IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 004205

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge John Cain, State Coroner
Deceased:	CFT
Date of birth:	[redacted]
Date of death:	4 August 2020
Cause of death:	1(a) Bronchopneumonia Contributing factor(s) 2 Coronary artery atherosclerosis, hypothermia
Place of death:	Monash Health, Monash Medical Centre, 246 Clayton Road, Clayton, Victoria, 3168
Keywords:	Adult safeguarding; vulnerable adults; adults with disability; at-risk adults; guardian advocate

INTRODUCTION

1. On 4 August 2020, CFT was 78 years old when she passed away at the Monash Medical Centre (**MMC**), Clayton. At the time of her death, CFT lived in [redacted] with her nephew, RDS and his father, JNB and her late husband moved in with RDS and JNB in about 2007, and RDS reported he was the couple's carer from that time. RDS received a carer's payment from about 2009 to assist with the couple's care.

2. CFT moved to Australia between 1962 and 1964. Some records document her place of birth as India, whilst others document her place of birth as Burma. Her husband was her carer for some time, however due to his own care needs, was unable to care for her prior to his own passing in 2017.

3. CFT's medical records indicate a medical history of chronic schizophrenia, intellectual disability, dementia, lung lobectomy secondary to cancer, type 2 diabetes and oesophagitis. She was medicated for schizophrenia and dementia, however her compliance with these medications is unclear.

THE CORONIAL INVESTIGATION

4. CFT'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.

5. 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.

6. 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.

7. This finding draws on the totality of the coronial investigation into the death of CFT. 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

8. On 4 August 2020, CFT, born [redacted], was visually identified by her nephew, RDS.

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

Medical cause of death

10. Forensic Pathologist Dr Yeliena Baber, from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 11 August 2020 and provided a written report of her findings dated 2 March 2021.

11. Dr Baber provided an opinion that the medical cause of death was due to bronchopneumonia. She explained that while the inflammatory response plays important roles in protecting the host and repairing tissues, it can also damage normal tissues. Molecules generated to kill pathogens, such as reactive oxygen species and proteases, leak from live and dying white blood cells and kill normal cells. These and other mediators that are generated may also cause significant pain and disability. In addition, severe bronchopneumonia effectively decreases the amount of lung available for normal gaseous exchange, thus decreasing the amount of oxygen available in arterial blood.

12. The post-mortem examination revealed the presence of Wishnevsky spots, which indicate that there had been a state of hypothermia prior to death. Attending paramedics stated that there had been a state of hypothermia prior to death with a body temperature of 27 degrees when they attended the scene. Although no cellular injury occurs as a result of hypothermia (unless frostbite occurs), severe hypothermia often results in death due to cardiac dysrhythmia, usually ventricular fibrillation.

13. Histology confirmed the macroscopic findings, including severe pneumonia of the right lung. Patchy pneumonia of the let lower lobe was also identified.

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[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

14. Toxicology was non-contributory. Vitreous electrolytes were acceptable for a postmortem sample.

15. C-reactive protein (a marker of infection or inflammation) was raised in keeping with acute bronchopneumonia in both the antemortem and postmortem specimens.

16. Tissue samples and swabs taken from the lungs grew *Staphylococcus aureus* but no evidence of nucleic acid. Blood cultures and urine cultures were negative for pathogens.

17. Dr Baber provided an opinion that the medical cause of death was *bronchopneumonia* with contributing factors of *coronary artery atherosclerosis* and *hypothermia*.

18. I accept Dr Baber's opinion.

Circumstances in which the death occurred

19. At 12.37pm on 3 August 2020, RDS called 000 to request an ambulance for CFT, advising that she was "*not herself*" and was "*acting peculiar*". RDS later advised the call-taker that CFT had declined over the prior few days, she appeared to be less responsive, and her condition appeared to be getting worse.
20. When paramedics arrived at 2.31pm, they observed CFT was in a very poor condition, malnourished, dehydrated and hypothermic. Paramedics also noted that the house was unkempt, and unclean, there was evidence of hoarding, and CFT was wearing a continence pad that appeared to have been in place for a long time. There were faeces on her skin and nails, a strong odour was emanating from her and her skin was dry. Paramedics noted that the history provided by RDS and his father appeared to be inconsistent and implausible.
21. Paramedics transported CFT to MMC where she was found to be in septic shock. Staff at MMC suspected that CFT had been neglected, and made the following observations:

    a) CFT's clothes appeared to have been worn for a long period of time and were so soiled that they needed to be cut off her and discarded.
    b) CFT had dried faecal matter on her front pubic area which required "*multiple soaks with cleaning foam to loos[en] and remove*".
    c) CFT had sacrum and knee pressure areas, and excoriation on her sacrum and under her left breast.

    d) She was dehydrated – "*oral mucosa dehydrated and skin turgor tenting due to dehydration*".

e) Staff had difficulty contacting her family members.

f) CFT's niece reported that CFT had not been eating for the past month and that RDS told her that CFT had looked particularly unwell for the past week and a half.

g) CFT was cachectic, with evidence of significant weight loss and the appearance of malnutrition.

22. CFT was palliated and passed away on 4 August 2020 at MMC.

FURTHER INVESTIGATIONS AND CPU REVIEW

23. As CFT's death occurred in circumstances suggesting she suffered a period of neglect, I requested that the Coroner's Prevention Unit (**CPU**)[2] examine the circumstances of her death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[3]
24. CFT received home care services consisting of visits from carers three times per week for support with personal care and three meals per week from the City of Greater Dandenong (**CGD**) Meals on Wheels. Mecwacare provided CFT's case management and enlisted a few different care agencies to provide her home care calls in the years prior to her death.

Care and support history

25. Evidence available to the Court suggested that Mecwacare held concerns about RDS's provision of care as early as 2017. These concerns included:

a) Failure to provide adequate continence care, including:

i. Not providing toilet paper and leaving newspaper in the bathroom to use instead

ii. Not providing continence pads leading to wet and soiled underwear

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

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

iii. Not providing assistance to change continence pads between carer visits (once these were arranged by Mecwacare)

iv. Compromised skin integrity due to poor continence care

b) Failure to follow up important medical appointments

c) Not providing assistance with laundry, leaving CFT with only soiled clothing

d) Failure to provide adequate housekeeping with a strong smell of cigarette smoke and urine inside the house and on CFT's clothing

e) CFT noticeably lost weight over a period of weeks in November 2017 and during one care call, reported she had not eaten for two days.

f) RDS allegedly being aggressive towards CFT's Mecwacare Care Advisor (**MCA**), and appearing "*paranoid about people coming into the home*"

g) Poor medication management, particularly of CFT's diabetes

26. In November 2017, the MCA contacted Seniors Rights Victoria (**SRV**) and reported that they were "*very concerned regarding caring relationship in place and would like some assistance to meet client and nephew RDS and discuss care*". SRV suggested that the MCA could contact the Office of the Public Advocate (**OPA**). Mecwacare notes on 7 December 2017 reflect that SRV advised that they had spoken with RDS, and because he was polite and there were "*no red flags*" raised during their conversation, that they would be closing the referral. The Mecwacare records also noted that SRV decided to close the case because CFT had "*advanced dementia and cannot make any decisions herself*".

2018

27. In May 2018, Mecwacare carried out an annual review of CFT's services. Their records indicated that there were multiple boarded up and broken windows in the house, there was a strong odour of smoke, and the house was quite dark as there were many lightbulbs missing.

28. In September 2018, one OF CFT's carers reported to Mecwacare that CFT had bruising on the front and back of her head and that her lower legs were swollen up to her knees. The MCA was unable to contact RDS to discuss these issues, so they passed a message onto him via the carer to take CFT to her general practitioner (**GP**). On 13 September 2018, RDS sent a text

message to the MCA confirming that CFT had been taken to the GP, however there is no record of this visit on the GP records provided to the Court and there is no explanation for CFT's bruising in the Mecwacare records.

2019

29. In March 2019, a "*large fight*" allegedly occurred at CFT's address between RDS and two other men, whilst a carer was present. The carer reported overhearing the men talking about drugs and stated that one of the men repeatedly tried to force his way into the bathroom where she was providing care to CFT during the fight. The carer left early as she felt unsafe. The MCA raised this incident with her manager and stated that CFT's home environment was unsafe and that she believed RDS had "*severe mental health concerns or a drug involvement*" due to his unpredictable behaviour. The MCA stated that without home care services, CFT would "*end up living in her own filth*" and that RDS would not consider permanent care for CFT as it would result in the loss of his carer's allowance. In response to these concerns, Mecwacare started sending two carers for each of CFT's care calls, however this did not appear to continue long-term.

30. Additionally in March 2019, the MCA contacted the OPA and shared their concerns. The OPA advised the MCA to apply to the Victorian Civil and Administrative Tribunal (**VCAT**) for a guardianship order for CFT. Alternatively, the OPA suggested that the MCA could call the police and report that CFT was in danger, which would enable them to transfer her to hospital. Mecwacare cancelled the external care agency they had been using for CFT and began sending their own carers in order to monitor the situation closely. Mecwacare did not apply to VCAT or contact police on this occasion.

31. In April 2019, the Aged Care Assessment Services (**ACAS**) completed a new assessment with CFT in the presence of CFT's new MCA and a geriatrician. The assessment revealed that CFT had a high level of need due to her limited mobility and cognitive impairment. She scored 8/30 on a mini mental state examination (**MMSE**), which demonstrated a deterioration in her cognition, previously scoring 17/30 in both 2009 and 2015. Her care needs were assessed to include daily personal care related to bowel and bladder incontinence, regular support with laundry, support with all meal preparation and medication administration, and support to attend medical appointments. The assessment also noted that CFT's capacity for self-care was significantly limited and that she required 24-hour, intensive supervision and support.

32. The ACAS assessors recorded several concerns about RDS's care of CFT, including:

a) General concern about RDS's ability to provide CFT with adequate care.

b) Concern about a risk of, or suspected/confirmed abuse.

c) During the assessment, CFT was wearing a soiled nightgown, jacket and socks, consistent with concerns raised by Mecwacare that CFT's clothing and bed linen were often soiled.

d) RDS asserted that CFT was independent with toileting, including changing her continence pads, despite reports from carers that they often found her in soiled continence pads, placing her at risk of urinary tract infections.

e) CFT was very skinny.

f) CFT had poor personal hygiene, her room had a strong smell of urine, and the house was unclean and smelled of pet and urine odour.

g) Despite stating that he administered CFT's medications, RDS demonstrated limited knowledge of her medication and gave a limited and unclear medical history. He did not check her blood sugar levels regularly, and that he "*administer[ed] diabetes medications according to 'how CFT appears and feels'*".

33. The ACAS assessment concluded that CFT's personal safety was at "*immediate risk*" and that her carer arrangements were "*unsustainable*". A plan was made for a Webster pack to be arranged, and for a referral to community nursing for monitoring of medication and health issues such as diabetes, lower limb swelling and skin integrity. The previous package of care, consisting of three one-hour personal care calls per week, delivery of three Meals on Wheels meals per week, six weekly podiatry appointments and regular deliveries of toilet paper was renewed. This left RDS to provide all other care including meal preparation, domestic tasks, administration of medication, facilitation of medical appointments and hygiene/continence care between visits.

34. In May 2019, a Bolton Clarke nurse visited CFT and noted concerns about her weight and oral intake, the fact that she did not have teeth or dentures and issues with her diabetes and oedema management. The records provided to the Court indicate that RDS allegedly did not permit the nurse to enter the home when they tried to visit CFT again later that month. As a result, Bolton Clarke closed their referral and updated Mecwacare about 10 days later.

35. On 27 June 2019, the MCA visited her at her home. CFT opened the door, but RDS was asleep, and CFT could not rouse him. The MCA also noted concerns including:

    a) CFT had a bruise on her cheek, which she explained had resulted from a dog biting her while she was at a shopping centre.

    b) CFT still did not have a Webster pack for her medication.

    c) The fridge did not appear to be working, and it was filled with a large quantity of Meals on Wheels meals, which were at least a few months old.

    d) When asked, CFT confirmed her room was not heated overnight.

36. The next day, the MCA contacted the OPA and advised them of their concerns. The OPA provided advice on applying for guardianship for CFT and suggested that the MCA contact police to perform a welfare check on CFT, given the level of risk. Mecwacare decided not to contact police, given that the MCA visited CFT the day before. On the same day, one of CFT's carers advised the MCA that sometimes when they visited CFT, she would be wearing the same clothing she was wearing during their last visit and that sometimes her continence pads were not changed or were not worn at all.

37. On 3 July 2019, CFT's MCA visited her again and noted that the fridge appeared to be working, although was not working well. They assisted RDS to obtain a new fridge. RDS had not organised CFT's Webster pack. The MCA made a GP appointment for CFT during their visit and offered RDS with support to transport CFT to the appointment. During this visit, RDS agreed to increase CFT's package of care from three to five care calls weekly. However, within two weeks, RDS refused to allow carers into the home more than three times per week and Mecwacare reduced CFT's package back to three calls per week accordingly.

38. On 19 July 2019, Mecwacare applied to VCAT for a guardianship order for CFT, citing their many concerns about RDS's care of CFT. On 2 August 2019, VCAT made a guardianship and administration order providing the OPA with the power to make decisions about accommodation and access to services and appointed the State Trustees to be the administrator of her estate. The order was due to be reassessed no later than 30 September 2020. Also on 2 August 2019, the MCA contacted police after no one answered the door to the carer for several days. Police advised Mecwacare that "*if the client advises there are no issues, even if that might not be true, there won't be a lot more they can do*". Police conducted a welfare check

but took no further action after noting that CFT "*appeared fine to police and confirmed she was being looked after*".

39. On 21 August 2019, an OPA Guardian Advocate (**GA**) was allocated to CFT's case. On 4 September 2019, the MCA and the GA visited CFT and RDS at their home. The OPA records indicated that the house was untidy and had a "*moderately strong smell*" and that CFT was dressed in a dirty dressing gown, had greasy hair and a flat affect. The OPA records documented RDS as "*jumpy*", "*possibly paranoid*" and "*quite bizarre*". During this visit, RDS again agreed to Mecwarecare increasing CFT's package of care from three to five care calls per week, and to CFT having two weeks of respite care, which the GA stated they strongly advocated for with RDS.

40. The GA's view was that the respite care should be arranged as soon as possible, however when Mecwacare attempted arrange respite care a few days later, the GA repeatedly emphasised the need to reaffirm RDS's support for CFT going into respite care. The plan was put on hold as Mecwacare was unable to contact RDS. RDS later declined the respite care and the additional care calls, stating that his father did "*not like people around in his house*", but eventually agreed to CFT's three weekly care calls being extended to two hours and 45 minutes each.

41. On 12 September 2019, the GA recorded that CFT's MCA would ask CFT's carer to speak with her about her wishes with respect to accessing additional services. However, there are no further records in relation to this.

42. On 18 September 2019, the MCA and GA visited CFT and RDS at home. The GA noted their ongoing concerns about the home environment and the care provided by RDS, stating "*formal residential respite could be used in emergency and might be something I will raise with RDS and [the Care Advisor] at a later date*".

43. On 20 September 2019, JNB told a carer that he was going into hospital for a week and was worried about how CFT would manage while he was gone. JNB reportedly asked the carer if Mecwacare could provide respite at home whilst he was away. The MCA told the carer that due to budget limitations; they could not provide this level of in-home care but told the carer to offer RDS respite instead. RDS declined respite care again.

44. On 16 October 2019, the GA emailed Mecwacare and requested an update on CFT. The MCA advised that RDS's communication with Mecwacare had improved, and that at a recent visit

the lounge and kitchen were neat, and CFT presented in a clean bathrobe with neat hair. They also stated that RDS had been allowing the carers inside for their calls and that the MCA had arranged the Webster pack for CFT as they were unsure if RDS knew how to organise same.

45. On 25 November 2019, Mecwacare requested that CFT's GP visit her at home after her carer reported that her behaviour had changed, and she was becoming non-compliant with care. The GP visited two days later and prescribed antibiotics due to dysuria. They noted that CFT appeared to have lost weight, and recorded speaking to CFT's carer about nutrition and 'energy drinks'. A nurse from the GP clinic later noted that the GP "*found it impossible to communicate with client and family*" at this visit and requested that they attend the clinic in future. No follow-up was arranged, and CFT did not see a GP again until July 2020.

46. On 4 December 2019, the GA asked for an update about CFT and RDS. The MCA responded that CFT's care calls "*always go ahead*", adding that RDS did not answer Mecwacare's calls but that there were no issues with service provision "*as far as I know*", suggesting that the MCA had not sought feedback from the carers about CFT's presentation during care calls. Nevertheless, on 20 December 2019, the GA recorded that CFT's care services were now working "*remarkably well*". They recorded that RDS preferred the longer care calls to the more frequent care calls and queried whether this was because this meant he was subject to less monitoring. The records do not indicate what the GA based this assessment on, as it is not attached to a record of contact with RDS or Mecwacare. The GA had no further contact with CFT or Mecwacare until after CFT's passing.

2020

47. On 29 January 2020, the MCA visited CFT at home and noted that the house was tidy, and RDS reported the Webster pack was working well.

48. On 18 March 2020, a carer reported that JNB had allegedly been aggressive towards them and asked them to leave. The MCA left a message for RDS about this, however there are no further records relating to this incident. On 3 April 2020, another carer reported that JNB had allegedly been aggressive towards them and had been unwilling to restrain his dog whilst the carer was in the home.

49. On 6 May 2020, the GA recorded that they had not been contacted about CFT since December 2019 and that they presumed this was "*good news*".

50. On 20 May 2020, the MCA visited CFT and RDS for an annual reassessment. They observed the house was clean and that RDS and his father were cooperative. During the visit, RDS reported that the pharmacy did not want to provide CFT's medication without updated blood tests. As a result, the MCA contacted CFT's GP to request they perform a home visit. Two days later, CFT's GP attempted to make an appointment for CFT but took no further action after leaving messages regarding an appointment.

51. A few months prior to CFT's passing, her niece contacted the GP and reported that since CFT's husband had died, she was not eating well and was losing weight. The GP suggested giving CFT 'Sustagen' drinks, then reviewing her weight in a few weeks' time. CFT's niece reportedly advised that she would ask RDS to bring CFT to the GP. There is no information on the records to suggest that the GP followed up with CFT.

52. On 31 July 2020, RDS returned to the GP with CFT and stated that the pharmacy refused to issue her Webster pack until she was reviewed by a GP and had undertaken updated blood tests. The GP contacted the pharmacy, and they reported that they had not dispensed CFT's medication since November 2019. CFT's Pharmaceutical Benefits Scheme (**PBS**) records confirm that no other pharmacy dispensed her medication after November 2019, and there is no evidence to suggest that she received them elsewhere. Despite this, RDS told the GP that he still had enough medication to last another few days. The GP planned for CFT to do some blood tests and then have another review in a week. The GP recorded that CFT's "*general condition*" was the same. There are no records to suggest that the GP took any further action, including a routine check-up or investigation of her niece's concerns about weight loss and nutritional intake.

Recent changes at the OPA

53. In their statement to the Court, the OPA outlined some changes which have improved practice since CFT's passing. This includes reduced case loads for guardian advocates, legislative changes requiring guardians to establish the represented person's will and preferences and act on them unless there is a risk of serious harm and requiring guardians to recognise and record a formal decision in every guardianship situation, including those where the action is to remain at the current living situation. I welcome these changes and any other changes the OPA makes in future to improve the service it provides to at-risk adults. These changes would have likely made some difference to the service provided by the OPA to CFT.

54. I note, however, a recent report released by the Victorian Auditor General's Office (**VAGO**) to Parliament, which outlined several ongoing issues with the OPA, including:

a) The OPA routinely fails to meet its minimum standards for the frequency of contact between represented persons and their guardian advocates,[4] the timeframe for allocating a guardian advocate, and for record keeping.[5]

b) Guardian advocates routinely fail to document their consideration of human rights when making decisions for represented people.[6]

c) While guardian advocates routinely consider the impacts of their decisions, the OPA's guidance to guardians on considering risk could be improved to ensure consistent of practice and to ensure guardians are confident in balancing risks with a person's will, preferences and human rights.[7]

55. VAGO made 13 recommendations to the OPA, including that the OPA review and update its guidance to staff on allocating orders and on balancing the risk of harm when making decisions. The OPA accepted this and nine other recommendations in full, and accepted three recommendations in principle, which require further funding. I commend the OPA for this approach, however I am of the view that further improvements could be made, namely:

a) The OPA should carry out appropriate investigations into any allegations of neglect or abuse of represented persons when a guardianship and administration order is made by VCAT. This investigation could be carried out by the OPA or by another agency at their request, The investigation results should inform guardian advocate's decision making, where appropriate.

b) When implementing the VAGO recommendation that the OPA "*review and update its guidance to staff, including guidance about allocating orders and balancing the risk of harm when making decisions*" the OPA should review their training, policies, procedures and guidelines to ensure guardian advocates have the guidance and skills necessary to appropriately consider and weigh up the risks of harm to represented people which emanate from neglect and unmet care needs.

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[4] VAGO, Guardianship and Decision-making for Vulnerable Adults, (Independent assurance report to Parliament, May 2024) 7.
[5] Ibid 1.
[6] Ibid 20.
[7] Ibid 22.

c) The Victorian Government should appropriately fund the OPA to enable it to implement all of the recommendations from the VAGO report.

Victoria's current adult safeguarding provisions

56. In August 2022, the 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*". There are numerous organisations who each play a limited role in adult safeguarding in Victoria. This includes SRV, the Elder Abuse Helpline, hospitals, the OPA, the NDIS Quality and Safeguards Commission, the Aged Care Quality and Safety Commission, and Victoria Police. Despite this, there are circumstances where at-risk adults such as CFT fall through the cracks.

57. The fragmented nature of the Victorian safeguarding system is 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, to deliver services and supports effectively*".[8] 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.[9] CFT's MCA explained this challenge, noting "*I have reported concerns about this client's nephew to our previous manager in the past and I also reported him to Elder abuse. No one has really known how to assist me*".

Adult safeguarding

58. Victoria does not have a comprehensive adult safeguarding framework for protecting at-risk adults from abuse, neglect and exploitation. This absence meant that despite Mecwacare staff raising concerns about RDS potentially neglecting CFT, and attempting to address these issues, the allegations were never investigated, no thorough risk assessment was conducted, and a safety plan was not prepared and implemented.

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[8] Australian Government, *Safety Targeted Action Plan* (Plan, December 2021) 2.

[9] *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* (Final Report, September 2023) Executive Summary and Recommendations, 171.

59. In the United Kingdom, adult safeguarding involves the investigation of, and coordination of responses to, suspected abuse and neglect of 'at-risk' adults. At-risk adults are defined as people aged 18 years and over who:

a) Have care and support needs; 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.

60. Adult safeguarding is important because people with a disability are often more likely to experience violence, abuse, and neglect, than people without a disability,[10] often from people on whom they depend upon for care and support.[11] 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%,[12] with those experiencing poor physical or psychological health and higher levels of social isolation more likely to experience abuse.[13]

61. 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 an 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.[14] Therefore, a specialised response to reports of abuse and neglect of at-risk adults is required.

62. Adult safeguarding may 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

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

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

[12] Australian Institute of Family Studies, National Elder Abuse Prevalence Study: Final Report (July 2021), 53 https://aifs.gov.au/sites/default/files/publication-documents/2021_national_elder_abuse_prevalence_study_final_report_0.pdf.

[13] Ibid, 68.

[14] ALRC, *Elder Abuse – A National Legal Response* (Final Report, May 2017), 379; *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* (Final Report, September 2023) vol 11, 25.

b) Investigating allegations of abuse and neglect of at-risk adults

c) Proactively making enquiries to establish whether any action needs to be taken to prevent abuse or neglect, and if so, by whom

d) 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

e) Facilitating decision-making support for at-risk adults

f) Assessing risk associated with neglect and abuse

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

h) Reporting the abuse to police

i) Applying for an intervention order in relation to the person allegedly causing harm to the at-risk adult

63. If adult safeguarding legislation and/or an agency were implemented in Victoria, CFT would have likely met the criteria for an adult safeguarding response due to her care and support needs, her cognitive impairment, her risk of experiencing neglect and her needs for care and support likely prevented her from protecting herself. If available, Mecwacare, another agency or any other person who was concerned could have reported their concerns to the agency, and the safeguarding agency would have the power to thoroughly investigate.

PROPOSED SAFEGUARDING LEGISLATION AND FUNCTION

Previous research/investigations into a safeguarding agency

64. Since 2017, the Australian Law Reform Commission (**ALRC**), the OPA and the Disability Royal Commission (**DRC**) into violence, abuse neglect, and exploitation of people with a disability have all recommended the introduction of adult safeguarding legislation to establish adult safeguarding functions including assessment, investigation, and coordination of responses to allegations of abuse of at-risk adults. The specifics of each recommendation differ, including with respect to which adults and types of abuse the safeguarding function should cover, and what type of agency should carry out the safeguarding function.

65. The OPA recommended that the safeguarding function should sit within an existing agency, such as the OPA, while the DRC recommended that it should sit within an independent statutory body. The ARLC was silent on this issue. I am not in a position to determine where such an agency should be located this is a matter that will likely require further stakeholder consultation and research to determine the most appropriate location or agency to carry out this function.

66. I note that in response to the DRC's recommendations, the Australian and Victorian Governments' do not commit to introducing safeguarding legislation, even in principle. Having regard to the ALRC's report, *Elder Abuse – A National Legal Response*, the OPA's *Line of Sight* report and the DRC's *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability Final* Report, I am of the view that a safeguarding framework supported by legislation is necessary, and I intend to make recommendations as follows:

    a) As a priority and with reference to relevant reports by the ALRC, OPA and the DRC, the Victorian Government implement adult safeguarding legislation to establish adult safeguarding functions including the assessment, investigation, and coordination of responses to allegations of abuse, neglect, and exploitation of at-risk adults.

    b) In framing legislation, the Victorian Government review the circumstances of CFTs passing and similar cases when considering implementation of the safeguarding recommendations of the ALRC, the OPA and the DRC.

    c) That any new adult safeguarding agencies be adequately funded to function in an effective manner.

Features, powers and capabilities of a new adult safeguarding agency

67. Having regard to the manner in which a safeguarding agency could have assisted CFT, it seems appropriate that any new safeguarding agency should be provided with clear pathways to facilitate the timely provision of or change to support services provided to at-risk adults through the NDIS and My Aged Care (depending upon eligibility). Timely liaison between an adult safeguarding agency, the OPA and Mecwacare could have increased CFT's home support to a level which more adequately met her needs and may have promoted her human rights and prevented her death in circumstances suggesting neglect.

68. It therefore appears appropriate that the Victorian Government in establishing any new safeguarding agency should ensure 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. I intend to make a recommendation to that effect.

Information sharing

69. It is also clear that any new adult safeguarding agency will need to be able to request and share information with other agencies in order to be able to carry out their functions effectively. An information sharing scheme may be complex, and the ARLC, OPA and DRC reports suggested different mechanisms by which this could occur.

70. The OPA recommended that the Victorian Government should negotiate with the Australian Government in relation to the prescription of Australian Government entities, including the NDIA and the NDIS Quality and Safeguards Commission, as Information Sharing Entities (**ISE**) under the Family Violence Information Sharing Scheme (**FVISS**) and in respect of the Multi-Agency Risk Assessment Management (**MARAM**) framework. One potential problem with this approach is that neglect is not explicitly included in the *Family Violence Protection Act 2008* (Vic) (**FVPA**) and therefore adequate information sharing may not be permitted. If the FVPA were amended to include neglect as a form of family violence, then this may have the impact of criminalising neglect when a family violence intervention order (**FVIO**) is breached. The OPA suggested that supportive interventions to address the needs of the carer and the at-risk adult may be a more appropriate response in cases of neglect and therefore recommended that the Victorian Government should "*ensure that robust information-sharing arrangements are in place in relation to violence against at-risk adults that are not instances of family violence*".

71. Having regard to the complexities that are likely to arise when developing an information sharing scheme, I am of the view that it would not be appropriate for me to prescribe a particular approach. Rather, I will recommend that the Victorian Government legislate for information sharing arrangements to enable any new adult safeguarding agency to receive and share information, including information about neglect, in a timely manner.

Building safeguarding capacity of mainstream services

72. Upon establishment of a new adult safeguarding agency, mainstream service providers will need to build their capacity to identify and respond to the abuse, neglect and exploitation of

at-risk adults. The professionals involved with CFT were appropriately concerned about possible neglect and were well-placed to report these concerns to a safeguarding agency, if one existed at that time.

The ALRC recommended that adult safeguarding agencies should work with relevant professional bodies to develop protocols for when prescribed professionals, particularly medical practitioners, should refer the abuse of at-risk adults to safeguarding agencies. Further, the OPA recommended that the Victorian Government should build the capacity of mainstream service providers to be able to identify and respond to the abuse of at-risk adults. This is a valuable and sensible recommendation, and I endorse this recommendation.

Community awareness

73. The DRC commented on the importance of raising community awareness of any new adult safeguarding agency to promote the agency, encourage reporting to the agency and build trust within the community. It also recommended that any adult safeguarding body must be adequately resourced to raise public awareness of matters relating to violence against, and abuse, neglect and exploitation of adults with a disability. Awareness is crucial to ensure that the community and mainstream services providers understand what they can do if they suspect an at-risk adult is being abused or neglected and how to escalate their concerns. I will therefore recommend that the Victorian Government provide funding for community awareness, media engagement and education campaigns promoting the work of any new adult safeguarding function, as suggested by the DRC.

Response to proposed findings

74. As a matter of procedural fairness, I directed that the Court contact RDS regarding the allegations raised by Mecwacare and the other agencies involved with CFT. RDS was provided with an opportunity to respond to the concerns raised. RDS explained that he and his father, JNB, were responsible for caring for CFT and that they cared for CFT "*to the best of [their] abilities, as she was a deeply loved member of [their] family*". RDS explained that his aunt had a long history of mental illness, specifically schizophrenia, and found comfort in familiar surroundings. She was not comfortable leaving her home and had a longstanding fear of doctors and institutions, making in-home care the most appropriate care option for her.

75. RDS also submitted that "*the statement provided by the services/carers does not fully reflect the entirety of her care*". It is correct that Mecwacare and the other carers only saw CFT for a

limited number of hours per week, and therefore did not have a full picture of the care that she received at home. However, the overwhelming evidence from multiple sources suggests during most of their contact with CFT, they had concerns about her welfare, hygiene and medical needs. This is further supported by the condition in which CFT was found the day before her passing.

76. As stated above, the role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. The purpose of a coronial investigation is to establish the facts, and *not* to cast blame or determine criminal or civil liability. Therefore, any comments I make about the condition of CFT is made within this context, and not to apportion blame or to determine criminal or civil liability.

FINDINGS AND CONCLUSION

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

a) the identity of the deceased was CFT, born 25 May 1942;

b) the death occurred on 4 August 2020 at Monash Health, Monash Medical Centre, 246 Clayton Road, Clayton, Victoria, 3168, from *bronchopneumonia*, with contributing factors of *coronary artery atherosclerosis and hypothermia*; and

c) the death occurred in the circumstances described above.

RECOMMENDATIONS

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

Office of the Public Advocate

1. That the **Office of the Public Advocate** whenever they become aware of any allegations of neglect or abuse of a represented persons where a guardianship and administrative order is made by VCAT conduct a thorough investigation. This investigation could be carried out by the Office of the Public Advocate or another agency at their request. The outcome of the investigation should inform the guardian advocate's decision-making, where appropriate.
2. When implementing the VAGO recommendation that the Office of the Public Advocate "*review and update its guidance about allocating orders and balancing the risk of harm when making decisions*", the **Office of the Public Advocate** should review their training, policies, procedures and guidelines to ensure guardian advocates have the guidance and skills necessary

to appropriately assess the risks of harm to represented people which may emanate from neglect and unmet care needs.

3. That the **Victorian Government** make available appropriate funding to the Office of the Public Advocate to enable it to implement all of the recommendations from the VAGO report.

Establishing adult safeguarding in Victoria

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

5. In framing legislation, the **Victorian Government** review the circumstances of CFT's passing and similar cases together with the safeguarding recommendations of the ALRC, the OPA and the DRC.

6. That any new adult safeguarding agencies be adequately funded by the **Victorian Government** to function in an effective manner.

7. That the **Victorian Government**, when establishing a new safeguarding agency, should ensure that the agency works cooperatively with other service providers to facilitate the timely provision of, or changes to, the support services provided to at-risk adults.

8. That the **Victorian Government** introduce legislation to permit an adult safeguarding agency to receive and share information in a timely manner, including information about neglect, with police, healthcare entities, government departments, the Office of the Public Advocate and any other agencies involved.

9. That the **Victorian Government** implement the recommendation of the Office of the Public Advocate, namely, to build the capacity of mainstream service providers to be able to identify and respond to the abuse of at-risk adults.

10. That the **Victorian Government** make funding available for regular community awareness, media engagement and education campaigns about any new adult safeguarding function, as suggested by the Disability Royal Commission.

I convey my sincere condolences to CFT'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:

RDS, Senior Next of Kin

Mecwacare

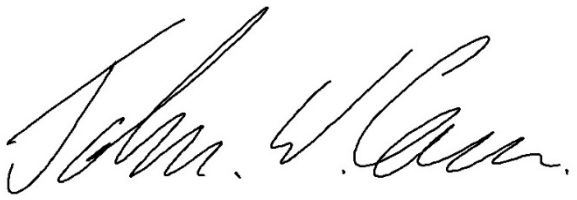
Monash Health

Office of the Public Advocate

Victorian Government

Senior Constable Liz Fraidine, Coronial Investigator

Signature:



Judge John Cain
State Coroner
Date: 26 February 2025

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