IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 4627

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:	Patricia Jocelyn Eve Grant
Date of birth:	19 April 1930
Date of death:	Between 12-13 October 2013
Cause of death:	1(a) Aspiration bronchopneumonia in a setting of cerebral infarction
Place of death:	60 Jellicoe Street, Noble Park, Victoria
Catchwords:	Elder abuse; family violence

INTRODUCTION

1. Ms Patricia Jocelyn Eve Grant was 83 years old and living with her adult son, Mr Vincent Grant (also known as "Vince"), her daughter in law, Ms Karen Dyball and her grandchildren at the time of her death.

2. Ms Grant was born in Wagga Wagga, New South Wales and unfortunately suffered from epilepsy for all of her adult life. She was on medication for epilepsy from the age of sixteen. At the time of her death, Ms Grant also suffered from osteoporosis, hypertension and degenerative arthritis in her joints, all conditions that require regular medical follow up and medical prescriptions.

3. In 2004, Ms Grant commenced living with her only child and son, Vince and his partner, Ms Dyball and their five children at the family home in Cranbourne. In November 2005, the family home was destroyed in a house fire and the family moved to caravans on a block of land in Cranbourne.

4. In January 2006, Ms Dyball applied to Centrelink to be the registered carer for Ms Grant. Ms Dyball claimed a carer's allowance for looking after Ms Grant.

5. On 12 June 2008, Ms Grant was transferred to Mayfair Lodge, a supported residential service in Stud Road, Dandenong. Ms Grant resided there for six months before returning to live with Vince and Ms Dyball in December 2008. At the time of leaving Mayfair Lodge, Ms Grant was still active and in regular receipt of medical attention and treatment.

6. In May 2009, Ms Dyball applied to Centrelink again to continue being the registered carer for Ms Grant.

7. In early 2011, Vince and Ms Dyball moved the family including Ms Grant to 60 Jellicoe Street in Noble Park.

THE CORONIAL INVESTIGATION

8. Ms Grant'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.

9. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances

are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

10. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

11. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Ms Grant's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

12. This finding draws on the totality of the coronial investigation into the death of Ms Grant, including evidence contained in the coronial brief and further evidence obtained under my direction. 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

Circumstances in which the death occurred

13. In the lead up to Ms Grant's death several significant events transpired which is evidence of a serious deterioration in her health and condition, a summary of these events is described below.

14. During March 2013, Ms Dyball ceased administering the deceased her prescribed epilepsy medication. Ms Dyball later advised police that she ceased administering this medication due to recent mood swings by the deceased.[2]

15. In the months prior to Ms Grant's death, her mobility decreased significantly. Ms Dyball later advised police that the deceased was unable to move more than one metre at a time. As a result of her immobility, Ms Grant began to regularly urinate whilst in her bed. Ms Grant also began to suffer from regular falls and regularly fell out of her bed and, in order to address this, the co-

[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.

[2] *Coronial Brief*, Statement of Karen Dyball dated 13 October 2013, 206-207

accused moved a dresser next to the side of Ms Grant's bed and no medical intervention was sought in relation to this.

16. During this time Ms Grant began to suffer from hallucinations and began to regularly scratch her arms, legs and abdomen to the point of bleeding.[3] During these hallucinations Ms Grant often complained to Vince and Ms Dyball and her grandchildren that a male was entering her bedroom and touching her. Ms Grant's hallucinations became so significant that she would often scream out at the persons she believed were in her bedroom.[4] Ms Dyball did not seek medical intervention or advice for Ms Grant's scratching or hallucinations, however, Vince instead purchased ear plugs for the family so they could sleep whilst she was screaming. He later described her screaming to police as being "*so loud and constant*".[5]

17. Approximately one month prior to her death, Ms Grant's cognitive function appeared to rapidly decline. Ms Grant was reported to often scream out for her parents who had, in fact, died some years earlier. Ms Grant also "*skipped back in time*" and was of the belief that the year was 1958.[6]

18. Approximately two weeks prior to Ms Grant's death, she reportedly suffered what Ms Dyball believed to be a stroke. Ms Dyball later advised police that as a result of this stroke, Ms Grant, lost her hand-eye coordination, lost the ability to swallow, lost the ability to talk and would only make groaning noises.[7] Ms Grant was observed by her grandson to be rolling on the bedroom floor, acting strange and shaking like she was having a fit. Again, medical intervention was not sought and Ms Grant remained bed-ridden.[8]

19. Ms Grant was last given food on Friday, 11 October 2013. There are varying accounts as to what this meal was and what time it was served, however, Ms Dyball recounts in her statement to the Court that she hand fed cereal to Ms Grant at midday.[9] She was then left by herself in her bedroom for the remainder of the day.

20. At approximately 12:30pm on Saturday, 12 October 2013, Vince briefly visited Ms Grant in her bedroom. He later advised police that he visited her for 30 seconds and that he observed

[3] Ibid, 207
[4] *Coronial Brief, Appendix 6 – VARE child interview,* 236-238
[5] *Coronial Brief*, Statement of Vince Grant dated 13 October 2013, 219-220
[6] *Coronial Brief*, Statement of Karen Dyball dated 13 October 2013, 208
[7] Ibid
[8] Ibid
[9] Ibid, 209

that her chest was rising and falling, which indicated to him that she was alive.[10] This is the only occasion on this day when anyone saw Ms Grant alive.

21. At approximately 12:20am on Sunday, 13 October 2013, Vince asked one of his daughters to check on Ms Grant in her bedroom. This occurred and, as a result, Vince's daughter noticed that Ms Grant was cold and not breathing. Vince called emergency services and advised them that his mother had died.[11]

22. At approximately 12:36am, paramedics attended the residence in Noble Park and upon entering Ms Grant's bedroom, they immediately became concerned over the condition of her bedroom.[12] One paramedic expressed further concern over several blood-stained injuries that were present on the Ms Grant's arms as well as a bruise on her central forehead. Both paramedics expressed concerns over the fact that Ms Grant was dressed in a heavy woollen jumper with several blankets placed over her as the weather had been quite hot during the day. As a result of these concerns police were notified and attended the scene shortly around 1:00am to commence a criminal investigation.[13]

23. On the 18 October 2013, both Vince and Ms Dyball attended the Dandenong Police Station as a result of a pre-arranged appointment. At this location they were arrested and a recorded interview was conducted.[14]

24. On 26 September 2018, Ms Dyball and Vince pleaded guilty to Reckless Conduct Endangering Life with respect to Ms Grant over the period 31 May 2012 to 13 October 2013. Vince was sentenced to 18 months imprisonment, and Ms Dyball was sentenced to 12 months imprisonment, wholly suspended for a period of two years.[15]

Identity of the deceased

25. On 12 October 2013, Vince Grant identified the body of the deceased to be his mother, Patricia Jocelyn Eve Grant born 19 April 1930.

[10] *Coronial Brief*, Statement of Vince Grant dated 13 October 2013, 219-220
[11] *Coronial Brief,* Appendix 1 – 000 transcript from 13 October 2013
[12] *Coronial Brief,* Statement of Caitlin Baile dated 7 January 2013, 161-162; Statement of Renee Mack dated 7 January 2013, 163
[13] *Coronial Brief,* Statement of Senior Constable Phoebe Coulson dated 13 January 2014, 175
[14] *Coronial Brief*, Statement of Detective Senior Constable Kane Taylor dated 12 January 2016, 198
[15] *DPP v D, K & Anor* [2018] VCC

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

Medical cause of death

27. Forensic Pathologist Dr David Ranson from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 14 October 2013 and provided a written report of his findings dated 24 April 2015.

28. Dr Ranson noted the following:

    (a) The postmortem examination revealed evidence of significant natural disease in the form of bronchopneumonia associated with significant amounts of aspirated food material in the airways. Ischaemic heart disease[16] with coronary artery atherosclerosis[17] was also present. There were also additional areas of cerebral infarction[18] identified;

    (b) Individuals who have suffered from a stroke may have difficulty with speaking and swallowing and in such situations they are vulnerable to aspirating food when being fed or when they are unable to protect their airway.

    (c) The large number of scab type lesions that were present on the body were associated with apparent small skin tears and/or abrasions. Many of these scabbed areas appeared to be encrusted with dirt having small fabric type fibres embedded within them; and

    (d) The bruising was noted to the head but this was not associated with an underlying brain injury and there was no evidence of skull fracture.

29. Toxicological analysis of post-mortem blood samples did not identify the presence of any alcohol or common drugs or poisons.

30. Dr Ranson provided an opinion that the medical cause of death was '1(a) Aspiration bronchopneumonia in a setting of cerebral infarction'.

31. I accept Dr Ranson's opinion.

[16] Ischaemic heart disease – is a condition in which the heart is starved of oxygen due to a reduced blood supply.
[17] Coronary artery atherosclerosis - is thickening or hardening of the arteries caused by a build-up of plaque in the inner lining of an artery.
[18] Cerebral infarction – this occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it.

FURTHER INVESTIGATIONS AND CPU REVIEW

Family violence investigation

32. As Ms Grant's death occurred in circumstances of recent family violence, I requested that the Coroners' Prevention Unit (**CPU**) [19] examine the circumstances of Ms Grant's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[20]

33. Ms Grant's relationship with her son, Vince, and daughter in law, Ms Dyball, met the definition of '*family member'* under the *Family Violence Protection Act 2008* (Vic) (**the FVPA**).[21] The family violence perpetrated by Vince towards Ms Grant in the form of coercive and controlling behaviour in the lead up to the fatal incident met the definition of '*family violence'* in the FVPA.

34. Elder abuse is a form of family or domestic violence that is experienced by older people. Similar to family violence, elder abuse is about one person having power and control over another person. This case evidences a prolonged period of elder abuse perpetrated by Vince and his partner, Ms Dyball against Ms Grant in the lead up to her death.

35. An in-depth family violence investigation was conducted in this case and I requested materials from several key service providers that had contact with Ms Grant and Vince and Ms Dyball prior to Ms Grant's death.

History of elder abuse and medical care

36. From at least the year 2000 through to 2009, Ms Grant regularly attended her local medical clinic in Frankston on a monthly basis but after returning to live with Vince and Ms Dyball in 2009, Ms Grant's visits to her normal GP became irregular. In the four years prior to Ms Grant's death there are only five records of attendance by her at the medical clinic she attended previously, with the last attendance being on 31 May 2012, approximately 16 months before her death. There is no evidence to suggest Ms Grant attended any other GP clinics during this period.

[19] 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.

[20] 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.

[21] Section 8(1)(c) of the *Family Violence Protection Act 2008*

37. Dr Joseph Ibrahim, an expert in geriatric medicine, examined Ms Grant following her death. He identified eight specific occasions upon which a reasonable person, carer or family member should have sought medical attention for Ms Grant during the period 2012-2013.[22] Dr Ibrahim concluded that the circumstances of Ms Grant's life in the 12 months prior to her death were consistent with severe neglect, and that there was a significant likelihood that she had experienced physical, financial, and social abuse.[23]

38. Ms Grant's GP was in the most significant position to monitor her wellbeing, and to identify and respond to indicators that she was experiencing abuse and neglect. The available evidence indicates that:

- Ms Grant had underlying medical conditions which were chronic in nature and required lifelong monitoring, management and medication[24]
- Ms Grant's GP had previously held concerns about her family physically and financially abusing her, and knew that she lived with her family and that her daughter-in-law was her primary carer[25]
- Ms Grant's GP had previously held concerns about her living conditions[26]
- Ms Grant's GP was aware of her increasing needs for care and support due to physical and cognitive impairments in the years prior to her death[27]
- Despite Ms Grant's increasing needs for care and support her attendance at the GP reduced from approximately once a month between 2000-2009, to five attendances in the four years prior to her death[28]
- Ms Grant's last GP appointment was on 31 May 2012, 16 months prior to her death. [29]

[22] Coronial brief, Independent medical opinion of J E Ibrahim, 81.
[23] Ibid, 87.
[24] Coronial brief, Independent medical opinion of J E Ibrahim, 82-83.
[25] Coronial brief, Appendix 19, Monash Medical Centre records for P Grant, 525; Coronial Brief, Appendix 13, GP records for P Grant, 413
[26] Coronial brief, Appendix 19, Monash Medical Centre records for P Grant, 525; Coronial Brief, Appendix 13, GP records for P Grant, 413
[27] Centrelink, Health professional assessment completed by N Gordon on 3 February 2006; Centrelink, Health professional assessment completed by N Gordon on 20 May 2009.
[28] Coronial brief, Independent medical opinion of J E Ibrahim,81; *DPP v D, K & Anor* [2018] VCC, 4.
[29] Coronial brief, Appendix 13, GP records for P Grant, 415.

39. The Royal Australian College of General Practitioners (**RACGP**) provided a statement to the Court about the responsibilities of GPs when older adults who have ongoing needs for medication, care and support stop attending appointments, or when their attendance reduces significantly without explanation. The RACGP stated that the Australian GP accreditation standards recommend that practices have processes in place to issue reminders for patients with chronic conditions. The RACGP noted that older people may have gaps in attending the GP for repeat prescriptions for many reasons, such as hospital admissions, and for this reason GPs do not rely on overdue prescribing to trigger clinical reviews. Instead, they stated that reminders are used '*for essential preventative and monitoring requirements'*.[30]

40. The RAGCP Standards suggest that GPs set reminders to ensure patients are invited to attend appointments to follow up test results,[31] undergo regular screenings such as those for cervical and bowel cancer,[32] and to receive relevant vaccines and immunisations.[33] The RACGP Standards state explicitly that GPs can have their information systems send out automated reminders in the form of text messages, emails or letters, and that GPs are not required to follow up when patients do not respond to reminders.[34]

41. The RACGP Standards also suggest the use of recalls – the process of requesting that a patient attend a consultation to receive further medical advice on matters of clinical significance.[35] The suggested uses of recalls in the RACGP Standards are to recall patients in relation to test results,[36] to discuss a preventative activity such as cancer screening,[37] or following a significant referral or diagnosis.[38]

[30] RACGP, statement dated 4 May 2021, 2.
[31] RACGP, *Standards for General Practices* (2021), 5th Edition, 130.
[32] Ibid, 55-56.
[33] Ibid,129.
[34] Ibid.
[35] Ibid, 173.
[36] Ibid, 126.
[37] Ibid.
[38] Ibid, 128.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death:

Elder abuse and the Victorian framework of adult safeguarding laws

42. I confirm that Victoria does not have a specialist agency or service which is mandated to investigate and respond to all allegations of abuse and neglect against older adults with needs for care and support. Whilst the RACGP clinical guides alert GPs to some of the various organisations which play a role in supporting older adults who have needs for care and support and who may be experiencing abuse, including the Office of the Public Advocate (OPA), police and Seniors Rights Victoria,[39] these agencies each have a limited role in responding to allegations of abuse.

43. The Australian Law Reform Commission (ALRC) released a report entitled *Elder Abuse – A National Legal Response* (ALRC Report) in 2017, which recommended that adult safeguarding laws similar to those in place in the United Kingdom and Canada be enacted in each state and territory in Australia. The ALRC Report recommended that these laws give adult safeguarding agencies the role of safeguarding and supporting 'at-risk adults'[40] by investigating and co-ordinating responses to allegations of abuse against them. At-risk adults are defined as people aged 18 years and over who '(a) have care and support needs; (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'.[41]

44. The ALRC Report made several recommendations as to how safeguarding agencies should investigate and respond to allegations of abuse, including actions which safeguarding agencies should take to support and protect adults who have experienced abuse.[42] The ALRC Report also recommends 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 adult safeguarding agencies.[43] Ms Grant mostly likely met the definition of an '*at-risk adult'* given her increasing care needs and apparent cognitive

[39] RACGP, *Aged Care Clinical Guide (Silver Book)*: *Part B Abuse of Older People* (2020), 5th edition, 4-5; RACGP, *Abuse and Violence: Working With our Patients in General Practice* (2014), 4th Edition, 101-102.
[40] Australian Law Reform Commission (ALRC), *Elder Abuse – A National Legal Response* (Final Report, May 2017), 377 <elder_abuse_131_final_report_31_may_2017.pdf (alrc.gov.au)>.
[41] Ibid, 387.
[42] Ibid, ch 14.
[43] Ibid, 413, 415.

impairment in the years leading up to her death, and the negative impact these factors likely had on her ability to protect herself from abuse and neglect.

45. In response to the ALRC Report the *National Plan to Respond to the Abuse of Older Australians (Elder Abuse) 2019-2023* (**National Plan**) was published in 2019. In response to the National Plan and the ALRC Report, the Victorian Government agreed to review its existing legislation relating to safeguarding and support for at-risk adults to identify gaps in safeguarding provisions.[44] The Department of Fairness, Families and Housing (**DFFH**)[45] and the Department of Justice and Community Safety (**DJCS**) indicated that this would be completed in period of 2019-2020 however in a statement provided to the Court in April 2021, the DFFH confirmed that the finalisation of this review has been delayed due to the COVID-19 pandemic.[46] DFFH indicate that the review is expected to be completed during 2021 and will provide the Victorian Government with options to consider improving Victoria's framework of adult safeguarding laws.[47]

46. I support of the Victorian Government prioritising the development and implementation of a Victorian framework of adult safeguarding laws and agencies following the DFFH and DJCS review of existing Victorian legislation relating to safeguarding and support for '*at-risk'* adults, and with regard to the recommendations made in chapter 14 of the ALRC Report.

The role of GPs in the prevention of elder abuse

47. The ongoing monitoring of patients with chronic conditions is an often overlooked gap in services provided by local GPs. In a statement provided to the Court, Ms Grant's GP indicated that he thought Ms Grant may have been attending another clinic after her last appointment on 31 May 2012 because she lived '*a long way from the surgery'*,[48] but confirmed that he had not received a request for Ms Grant's medical documentation from another doctor and that this is the normal practice for someone changing doctors.[49] Dr Joseph Ibrahim, an expert in geriatric

[44] Council of Attorneys-General, *National Plan to Respond to the Abuse of Older Australians (Elder Abuse) 2019-2023* (Report, 2019), 32 <National-plan-to-respond-to-the-abuse-of-older-australians-elder 2019.pdf (internal.vic.gov.au)>; Council of Attorney-General, *Implementation Plan to Support the National Plan to Respond to the Abuse of Older Australians 2019-2023* (2019), 27 <National Plan to respond to the abuse of older people 2019 2023 Victoria Implementation_Plan.pdf (internal.vic.gov.au)>.
[45] Then known as the Department of Health and Human Services.
[46] DFFH, Statement dated 26 April 2021, 2.
[47] Ibid, 2.
[48] Coronial brief, Statement of Ms Grant's treating GP, 101.
[49] Ibid.

medicine, examined Ms Grant after her death and confirmed that there was no apparent explanation for Ms Grant to have voluntarily ceased attending her GP for health care for her underlying medical conditions.[50] Dr Ibrahim also commented that although Ms Grant moved from Cranbourne/Carrum Downs to Noble Park in 2011, both addresses were approximately 19 minutes by car from her regular GP's surgery,[51] indicating that a change in travel time to the clinic would not explain Ms Grant's reduction in attendance.

48. A visit to the GP could be one of the few opportunities for an older person experiencing or at risk of abuse to access external help. More proactive efforts by the GP to engage with Ms Grant following her last appointment may have led to her receiving appropriate medical care, or further information about the neglect she was being subjected to becoming known to the GP.

49. There appears to be nothing within the RACGP Standards and practice guides which would have required or encouraged Ms Grant's GP to set up reminders to proactively encourage Ms Grant to regularly attend the clinic for monitoring of her chronic conditions.

50. In May 2021, Deputy State Coroner English noted in her finding into the death of Aziza Beck that the current model of care does not encourage or facilitate assertive follow-up by GPs if patients stop attending appointments. Deputy State Coroner English subsequently recommended that the RACGP consider issuing or updating practice guidelines to GPs treating patients who are prescribed psychotropic medication to incorporate a flag or alert in their patient management software systems to prompt a follow-up for patients who require a repeat script or mental health review.[52] Similarly, I note that it is important for GPs to engage in proactive clinical practice, especially when it comes to the management of older patients who discontinue care without any reasonable explanation.

51. The recent Royal Commission into Aged Care Quality and Safety[53] report contained damning stories of abuse and neglect of older people in Australia. One of the recommendations is a new online training package, funded by the Department of Health and developed for GPs and other healthcare professionals, "*Abuse of the older person: eLearning program for Health Professionals"*. The package is designed to enhance the skills of health professionals to support

[50] Coronial brief, Independent medical opinion of J E Ibrahim, 82-83.
[51] Coronial brief, Independent medical opinion of J E Ibrahim, 80.
[52] Findings for Aziza Beck COR 2017/0486, <S65KS00AAPS21050511040.pdf (coronerscourt.vic.gov.au)>, 16.
[53] *Final Report of the Royal Commission into Aged Care Quality and Safety* (26 February 2021), available online at: https://agedcare.royalcommission.gov.au/publications/final-report

older people at risk of or experiencing abuse through enhanced risk identification and referral action.

RECOMMENDATIONS

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

RACGP:

I recommend that RACGP amend the *Standards for General Practices* and the relevant RACGP clinical guides, the White and Silver Books,[54] to encourage GPs to consider taking further action to address risks to patients who do not respond to reminders in their practice management software where those patients have chronic conditions requiring ongoing monitoring and are at risk of elder abuse including neglect.

FINDINGS AND CONCLUSION

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

(a) the identity of the deceased was Patricia Jocelyn Eve Grant, born 19 April 1930;

(b) the death occurred between 12-13 October 2013 at 60 Jellicoe Street, Noble Park, Victoria from 1(a) Aspiration bronchopneumonia in a setting of cerebral infarction; and

(c) the death occurred in the circumstances described above.

54. Having considered all the available evidence, I am satisfied that no further investigation is required in this case.

55. I convey my sincere condolences to Ms Grant's family for their loss.

56. 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.

[54] RACGP, *Abuse and Violence: Working With our Patients in General Practice* (2014), 4th Edition; RACGP, *Aged Care Clinical Guide (Silver Book)*: *Part B Abuse of Older People* (2020), 5th edition.

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

Mr Vincent Grant, Senior Next of Kin

Mr Anthony Plummer, Executive Director, Fairer Victoria

Dr Anita Muñoz, Chair, Royal Australian College of General Practitioners

Ms Eleri Butler, CEO, Family Safety Victoria

Detective Sergeant Tim Bell, Homicide Squad, Victoria Police

Detective Senior Constable Kane Taylor, Coroner's Investigator

Signature:

JUDGE JOHN CAIN

STATE CORONER

Date: 3/1/2022

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.