



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 008520
COR 2025 008521

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: **Despina Ganakas**

Date of birth: 10 December 1942

Date of death: Between 15 November and 9 December 2025

Cause of death: 1(a) Unascertained

Place of death: 32 Haughton Parade
Rosanna Victoria 3084

Deceased: **Ann-Marie Ganakas**

Date of birth: 29 December 1963

Date of death: On or before 9 December 2025

Cause of death: 1(a) Unascertained (natural causes)

Place of death:

32 Haughton Parade
Rosanna Victoria 3084

Keywords:

Adult safeguarding; care and support needs;
unascertained cause of death

INTRODUCTION

1. On 9 December 2025, Despina Ganakas and her daughter, Ann-Marie Ganakas, were found deceased at their home in Rosanna, Victoria. Despina and Ann-Marie were aged 82 years old and 61 years old, respectively, when they died.

BACKGROUND

2. Despina was born in Karya, a village on Mount Olympus, Greece. She migrated to Australia with her parents and siblings, Helen and Sotiris ‘Sam’, at a young age. Despina met her future husband in 1960 or 1961 and they married in 1962.
3. Despina and her husband welcomed two children: Ann-Marie and George Ganakas. Despina was described as a dedicated mother who “*made it her life’s mission to look after and care for [her children]*”. She previously worked as a hairdresser, however stopped working to care for her family.
4. Ann-Marie was described as a happy and outgoing person who was dedicated to caring for her parents as they grew older. She studied at university and obtained several degrees relating to chemistry and pharmacy. She worked at the university and as a pharmacist for some time.
5. Despina and Ann-Marie did not regularly attend a doctor and reportedly did not believe in medical intervention. According to Helen, Ann-Marie reportedly suffered mental health issues including depression throughout her life. Ann-Marie reportedly threatened to take her own life if anything happened to Despina. Ann-Marie told her family that if they attempted to intervene or obtain medical intervention for Despina that she would no longer care for Despina.
6. In about mid-2025, Despina fell on a concrete path or driveway. She was unable to walk properly after the fall but refused to attend a doctor or hospital. Her family feared that she fractured her hip in the fall. Despina was afraid of having to move into a residential aged care facility if she sought medical attention.
7. In the 10 years prior to their deaths, Ann-Marie did not make any Medicare or Pharmaceutical Benefits Scheme (PBS) claims. Despina last consulted with a doctor in 2016. Despina’s medical records from 2016 indicate that she may have been experiencing paranoia and/or mental ill-health. During an appointment for a sore ear and lower lip ulcer, Despina stated her belief that her neighbours were trying to poison her and spy on her. She stated that the “*whole*

street [was] in a conspiracy” and she was unable to approach the police. On another occasion when Despina attended for an earache, she noted that her neighbour was “*throwing chemicals around her home*” and that she had “*people to follow her all over Melbourne*”. The doctor documented Despina’s behaviour was unusual and queried her “*paranoid delusions*”.

THE CORONIAL INVESTIGATION

8. The deaths of Despina and Ann-Marie Ganakas were reported to the coroner as they fell within the definition of a reportable death in the *Coroners Act 2008 (the Act)*. Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.
9. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.
10. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.
11. Victoria Police assigned Senior Constable Jaclyn Smith to be the Coronal Investigator for the investigation of Despina and Ann-Marie’s deaths. The Coronal 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.
12. This finding draws on the totality of the coronial investigation into the deaths of Despina and Ann-Marie Ganakas 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

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.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the deceased (Despina)

13. On 16 December 2025, Coroner Therese McCarthy made a formal determination identifying the deceased as Despina Ganakas, born 10 December 1942 based on the Victorian Institute of Forensic Medicine (VIFM) identification report.
14. Identity is not in dispute and requires no further investigation.

Identity of the deceased (Ann-Marie)

15. On 17 December 2025, I made a formal determination identifying the deceased as Ann-Marie Ganakas, born 29 December 1963 based on the VIFM identification report.
16. Identity is not in dispute and requires no further investigation.

Medical cause of death (Despina)

17. Forensic Pathologist Dr Victoria Francis from the VIFM conducted an autopsy on 10 December 2025 and provided a written report of her findings dated 16 February 2026.
18. The post-mortem examination revealed advanced decomposition changes. There was an old/chronic fractured left neck of femur. There was no evidence of significant acute injury.
19. Toxicological analysis of post-mortem hair samples did not identify the presence of any common drugs or poisons.
20. Dr Francis provided an opinion that the medical cause of death was *1(a) Unascertained*.
21. I accept Dr Francis' opinion as to the medical cause of death.

Medical cause of death (Ann-Marie)

22. Forensic Pathologist Associate Professor Joanna Glengarry (**A/Prof Glengarry**) from the VIFM conducted an external examination on 12 December 2025 and provided a written report of her findings dated 5 January 2026.
23. The post-mortem examination revealed the remains were moderately decomposed. There was no natural disease identified during the post-mortem examination.

24. A/Prof Glengarry noted that there are certain processes such as metabolic or biochemical changes that cannot be detected at autopsy. The ability to detect these changes is further hampered when there is decomposition.
25. Toxicological analysis of post-mortem samples identified the presence of ethanol (alcohol) at 0.04 g/100mL. A/Prof Glengarry explained that this may have arisen due to post-mortem artefact, and that it did not necessarily imply ante-mortem alcohol ingestion.
26. A/Prof Glengarry provided an opinion that the medical cause of death was *1(a) Unascertained (natural causes)*.
27. I accept A/Prof Glengarry's opinion as to the medical cause of death.

Circumstances in which the death occurred

28. On 9 December 2025, Despina and Ann-Marie's neighbour called police to request a welfare check at their home. The neighbour reported a strong smell emanating from Despina and Ann-Marie's home for the previous three to four weeks. The neighbour noted that they had not seen either woman for an extended period of time, however explained that Despina was a "*recluse*" and therefore this was not unusual.
29. Police attended Despina and Ann-Marie's home and observed numerous flies in the front window next to the front door. They also observed a strong smell from the property. The front door was locked, so police attempted to gain entry via the rear of the property. Police found all doors and windows locked, so they contacted Fire Rescue Victoria (**FRV**) for assistance.
30. While waiting for FRV to arrive, police observed the letterbox was overflowing with mail. Police opined that the unopened mail had been abandoned for a significant period of time.
31. FRV arrived and promptly gained access to the property. Inside the house, police located Despina's remains in the front lounge room in front of a small heater. Police opined that she had been lying on the floor for some time before her death and may have been unable to stand up or care for herself. Surrounding her body, police observed bags of tissues, toilet paper and sanitary items. Police also observed food scraps near Despina's remains.
32. Subsequently, police located Ann-Marie's remains in one of the bedrooms. It appears she had fallen or rolled out of the bed into a gap between the bed and the bedside table. Her head was facing down towards the floor, with her right arm on the bedside table.

33. In the kitchen, police observed minimal food supplies in the house. There was a bottle of milk in the fridge with an expiry of 29 October 2025. The rear yard appeared unkempt. The backdoor was locked and may not have been opened for some time as there was a build-up of cobwebs in the doorframe.
34. Police spoke to some neighbours who reported that Despina and Ann-Marie were reclusive and were not seen often. They also spoke to Despina's sister, Helen, who noted that she had been trying to contact Despina and Ann-Marie for several months without success. Police also found out that Sotiris requested a welfare check on his sister and niece in November 2025. This is discussed in further detail below.
35. Police did not identify any suspicious circumstances or evidence of third-party intervention in connection with Despina and Ann-Marie's deaths.

FURTHER INVESTIGATIONS

Police welfare check on 15 November 2025

36. As noted above, Sotiris requested a welfare check on Despina and Ann-Marie on 15 November 2025. An Acting Sergeant (**A/Sgt**) and a Senior Constable (**SC**) were tasked with attending the welfare check that day.
37. When the A/Sgt and SC arrived at Despina and Ann-Marie's house, they knocked on the front door. The A/Sgt noted that the front door and windows were all locked. The A/Sgt stated he could hear Despina inside the house, although upon a review of the member's Body Worn Camera (**BWC**) footage, her voice could not be heard. Police attempted to call Ann-Marie's mobile phone; however, it was switched off,
38. The A/Sgt contacted Sotiris via phone to obtain more information. Sotiris explained that Despina was bedridden and would be unable to move or open the door. The A/Sgt informed Sotiris that there was a vehicle (a silver Renault) in the driveway and asked Sotiris if he wanted police to force entry to the property. Sotiris initially agreed to force entry to the property.
39. The A/Sgt also asked Sotiris if there was anyone else who had keys to the property or any other family members' contact details. The A/Sgt noted that if he were to force entry to the property and break a door that Sotiris (or someone other than police) would have to pay for it. The A/Sgt and Sotiris spoke at length about payment for a broken front door. Eventually, the A/Sgt asked, "*so you don't want me to force entry*".

40. The A/Sgt spoke to Despina again through the front window and asked her where her daughter was. It does not appear that the A/Sgt could understand the response. The A/Sgt asked Despina if she was okay and it appears that she said “yes”.
41. The A/Sgt contacted Sotiris again via phone and advised that he believed Despina was okay, however they were unable to reach Ann-Marie. Sotiris told police that he believed Ann-Marie was inside the house. The A/Sgt advised Sotiris to continue making enquiries with Ann-Marie and other family members and arrange family members to attend the property with spare keys.
42. Police also spoke to neighbours who noted that Despina and Ann-Marie were reclusive and “*never come outside*”.
43. In the relevant Computer-Aided Dispatch (CAD) Event Report, the A/Sgt documented “[n]o powers to force entry on this occasion. Nil reports of mental health or self-harm.” Police left the property without sighting Despina or Ann-Marie, and without speaking to Ann-Marie.

Analysis of police welfare check on 15 November 2025

44. While Victoria Police have a range of policies and procedures that govern most of their work, they do not have a specific guideline or manual that covers welfare checks. I note in other cases² Victoria Police advised the Court that “*police members are expected to draw upon their training and experience*”. Ultimately, the “*police response should be appropriate to the circumstances and demonstrate sound judgment and reflect contemporary organisational and community expectations*”.³ I accept that welfare checks are complex and there may not be one ‘universal’ approach that covers all scenarios. However, I am concerned about the decision-making process when deciding whether to force entry to the property in this case.
45. In relation to forcing entry to the house, the *Victoria Police Manual (VPM) – Searches of Property* contains a specific section for suspected injured, ill or deceased persons:

Police have a common law power to enter any premises to search for suspected ill, injured or deceased persons when they believe on reasonable grounds that entry is necessary to provide assistance.

² See, for example, [Finding into death without inquest – Mrs R.](#)

³ Ibid, 8.

Unless urgent entry is required, members should undertake the following actions before gaining entry:

- *Verify the complaint*
- *Speak to neighbours*
- *Ascertain if keys are available*
- *Obtain authority from a sergeant or above.*

46. When Sotiris requested the welfare check, he noted the following about Despina:
- a) Despina had health concerns. He suspected she suffered a broken hip bone or fractured hip bone about five months earlier which had not been attended to.
 - b) Despina was known to be bedridden.
 - c) Despina was last spoken to about three weeks' earlier.
47. Police followed the relevant VPM in attempting to verify the complaint, speaking to neighbours and attempting to ascertain if keys were available. It is unclear if the A/Sgt attempted to speak with a supervisor, prior to making the decision to leave without sighting either woman. Given that he was an acting sergeant, he may have satisfied this criterion by virtue of his position.
48. From the available BWC footage, it appears that Sotiris initially provided approval for police to force entry to the property, however this approval was revoked after their discussion about the costs associated with repairing any damage. While the cost may have been a relevant consideration for Sotiris, it is not a relevant factor for police to consider when determining whether to force entry to a property according to the VPM.
49. I also note that this VPM also has a special provision for payment where property damage occurs. An officer or divisional patrol supervisor is required to attend the property to inspect the damage, submit a report of the circumstances to the relevant local area commander and can process claims of restitution in accordance with the relevant Victoria Police financial policy.
50. I am concerned that the potential cost of repairing the door became the overriding factor when deciding whether to force entry to Despina and Ann-Marie's home. Given the known information about Despina, only speaking briefly to her via a window was, in my view, insufficient to satisfy her welfare. She was known to be bedridden and reliant on her daughter;

however, police did not speak to Ann-Marie. Her family were also unable to reach Ann-Marie. In those circumstances, police could not be fully satisfied of Despina's safety and wellbeing. In my view, it would have been preferable to visually sight Despina to confirm her safety, which may have necessitated forcing entry to the property.

51. I cannot determine with precision what might have happened if police *did* force entry to Despina and Ann-Marie's home. The Coronial Investigator opined that Ann-Marie was likely deceased when police attended on 15 November 2025. The milk in the fridge with an expiry of 29 October 2025 may suggest that Ann-Marie was deceased at that time, as she was unable to purchase new milk for the house. At a minimum, police may have been able to see the conditions Despina was living in, namely, living on the floor of the lounge room with no ability to access food, water or a bathroom.

Procedural fairness response

52. As a matter of procedural fairness, the Court wrote to Victoria Police with an extract of my draft proposed findings and provided an opportunity to respond. Victoria Police thanked the Court for the opportunity to respond but did not wish to file a formal response.

SYSTEMIC ISSUES – ADULT SAFEGUARDING

53. This case sadly involves the death of a vulnerable adult who had complex needs for care and support. Despina's needs for care and support may have prevented her from independently accessing the support she required. The most substantive issue in this case appears to relate to Victoria's lack of a comprehensive framework for safeguarding at-risk adults from abuse, neglect and exploitation.⁴ This gap in the Victorian service sector meant that when concerns arose about Despina's need for medical attention, her family were left without a clear referral pathway to address these concerns. Below is an explanation of adult safeguarding, and its relevance to the circumstances surrounding Despina's death.

Definition

54. Broadly, adult safeguarding means protecting the rights of adults to live in safety, free from abuse and neglect.⁵ In the United Kingdom (UK), adult safeguarding involves the

⁴ OPA, *Line of Sight: Refocussing Victoria's Adult Safeguarding Laws and Practices* (Review, 18 August 2022) 13 < [Line of Sight \(11\).pdf](#)>.

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

investigation of, and co-ordination of responses to, suspected abuse and neglect of ‘at-risk’ adults.⁶ At-risk adults are defined as people aged 18-years-old and over, who:

- a) have care and support needs;⁷ 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.⁸

55. Adult safeguarding is important because people with a disability are more likely to experience violence, abuse, and neglect than people without a disability,⁹ often from people on whom they depend for care and support.¹⁰ 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%,¹¹ with those experiencing poor physical or psychological health and higher levels of social isolation more likely to experience abuse.¹²
56. 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.¹³ A specialised response to reports of abuse and neglect of at-risk adults is therefore required.
57. Adult safeguarding can include actions such as:

⁶ 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 \(alrc.gov.au\)](#)>.

⁷ In the UK these needs may relate to a physical or mental impairment or illness, including conditions such as physical, mental, sensory, learning or cognitive disabilities or illnesses, and brain injuries. This list is not exhaustive, and the criteria for accessing a safeguarding response is broader than that for accessing publicly funded care and support services - UK Department of Health, *Care and support statutory guidance*, (5 October 2023) s 6.104 and s 14.5 <[Care and support statutory guidance - GOV.UK \(www.gov.uk\)](#)>.

⁸ 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).

⁹ 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.

¹⁰ *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* (Final Report, September 2023) vol 11, 25.

¹¹ Australian Institute of Family Studies, *National Elder Abuse Prevalence Study: Final Report* (July 2021), 53 <[National Elder Abuse Prevalence Study: Final Report \(aifs.gov.au\)](#)>.

¹² Australian Institute of Family Studies, *National Elder Abuse Prevalence Study: Final Report* (July 2021), 68.

¹³ ALRC, *Elder Abuse – A National Legal Response* (Final Report, May 2017), 379; DRC vol 11, 25.

- a) taking reports from professionals and community members, and raising own-motion reports about alleged abuse and neglect of at-risk adults
- b) proactively making enquiries to establish whether any action needs to be taken to prevent abuse or neglect, and if so, by whom
- c) considering the mental capacity of the at-risk adult to engage in the adult safeguarding process and to make decisions related to it, including in relation to safety planning
- d) facilitating decision-making support for at-risk adults
- 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.¹⁴

How adult safeguarding could have assisted Despina

58. Despina would have likely met the criteria for an adult safeguarding response given:

- a) She had needs for care and support related to her physical and (potentially) her mental health.
- b) She was at risk of neglect.
- c) Her needs for care and support may have prevented her from accessing the support required to address this risk.

59. If an adult safeguarding mechanism existed at the time of Despina's fall in mid-2025, her concerned family may have had a service to refer or escalate their concerns. Similarly, the police who attended on 15 November 2025 could have also made a referral to this service. An adult safeguarding mechanism could have assisted Despina, Ann-Marie and their family with:

- a) Provision of an accessible service.
- b) Thorough investigation of Despina's physical and mental health, and whether she had experienced, or was at risk of, neglect.

¹⁴ 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.

- c) Facilitating an assessment of Despina’s capacity to make decisions about her care and the need for guardianship.

Previous adult safeguarding cases and discussion

60. Despina’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 CFT¹⁵, William Heddergott¹⁶, MHT¹⁷, YTR¹⁸, and DRF¹⁹.
61. 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.*

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 \(COR 2022 0022\).](#)

*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

62. In response to his Honour's recommendations in CFT, the Department of Families, Fairness and Housing (**DFFH**) advised that it had taken all the recommendations into consideration. It further noted that the Victorian Government is working with the Disability Reform Ministerial Council to consider reform options in response to the Disability Royal Commission (**DRC**), which also recommended the introduction of adult safeguarding legislation.
63. 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 Australian Law Reform Commission (**ALRC**), the Office of the Public Advocate (**OPA**) and the DRC over the course of several years. His Honour noted that at-risk adults who live in their own homes continue to experience abuse and neglect at the hands of people known to them, and the service sector is not equipped to respond to this risk.
64. Finally, DFFH referenced the new Social Services Regulator as an initiative to reduce the risk to vulnerable adults with care and support needs. However, this body does not have a role in assisting vulnerable adults who are not currently accessing any state-funded disability services. This body also does not have any role in investigating concerns of neglect caused by family members who are informally caring for vulnerable adults. As Despina did not receive any in-home services, the Social Services Regulator is therefore unlikely to have made any difference in her case.
65. I remain concerned that that without a comprehensive adult safeguarding framework in Victoria, vulnerable adults such as Despina (and their carers/families/professionals) have no centralised avenue to seek advice or raise concerns. In my 2025 finding into the death of JZA, I reiterated Judge Cain's recommendations 4 to 10.²¹
66. The Department of Justice and Community Safety (**DJCS**) responded to the recommendations in JZA. Other than to advise that my adult safeguarding recommendations in JZA would

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

²¹ [Finding into death without inquest – JZA](#), 17-18.

require funding via future budget processes, DJCS did not further address the recommendations (nor the preceding findings).

67. DFFH also responded to my recommendations in JZA by reiterating the response²² 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.
68. I acknowledge these changes appear to be promising and positive, however as noted above, they do not address concerns for vulnerable adults who use federally funded disability services (i.e., the NDIS) or those who do not receive any state-funded disability services. The purpose of the safeguarding mechanism is to ensure that *all* vulnerable adults, regardless of which services they engage with (if any) are protected from harm and exploitation. Of note, the recently published Victorian Government response to the DRC recommendation that states and territories should introduce legislation to establish nationally consistent adult safeguarding functions, expresses similar sentiments, noting that the Social Services Regulator does not consist of the same functions as an adult safeguarding service of the kind recommended by the ALRC, OPA, DRC. The Victorian Government response states that this DRC recommendation is ‘subject to further consideration’²³.
69. Since my finding into the death of JZA was published, the Commonwealth Government published the National Plan to End the Abuse and Mistreatment of Older People 2026-2036 (**‘the National Plan’**). One focus of the National Plan is to “*clarify the avenues for reporting abuse and mistreatment within each jurisdiction*’, *given the importance of clear avenues for reporting concerns about abuse and mistreatment of older people*”.²⁴ I note that the OPA undertook a review of the current safeguarding supports available in Victoria, including

²² 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%20DFFH_CFT.pdf.

²³ Victorian Government, Response to DRC, 243.

²⁴ Australian Government, [National Plan to End the Abuse and Mistreatment of Older People 2026-2036](#) (16 March 2026) 67.

avenues for reporting abuse, before recommending the introduction of Victorian adult safeguarding legislation in 2022.²⁵

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

2.4 Adopt recommendations of the Disability Royal Commission relevant to ending the abuse and mistreatment of older people, in accordance with Government responses in each jurisdiction

2.5 Strengthen safeguarding frameworks and clarify pathways for abuse and mistreatment to be reported and addressed. This includes further education and training on reporting obligations for relevant sectors²⁶

71. The Victorian Government also published its response to the recommendations of the DRC. Recommendation 11.1 of the DRC recommended that states and territories should each introduce legislation to establish nationally consistent adult safeguarding functions. The Victorian Government advised that this recommendation is 'subject to further consideration'.²⁷
72. The Victorian Government's response to the DRC's recommendations also echoed sentiments that I have previously expressed in findings. This is notable, given that DFFH previously referenced the Social Services Regulator as a solution, when responding to coroners' recommendations about the need for an adult safeguarding mechanism.
73. More recently, I reiterated my recommendations in JZA in my finding into the death of JNY²⁸, which reiterated his Honour's recommendations in CFT. In response, the Honourable Lizzie Blandthorn, Minister for Disability, noted my recommendations required further consideration as they raised significant and complex policy issues that would require legislative change and significant investment to implement. Ms Blandthorn explained that my recommendations therefore needed to be progressed and considered by government through established decision-making processes, including the annual budget process.

²⁵ OPA, *Line of Sight: Refocussing Victoria's Adult Safeguarding Laws and Practices* (Review, 18 August 2022) 15.

²⁶ Australian Government, [National Plan to End the Abuse and Mistreatment of Older People 2026-2036](#) (16 March 2026) 71.

²⁷ Victorian Government, Response to DRC, 243.

²⁸ [Finding into death without inquest – JNY \(COR 2023 3518\)](#).

74. Ms Blandthorn confirmed that the Victorian Government is committed to protecting service users from harm and neglect, and to improve the safeguarding framework so that all Victorians with vulnerabilities can live in safety and with dignity. Ms Blandthorn noted the Victorian Government has several initiatives in place to prevent and respond to elder abuse, increase awareness of the issue and encourage connectedness within communities. This includes the recent launch of the *Respecting and Valuing Older People: Victoria's Primary Prevention of Elder Abuse Framework Handbook*. Ms Blandthorn noted the Victorian Government's current funding available for support services, and the new Social Services Regulator (as discussed above).
75. DJCS also responded to the recommendations in *JNY*. DJCS noted that DJCS and the OPA support the 10 recommendations made in the report by the Victorian Auditor-General's Office (VAGO) entitled *Guardianship and Decision-Making for Vulnerable Adults*. All 10 recommendations were either accepted in full or accepted in principle and noted that implementation is underway. DJCS otherwise noted that DFFH would provide a separate response to my recommendations in *JNY*. At the time of writing, DFFH have not yet provided their response. As such, I intend to provide a copy of these findings to DFFH, DJCS and Ms Blandthorn for their consideration.

FINDINGS AND CONCLUSION

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

Despina Ganakas

- a) the identity of the deceased was Despina Ganakas, born 10 December 1942;
- b) the death occurred between 15 November and 9 December 2025 at 32 Haughton Parade Rosanna Victoria 3084, from unascertained; and
- c) the death occurred in the circumstances described above.

Ann-Marie Ganakas

- a) the identity of the deceased was Ann-Marie Ganakas, born 29 December 1963;
- b) the death occurred on or before 9 December 2025 at 32 Haughton Parade Rosanna Victoria 3084, from unascertained (natural causes); and

c) the death occurred in the circumstances described above.

I convey my sincere condolences to the family of Despina and Ann-Marie 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:

George Ganakas, Senior Next of Kin

Department of Families, Fairness and Housing

Department of Justice and Community Safety

Department of Premier and Cabinet

The Hon. Lizzie Blandthorn, Minister for Disability

Victoria Police

Senior Constable Jaclyn Smith, Coronial Investigator

Signature:



Judge Liberty Sanger, State Coroner

Date: 07 October 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.
