Lizzie Blandthorn, Minister for Disability

Detective Senior Constable Jarrad Brookman, Coronial Investigator

Signature:

Judge Liberty Sanger, State Coroner

Date: 01 May 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.