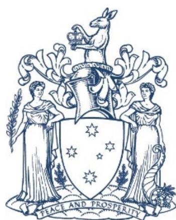

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 003518

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:	JNY
Date of birth:	[redacted]
Date of death:	29 June 2023
Cause of death:	1(a) Pulmonary thromboembolism and bronchopneumonia 1(b) Deep vein thrombosis <u>Contributing factor(s)</u> Metastatic small cell carcinoma, ischaemic heart disease, chronic obstructive pulmonary disease
Place of death:	West Gippsland Hospital 41 Landsborough Street Warragul Victoria 3820
Keywords:	Adult safeguarding; natural causes; complex care and support needs

INTRODUCTION

1. On 29 June 2023, JNY was ██ years old when he passed away at the West Gippsland Hospital Warragul, Victoria. At the time of his death, JNY lived with his long-term partner, PJN, at their home in regional Victoria.

Background - JNY

2. JNY married his first wife, CBV and they had a son, JER born in ███. Following the end of this marriage, JNY commenced a relationship with PJN sometime in the early 2000s and the pair moved in together and lived in a de facto relationship.

3. In the years prior to his death, JNY was diagnosed with lung cancer secondary to long-term smoking. He underwent treatment at Latrobe Regional Hospital; however, the treatment was unsuccessful and the cancer spread to his brain. He received support from a palliative care service, and full-time care by PJN. There is limited information about JNY contained within the coronial brief, however he reportedly enjoyed working in the mining industry for many years before he became ill.

Background – PJN

4. PJN was born in ███ and was ██ years old at the time of JNY's death. There is no information contained within the coronial brief about her history; however, she disclosed a challenging personal history, which included mental health issues and minor criminal offending.

5. The various services involved with JNY and PJN did not make any reference to PJN's history of violence, indicating that they were not aware of it. Additionally, the services did not document any concerns that PJN was violent towards JNY prior to June 2023.

THE CORONIAL INVESTIGATION

6. JNY'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.

7. 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.

8. 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.

9. Victoria Police assigned Senior Constable Jesse Mansfield to be the Coronial Investigator for the investigation of JNY'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.

10. 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.

11. This finding draws on the totality of the coronial investigation into the death of JNY 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

12. On 29 June 2023, JNY, born [redacted] was visually identified by his son, JER.

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

Medical cause of death

14. Forensic Pathology Registrar Dr Michael Duffy supervised by Dr Gregory Young from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 3 July 2023 and provided a written report of his findings dated 26 September 2023.

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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.

15. At autopsy, the deceased had evidence of pulmonary thromboembolism (**PE**) and bronchopneumonia with a right lower leg deep vein thrombosis (**DVT**). Dr Duffy explained that a PE is a blood clot in the blood vessel that transports blood from the heart to the lungs. The clot burden was higher in the right lung compared to the left in this case, with no large saddle PE. The blood clot typically arises elsewhere in the body, which in this case, was the right lower leg. It can dislodge and travel to the right side of the heart and then into the pulmonary artery, causing right heart strain.

16. The deceased also had evidence of bronchopneumonia (lung infection) in both lungs. The extent of the infection could cause death, especially in a man with ischaemic heart disease and chronic obstructive pulmonary disease (**COPD**), due to a reduction in cardiac and respiratory reserve. It is uncertain whether the bronchopneumonia or PE occurred first and caused the other. There were acute changes histologically without any features of chronicity to suggest that one occurred earlier than the other. Risk factors relevant to the deceased for both PE and bronchopneumonia included cancer (metastatic small cell carcinoma), history of COPD and likely immobility in the period leading to death (particularly in hospital).

17. Dr Duffy explained that both PE and bronchopneumonia have the combined effect of causing cardiorespiratory failure.

18. The deceased's body mass index (**BMI**) was 16.3 kg/m^2, which is considered underweight and was likely due to has cancer progression. This also reduced his physiological reserve. There was no evidence of injuries (particularly no acute or remote rib fractures) or physical abuse that may have caused or contributed to the death. Non-physical forms of neglect could not be addressed at autopsy.

19. There were no signs of asphyxia (although non-specific) such as conjunctival or facial petechial haemorrhages, facial lacerations, or abrasions, and he survived several days in hospital. Therefore, there was no suggestion that the death was related to smothering or asphyxia.

20. Dr Duffy opined that the death was due to natural causes.

21. Toxicological analysis of ante-mortem samples was not possible as there were no suitable samples available from the admitting hospital.

22. Dr Duffy provided an opinion that the medical cause of death was 1(a) Pulmonary thromboembolism and bronchopneumonia secondary to 1(b) Deep vein thrombosis with

contributing factors of metastatic small cell carcinoma, ischaemic heart disease, and chronic obstructive pulmonary disease.

23. I accept Dr Duffy's opinion as to the medical cause of death.

Circumstances in which the death occurred

24. From 5 to 8 June 2023, JNY was admitted to hospital with community acquired pneumonia, and for pain management needs. After being discharged from hospital, his condition deteriorated further.

25. On 21 June 2023, PJN contacted JER to advise him that JNY's health was deteriorating and that he might pass away soon. JER and his partner, left their home in a neighbouring State and drove to JNY's house, arriving on 22 June 2023. When they arrived, PJN and her sister were present at the home. JER and his partner spent time with JNY that day.

26. In the early afternoon, JER and his partner briefly left the house to purchase some alcohol, so that they could share some drinks together. JER reported that PJN started drinking when they returned with the alcohol.

27. At some point that afternoon, PJN, JER and his partner reviewed a new draft of JNY's will. JER told PJN about JNY's wishes for his ashes. PJN was JNY's power of attorney, while his first wife, CBV, was the executor of his will. PJN was reportedly upset that CBV was listed as executor of the will.

28. JER and his partner left the home between 6.00pm and 7.00pm. When they left, they noted PJN was still upset about the will.

29. Sometime that evening, PJN reportedly called CBV, upset about perceived discrepancies in the will. Additionally, that evening, PJN reportedly entered JNY's bedroom and pinched his nose for about two seconds and stated, "*thank you very much for nothing*". JNY pushed her hand away and PJN left the room. PJN's sister, who was also present at the home, reportedly witnessed PJN make a threat to smother JNY.

30. At about 9.30am on 23 June 2023, a registered nurse (**RN**) was attending to a palliative care patient with a student nurse when they received a call from their office. PJN called their office to advise that JNY was on the floor. The RN spoke to PJN over the phone who reportedly said, "*JNY is on the floor and he can fucking stay there*". When the RN asked how PJN was going to pick him up, she repeated that he could stay there. The RN and the student nurse

immediately finished with their other patient, then drove to JNY and PJN's home, arriving a few minutes later.

31. JER and his partner arrived at his father's home shortly after the RN and the student nurse. When they entered the house, PJN reportedly said "*your father is on the floor he fell out of bed. He can stay there I don't want him here anymore, your mother can have him. I tried smothering him numerous times last night by putting my hand over his mouth and pinching his nose to stop him from breathing*". PJN reportedly kicked JNY in the legs as she left the room.

32. The RN noted that JNY was on the floor with a doona covering him. He was conscious and breathing, however his cognitive ability was impaired, and he could not speak in full sentences. PJN called Triple Zero and handed the phone to the RN to speak to the call-taker. PJN started pacing around the house and reportedly said "*wish you would die you cunt, go back to your ex wife*". PJN started pacing around the house and yelling that she wanted JNY out of the house. Due to PJN's behaviour, the RN decided to call for police.

33. Victoria Police arrived on scene first, followed by Ambulance Victoria paramedics. Police observed PJN try to kick JNY while he was lying on the floor, being treated. As paramedics attempted to assist JNY, PJN reportedly tried to kick JNY's legs and stated, "*if you bring him back here I'm going to fucking kill him*".

34. First Constable Andrew Harding (**FC Harding**) noted that PJN was "*combative and abusive*" towards him, however he did not immediately feel the need to handcuff her as she became compliant when he told her to sit down on the front porch.

35. While seated on the porch, PJN told FC Harding and Leading Senior Constable Anthony Davis (**LSC Davis**) about "*smothering the cunt a couple of times*" and words to the effect of "*I would have succeeded too if he hadn't have licked me*". PJN used her hands to demonstrate how she covered JNY's mouth and pinched his nose.

36. LSC Davis and FC Harding were taken aback by what they heard, so LSC Davis contacted their patrol supervisor who advised them to provide PJN with her caution and rights, then arrest her. LSC Davis asked PJN "*You just told me before you smothered him? Why did ya do that, to kill him?*" PJN responded "*Yes*" and when asked why, she said "*Cos he's a cunt*". LSC Davis arrested PJN for attempted murder and formally cautioned her.

37. PJN's sister told police that at about 4.15am that morning, she witnessed PJN "*make a threat to smother the [c]unt*". PJN's sister did not believe her and told her "*enough is enough, stop drinking [and] go to bed*". PJN's sister provided a statement to police to this effect.

38. Paramedics transported JNY to West Gippsland Hospital (**WGH**) accompanied by a police officer. He underwent imaging which ruled out any new/acute injuries, then received palliative care until he passed on 29 June 2023.

39. PJN was formally interviewed by police for the offence of attempted murder. And released pending further enquiries. Police subsequently charged her with one count of common law assault and two counts of unlawful assault. On 29 June 2024, PJN was convicted of one count of common law assault and received a 12-month Community Corrections Order.

FURTHER INVESTIGATIONS AND CPU REVIEW

40. As JNY's death occurred in circumstances where he was experiencing family violence in the lead-up to his passing, this case was referred to the Coroner's Prevention Unit (**CPU**)[2] to examine the circumstances of JNY's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**)[3]

41. I make observations concerning service engagement with JNY and PJN as they arise from the coronial investigation into JNY's death and are thus connected thereto. However, the available evidence does not support a finding that there is any <u>direct causal</u> connection between the circumstances highlighted in the observations made below and JNY's death.

42. I further note that a coronial inquiry is by its very nature a wholly retrospective endeavour and this carries with it an implicit danger in prospectively evaluating events through the "*the potentially distorting prism of hindsight*".[4] I make observations about services that had contact with JNY and PJN to assist in identifying any areas of practice improvement and to ensure that any future prevention opportunities are appropriately identified and addressed.

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

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

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

43. I further note that PJN was not convicted of any homicide or attempted homicide offences in relation to JNY's death.

44. As a matter of procedural fairness, the Court wrote to PJN to provide her with an opportunity to respond to the allegations or make any other submissions in response. PJN did not provide any response or submissions.

Summary of care provided to JNY

45. In early-2023, JNY was admitted to Latrobe Regional Hospital for cerebral oedema and functional decline. Following JNY's discharge, he began receiving community-based palliative care services which provided monitoring of his condition, personal care and medication assistance. Initially, this assistance was fortnightly or weekly, however increased to daily as his condition deteriorated. By June 2023, palliative care nurses attended daily to administer medications and called JNY every evening for monitoring.

46. PJN provided all other care for JNY, and both declined additional in-home supports when offered. PJN also provided care to another male who lived at their home. From the information provided, it is unclear how this person was related to PJN/JNY, his condition, or the level of care he required.

47. The available records indicate that both palliative care staff and JNY's family expressed concerns about PJN's ability to care for JNY, prior to the incident in June 2023.

48. On 21 April 2023, palliative care nurses observed PJN to be "*very emotional*", and she advised that she might have a "*breakdown*". Staff spoke with PJN at length, and she consented to social work input.

49. On 2 May 2023, the palliative care coordinator received a call from JER's partner who advised that she had concerns for JNY's welfare in PJN's care. These concerns included:

    a) An incident when PJN became intoxicated, "*passed out*" and left JNY naked, other than an 'Oodie' (an oversized jumper).

    b) Instances where JNY had fallen and PJN had not done "*anything*" to help him.

    c) That PJN forced JNY to sign legal documentation, making her his guardian.

50. Following this discussion, the family were involved with a social worker, and these concerns were raised directly with JNY (without PJN present). JNY advised that he was "*happy with current arrangements and feels safe*", that he did not wish to relocate to live with JER, as requested by JER's partner. He explained that he was in the process of arranging his will and medical power of attorney.

51. In a separate discussion between PJN and the social worker, PJN advised that she was caring for another person in the home and that she was having difficulty caring for his hygiene. Social work staff worked with PJN to identify how to manage this situation and she agreed for ongoing support from the social worker.

52. On 8 May 2023, the social worker attended the home and observed PJN to be "*very heightened and tearful*", and she noted that they had no money to live on. The social worker assisted PJN and JNY to access part of JNY's superannuation to cover their debts and arranged for an amount to be released fortnightly to cover their living expenses while they organised access to Centrelink payments. PJN was reportedly relieved at the conclusion of this visit.

53. On 14 May 2023, palliative care staff were advised that PJN requested for JNY to remain in bed as she wanted to consume alcohol and would have difficulty getting him back into bed later. On this occasion, staff documented concerns for PJN's ability to "*provide safe and effective care due to own emotional health concerns/health concerns*". Staff documented that they intended to monitor the situation.

54. On 26 May 2023, PJN advised palliative care staff that she had tried to take her life several nights prior; however, she was feeling better. This information was relayed to the social worker who spoke to PJN on 30 May 2023. The social worker performed a risk assessment and noted no initial concerns for PJN's welfare.

55. As noted above, JNY was admitted to Latrobe Regional Hospital from 5 to 8 June 2023. During this admission, an occupational therapist and physiotherapist raised concerns with JNY and PJN about their capacity to manage JNY's care at home. Staff documented that JNY and PJN were "*adamant*" that they wanted to go home and were confident that PJN could provide all care required.

56. On 14 June 2023, palliative care nurses documented concerns about PJN's capacity to manage JNY's care and medication safely, and PJN appears to have agreed to increased nursing visits.

57. On 15 June 2023, an occupational therapist noted that PJN was rushing JNY to complete tasks which was causing him pain. Following this observation, the occupational therapist enquired with JNY as to whether he had any concerns for his care or safety. JNY advised he was not concerned and stated that he felt safe in PJN's care.

58. On 20 June 2023, palliative care nurses observed that PJN had a black eye and a significant bruise to her upper arm. PJN was unable to recall how she received these injuries but stated it may have occurred while trying to keep JNY in bed. She also disclosed that she was struggling with her mental health and staff helped her book an appointment with her general practitioner (**GP**). This is discussed further below.

59. On 22 June 2023, palliative care nurses noted PJN was very repetitive in her conversation with them, however they spoke to JER and he indicated that PJN appeared was "*going ok and appears to be managing*".

60. Palliative care staff consistently noted concerns regarding PJN's administration of medication, noting that she had withheld medication from him or struggled with administration. Palliative care staff organised additional nursing visits to support PJN with this task, however PJN often cancelled these appointments.

61. In her statement to the Court, JER's partner also advised that JNY's extended family held concerns that PJN had allegedly abused JNY. She noted an incident in April 2023 when PJN was witnessed allegedly abusing JNY and "*slapping him around the head*". These allegations do not appear to have been reported to police or support services prior to JNY's passing.

Civic Park Consulting Suites (GP)

62. As noted above, PJN disclosed to palliative care staff on 20 June 2023 that she was struggling with her mental health, and staff assisted her to book an appointment with her GP. PJN attended her GP on 21 June 2023 where she discussed JNY's diagnosis and her mental health. The GP offered PJN a referral to a psychologist, however she declined same. PJN asked to change her antidepressant medication, and the GP ceased desvenlafaxine and commenced sertraline. During this appointment, PJN also disclosed that she had "*mild anger issues*" and the GP discussed calming techniques with her, which PJN appeared to be receptive to.

63. Upon a review of PJN's prior contact with this clinic, it is apparent that the clinic was aware of her mental health history and had previously referred her to hospital and psychological

services when required. There was no indication that the GP was aware of PJN's prior history of offending. I have not identified any deficiencies with respect to the GP's treatment.

West Gippsland Healthcare

64. Upon a review of JNY's contact with West Gippsland Healthcare (**WGH**) (responsible for his palliative care treatment), staff appropriately made attempts to address concerns documented by family members and other staff members. WGH repeatedly offered PJN and JNY additional support, raised concerns with JNY alone, increased home visits when able, referred to social work when risks became known and undertook risk assessments when PJN's mental health concerns became known.

65. While WGH attempted to work in collaboration with JNY and PJN to provide safe in-home care, without an adult safeguarding framework and without the permission of JNY, family members and health professionals did not have a specialist adult safeguarding service available to them when concerns for JNY's care arose. In my view, the key issue in this case relates to Victoria's lack of a comprehensive framework for safeguarding at-risk adults from abuse, neglect and exploitation. I make no criticism of the service provided by WGH.

Adult safeguarding explanation

66. 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 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

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[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)>.

[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)>.

c) are unable to protect themselves from the abuse or neglect because of their care and support needs.[8]

67. 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]

68. 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.

69. 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

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

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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.

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].

Victoria's adult safeguarding provisions

70. 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'.[15]

71. 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.[16] 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.[17]

72. 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, to deliver services and supports effectively.'[18] This complex system also makes it 'very difficult for third parties who are concerned about an at-risk adult experiencing abuse to know

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[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)>; Australian Law Reform Commission (ALRC), *Elder Abuse – A National Legal Response* (Final Report, May 2017), 402-3.
[15] OPA, *Line of Sight: Refocussing Victoria's Adult Safeguarding Laws and Practices* (Review, 18 August 2022) 13.
[16] Ibid 47.
[17] Ibid 48
[18] Australian Government, *Safety Targeted Action Plan* (Plan, December 2021) 2.

where to go for help' and contributes to the under-reporting of violence, abuse, neglect and exploitation of at-risk adults.[19]

73. 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.[20]

Adult safeguarding in relation to JNY

74. JNY may have met the criteria for an adult safeguarding response, given that he had needs for care and support, and that PJN may not have had the capacity to provide the level of care he required. With current referral options, WGH and JNY's family were restricted to raising these concerns directly with JNY and PJN. Upon their refusal of additional support, services were left without an alternative route to address noted risks.

75. If a safeguarding mechanism were available in Victoria, services and family would have been able to contact this service to seek advice and facilitate specialist investigation of their concerns. A safeguarding response in this case may have involved:

    a) An assessment of PJN's wellbeing and needs as a carer;

    b) An assessment of JNY's mental capacity to make decisions regarding his care and support needs and safeguarding concerns;

    c) Facilitation of a multi-disciplinary care team meeting involving family as appropriate; and

    d) Robust safety planning and monitoring.

Previous adult safeguarding cases and discussion

76. JNY'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,

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

[20] 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.

extensively canvassed the issue of adult safeguarding in several findings handed down in 2025, including the deaths of CFT[21], William Heddergott[22], MHT[23], YTR[24], and DRF[25].

77. In Judge Cain's finding into the death of CFT, his Honour recommended:

a) 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.

b) 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.

c) 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.

d) 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.

e) 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.

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

g) 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.

h) 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.

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[21] Finding into death without inquest – CFT (COR 2020 4205).
[22] Finding into death without inquest – William Heddergott (COR 2020 6253).
[23] Finding into death without inquest – MHT (COR 2022 4511).
[24] Finding into death without inquest – YTR (COR 2020 6157).
[25] Finding into death without inquest – DRF (COR 2022 0022).

i) *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.*

j) *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.*[26]

78. 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.

79. 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.

80. Finally, DFFH referenced the new Social Services Regulator as a new initiative to reduce the risk to vulnerable adults with care and support needs, however this body only covers state-funded disability services. In the present case, JNY was not receiving any state-funded disability services, so the Social Services Regulator is unlikely to have made any difference in his case.

81. I remain concerned that that without a comprehensive adult safeguarding framework in Victoria, vulnerable adults such as JNY (and their carers/families/professionals) have no centralised avenue to seek advice or raise concerns. Therefore, in my recent finding into the death of JZA, I reiterated Judge Cain's recommendations 4 to 10.[27]

82. 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*

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

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

83. 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, and that support for my recommendation in JZA would be subject to further funding considerations by government during future budget processes.

84. 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).

85. DFFH also responded to my recommendations in JZA by reiterating the response[28] 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.

86. 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 JNY.

[28] 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.

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.

87. In those circumstances, I am not convinced that the recommendations of the VAGO report in isolation, nor the reforms in relation to the Social Servies Regulator go far enough to address the concerns identified in this case, as well as the many others before it. Therefore, I intend to make pertinent recommendations, drawing upon my previous recommendations in JZA and will direct the Victorian Government to provide funding to ensure that the recommendations can be implemented by the relevant department(s).

FINDINGS AND CONCLUSION

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

   a) the identity of the deceased was JNY, born

   b) the death occurred on 29 June 2023 at West Gippsland Hospital, 41 Landsborough Street Warragul Victoria 3820, from pulmonary thromboembolism and bronchopneumonia secondary to deep vein thrombosis with contributing factors of metastatic small cell carcinoma, ischaemic heart disease, and chronic obstructive pulmonary disease; and

   c) the death occurred in the circumstances described above.

RECOMMENDATIONS

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

i. That the **Minister for Disability** and the **Victorian Government** make available appropriate funding to the Office of the Public Advocate to enable it to implement all of the recommendations from the VAGO report.

ii. The **Victorian Government** implement (and the **Minister for Disability** provide funding for) as a priority, adult safeguarding legislation to establish adult safeguarding functions including but not limited to the assessment and investigation of, and coordination of responses to allegations of abuse, neglect, and exploitation of at-risk adults.

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

iv. That any new adult safeguarding agency be adequately funded by the **Victorian Government** and **Minister for Disability** to function in an effective manner.

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

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

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

viii. That the **Victorian Government** and the **Minister for Disability** 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 JNY'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:

PJN, Senior Next of Kin

JER

HGF

Department of Families, Fairness and Housing

Department of Justice and Community Safety

Department of Premier and Cabinet

The Hon. Lizzie Blandthorn, Member for Disability

West Gippsland Healthcare Group

Senior Constable Jesse Mansfield, Coronial Investigator

Signature:

Judge Liberty Sanger, State Coroner

Date: 24 April 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.