IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 007440

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:	CWQ
Date of birth:	[redacted]
Date of death:	Between early-August 2022 and 28 December 2022
Cause of death:	1(a) Unascertained
Place of death:	[redacted]
Keywords:	Adult safeguarding; care and support needs; mental ill-health; unascertained cause of death

INTRODUCTION

1. On 28 December 2022, CWQ was 74 years old when his remains were discovered at his home in a suburb of Melbourne, Victoria. CWQ lived in a unit provided by the Department of Families, Fairness and Housing (**DFFH**) with his sister, JYT, at the time of his passing.

2. CWQ had a significant history of mental ill-health, dating back to at least 1995. He was diagnosed with delusional disorder and social phobia and reported strongly held beliefs involving conspiracy theories with multiple government agencies. He believed that the government was watching him via cameras and wanted to harm him. He had a significant mistrust for many services including Centrelink (Services Australia), landlords and health services.

3. CWQ and JYT lived together for many years prior to the fatal incident. While CWQ appeared to heavily rely on his sister for care and support, it appears that JYT had her own care and support needs. JYT also struggled with engaging services. For example, in 2005 when the Office of the Public Advocate (**OPA**) applied for permanent housing for the pair, they noted that CWQ was at significant risk of physical neglect and that he was "*passively restrictive*", preferring to allow JYT to "*act in both their interests*". The OPA further noted that despite JYT's own needs, she provided CWQ with important support and without this, CWQ's mental health would have likely deteriorated.

4. CWQ did not have a phone, and he did not have any Medicare or Pharmaceutical Benefits Scheme (**PBS**) claims, suggesting that he did not have a general practitioner. While CWQ had a bank account, he did not access it regularly and it is unclear how he purchased food and other necessities.

THE CORONIAL INVESTIGATION

5. CWQ'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.

6. 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.

7. 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.

8. Victoria Police assigned Sergeant Darcy Spence to be the Coronial Investigator for the investigation of CWQ'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.

9. 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.

10. This finding draws on the totality of the coronial investigation into the death of CWQ 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

11. On 27 January 2023, Coroner David Ryan made a formal determination identifying the deceased as CWQ, born [redacted], via the police report of death, preliminary examination form and initial family contact log.

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

Medical cause of death

13. Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 3 January 2023 and provided a written report of his findings dated 6 April 2023.

[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. The post-mortem examination revealed extensive decomposition changes with maggots and extensive loss of tissue, particularly around the lower half of the body where the bones are exposed with no covering of subcutaneous or muscular tissue. There were no residual internal organs able to be examined.

15. The head was covered with a greenish-coloured beanie, with facial bones and skull exposed. Under the body was a layer of black plastic, with clothing remnants seen on the upper half of the body. After removal of the clothing, there was marked fragmentation of the bony elements of the body. No non-decomposed injuries were identified.

16. A full body CT scan did not identify any skeletal injuries.

17. No toxicology samples were available for analysis.

18. Dr Bedford provided an opinion that the medical cause of death was 1(a) Unascertained.

19. I accept Dr Bedford's opinion as to the medical cause of death.

Circumstances in which the death occurred

20. On 9 May 2022, a State Trustees (**ST**) employee (who managed CWQ's financial affairs) was liaising with the support service GenU on another matter. The ST employee asked if GenU might be able to assist with CWQ's case. GenU advised that they would attempt "*assertive outreach* to try and locate CWQ.

21. On 19 May 2022, a GenU worker attended CWQ's home. She reported back to ST that she knocked on the door but did not receive a response. She noted that the home was in squalor and that there was a significant smell emanating from inside the home.

22. On 6 September 2022, DFFH attended CWQ's home with a 'Notice to Enter', however CWQ was not home so they left a calling card. DFFH representatives observed a significant number of belongings at the home and documented safety concerns.

23. On 15 September 2022, an ST employee contacted DFFH regarding legal options to enter CWQ's home. DFFH advised that they did not have any legal rights to enter CWQ's home without an order from the Victorian Civil and Administrative Tribunal (**VCAT**). DFFH advised ST that if they were concerned about CWQ's welfare, that Victoria Police *did* have the right to enter and that they could call police for assistance. DFFH further noted that they had issued a 'Notice to Enter' earlier that month, but they did not receive any contact from

CWQ in response. ST requested DFFH arrange urgent access to CWQ's property with the assistance of Victoria Police.

24. DFFH contacted Geelong Police Station and requested a welfare check for CWQ. Two members attended CWQ's home and knocked on the door but did not receive a response. The members spoke to a neighbour who advised they had seen JYT about three days earlier but had not seen CWQ for about a month.

25. On 16 September 2022, DFFH advised ST that they had issued a 'Notice to Enter', scheduled for 28 September 2022. DFFH advised ST that if they were unable to gain access on that occasion, the next step would be to make an application to VCAT to seek an order to enter the property. DFFH also suggested that ST could contact Victoria Police to request a welfare check.

26. DFFH representatives returned to CWQ's home on 28 September 2022 with a 'Notice to Enter'. DFFH did not sight CWQ, and no one answered the door. The representatives left a calling card and a copy of the 'Notice to Enter' at the door, then walked down the street to speak to some neighbours. After speaking to the neighbours, the DFFH representatives walked back past CWQ's home and observed that the 'Notice to Enter' and the calling card had been removed from the front door, however they did not sight anyone in or around CWQ's home.

27. On 17 October 2022, ST contacted DFFH and requested an update on the recent 'Notice to Enter'. DFFH confirmed that they did not gain access to the property and that there was a process that they needed to follow (via VCAT) to gain access to the property.

28. On 20 October 2022, ST contacted DFFH and asked about the timeframes for gaining access to the property and what was involved in the process.

29. On 15 December 2022, ST contacted DFFH, to follow up on their 20 October email. The next day, DFFH contacted ST and advised that they were awaiting a hearing date at VCAT. ST corresponded with Victoria Police for assistance and spoke to a member they previously spoke to in 2021 regarding a welfare check.

30. On 28 December 2022, ST spoke to Victoria Police again and requested another welfare check. When police attended CWQ's home, no-one answered the door, so police forced entry to the property via a boarded-up bathroom window. The attending members noted that the home was in a state of extreme squalor, with belongings and rubbish piled from the floor to the ceiling. The house was also littered with faecal matter, urine and cobwebs.

31. Once police were inside the property, JYT made herself known to police, however she was uncooperative and erratic. JYT told police that she did not live at that house, that she lived in Melbourne and that this home was used as a storage facility only. She stated that she lived alone, that she did not know a 'CWQ' and that she did not have a brother. Police arrested her as she had an outstanding warrant.

32. After JYT was removed from the property, police searched the property and located human remains in one of the bedrooms, lying on what appeared to be a sheet of black plastic, a green beanie on his head and he was covered with a blanket. The remains were significantly decomposed. The members who originally attended called for detectives to attend, given the unusual circumstances. When detectives arrived on scene, they were required to climb over the numerous piles of rubbish to access the bedroom where the remains were located.

33. Once JYT arrived at the Police Station, police attempted to speak to her, however they formed the view that she was severely mentally unwell and did not take a statement from her. Police consulted with the Barwon Health mental health team and released her into their care. Police have since been unable to locate JYT to speak to her in relation to her brother's passing. Police did not identify any suspicious circumstances in connection with CWQ's death, noting that the results of the autopsy were unascertained.

FURTHER INVESTIGATIONS AND CPU REVIEW

34. Given the circumstances of CWQ's death, this case was referred to the Coroner's Prevention Unit (**CPU**)[2] as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[3]

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

[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.

36. 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 CWQ and JYT to assist in identifying any areas of practice improvement and to ensure that any future prevention opportunities are appropriately identified and addressed.

Barwon Health

37. CWQ received treatment from Barwon Health mental health services from 2004 to 2009, with their last contact in 2017.

38. In 2004, CWQ was evicted from the caravan park where he was residing at the time with sister, and he was admitted to the Acute Psychiatric Admission Unit at University Hospital Geelong (**UHG**) for 26 days. During this admission, CWQ believed that he was under surveillance by government agencies who wanted to harm him. UHG staff placed him on a Compulsory Treatment Order (**CTO**) and prescribed depot antipsychotic medication.

39. UHG staff also applied to VCAT for the appointment of an administrator over CWQ's estate, given he was unable to engage in services such as Centrelink, he was homeless, he had no income, and he relied on his sister for support (despite JYT having her own difficulties with engaging services).

40. CWQ also experienced an involuntary mental health admission in June 2005.

41. In January 2008, CWQ was discharged from the CTO after replacing his depot medication with an oral antipsychotic medication. His mental health was stable at the time, and Barwon Health mental health services discharged him with an 11-month supply of medication in 2009.

42. DFFH contacted Barwon Health in 2011 after they unsuccessfully tried to access his home for necessary maintenance. Barwon Health staff attempted to visit CWQ twice in May 2011; however, CWQ did not answer the door. Following discussions with DFFH, Barwon Health closed his case.

43. Barwon Health clinicians attended CWQ's home in 2017 with DFFH staff and police. They concluded that although CWQ was guarded and superficial in his engagement, there was no evidence of an acute mental illness. CWQ declined all offers of support from the service, and

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

Barwon Health determined that there was no role for mental health services at the time. This was Barwon Health's last contact with CWQ.

Office of the Public Advocate

44. In 2004, VCAT appointed the OPA as CWQ's guardian to make decisions about his accommodation. In 2005, the OPA successfully applied for permanent housing for CWQ and his sister, and the Guardianship Order was revoked later that year.

State Trustees

45. In 2004, VCAT appointed ST as the administrators of CWQ's estate, and they remained in this role until his passing. ST only met with CWQ once, on 23 September 2004. They made numerous attempts to contact him again to arrange another meeting, however he did not respond and there was no further contact.

46. In 2004, ST applied for the Disability Support Pension (**DSP**) on CWQ's behalf and opened a bank account for him. ST deposited money into this account weekly. In 2005, CWQ's Barwon Health case manager called ST to advise that CWQ was not accessing the funds in his bank account and to discuss whether ST should cease his payments. These payments were briefly ceased in March 2005 but were recommenced in August 2005. The payments continued until 2016 and increased gradually over time. It does not appear CWQ's bank account was monitored during this time to determine whether he was using his payments.

47. In September 2016, DFFH contacted ST regarding concerns for CWQ's welfare, and ST reportedly advised that they had not spoken to CWQ in more than four years. ST agreed to obtain CWQ's bank records to see if he was using his account. ST received these records in October 2016 and found that CWQ never accessed his account. ST subsequently removed most of the money from that account, pursuant to their policies, and reinvested it. They also decreased CWQ's weekly payment to $100. The $100 payments continued until April 2017, when ST ceased the payments as CWQ was still not accessing the funds.

48. In November 2016, ST contacted DFFH and advised that CWQ's gas bills showed no gas usage. Meanwhile, VCAT reassessed CWQ's Administration Order and encouraged ST to contact CWQ to establish whether he needed a higher level of support. ST referred CWQ to their Intensive Support Program (**ISP**), which made multiple attempts to contact CWQ, including by requesting police welfare checks, attending his home and consulting with

Barwon Health. ISP were unable to contact CWQ and discharged him from the program in February 2020 due to his lack of engagement.

49. In March 2019, DFFH advised ST that CWQ's rental account had fallen into arrears. ST reportedly advised DFFH that they would investigate, that they were concerned about "*how CWQ is managing to purchase food to survive*" and that they would contact him. There are no further details available about this contact in the records provided to the Court.

50. ST requested welfare checks from Victoria Police at various times over the years of their engagement and communicated concerns about CWQ to DFFH. However, the records provided to the Court indicate that after requesting a police welfare check in April 2017, ST did not request any further welfare checks or communicate any further concerns to DFFH until May 2021. All ST's subsequent attempts to contact CWQ were "*unsuccessful in confirming his welfare or whether he was alive*".

51. On 25 May 2021, ST internally transitioned CWQ to their Specialised Support Team (**SST**). The SST was established in 2020 in response to recommendations made by the Victorian Ombudsman's investigation into ST and was designed to provide individualised support and case management to clients with multiple and complex needs.

52. ST communicated with DFFH between May and July 2021 about DFFH's plans to visit CWQ at home, and about ST's concerns about CWQ potentially no longer living at the home (due to the low to no use of utilities). In September 2021, ST contacted police to ascertain whether they had had any contact with CWQ. Police attempted a welfare check at CWQ's home; however, no one answered the door.

53. On 14 September 2021, ST contacted the disability service GenU to enquire about whether they could assist with engaging CWQ. ST left a voice message but did not speak to GenU until May 2022 (as noted above). GenU attempted a home visit on 19 May 2022, however CWQ did not answer the door and found the "*house was in squalor and that there was a significant smell coming from inside*". It does not appear that ST had any further contact with GenU in relation to CWQ.

54. It is not clear what ST did from May to 15 September 2022, when they contacted DFFH requesting that DFFH urgently access CWQ's home with police due to various concerns. These concerns included that CWQ had not accessed his bank account since May 2017, that GenU visited the property in May 2022 and noted mould "*surrounding the exterior*" of the

house, and a strong smell coming from the house. ST followed up with DFFH on 17 October and 15 December 2022, and requested a further welfare check on 28 December 2022, which led to the discovery of CWQ's remains.

Department of Families, Fairness and Housing

55. As noted above, CWQ and JYT moved into the unit (owned by DFFH[5]) in May 2005. From 2006 to 2017, staff from DFFH attempted to visit CWQ many times in relation to rental arrears, maintenance issues, issues with utilities (including utilities not being connected to the house), concerns about the state of the home and for welfare checks. These visits were largely unsuccessful, as CWQ and his sister rarely engaged or answered the door.

56. In April 2017, DFFH staff and police attended CWQ's home to execute an eviction notice. The eviction notice was issued due to CWQ and his sister's refusal to permit DFFH access to the home to complete urgent maintenance. Following this visit, CWQ and his sister agreed for the works to be completed. At this time, the home had no access to water, gas or electricity and it was reportedly in a state of "*squalor*". However, CWQ and JYT improved the state of the home and allowed the maintenance works to be performed.

57. DFFH representatives last sighted CWQ on 15 May 2017 when they attended his home. DFFH representatives attempted to visit CWQ and enter the property on several occasions between May and September 2017 due to complaints about rubbish outside the home, however no-one answered the door. After September 2017, it does not appear that DFFH made any further attempts to visit the home until July 2021.

58. On 1 July 2021, DFFH representatives attempted a home visit with CWQ, however no-one answered the door. DFFH indicated an intention to issue of 'Notice of Breach' on CWQ, however it is unclear whether this was ever issued based on the records available to the Court.

59. After the July 2021 visit, it does not appear that DFFH made any further attempts to visit CWQ until 6 September 2022 when DFFH representatives attended his home with a 'Notice to Enter'. This was followed by a further home visit on 28 September 2022 with another 'Notice to Enter'. In correspondence between DFFH and ST from October to December 2022, DFFH indicated that they were following their usual process to obtain an order from VCAT to enter the property. Beyond this correspondence, it is unclear what steps DFFH took to

[5] I note that at various times time, public housing in Victoria was administered by the Office of Housing, Department of Health and Human Services (**DHHS**) and DFFH. For simplicity, I have referred to these various offices/departments as DFFH, as it is currently known.

obtain the VCAT order, although they advised ST in December 2022 that they were awaiting a hearing date.

Victoria Police

60. Victoria Police were called to perform welfare checks on CWQ and his sister on numerous occasions. The last sighting of the pair by Victoria Police was on 21 April 2017, when they attended a home visit with DFFH. Before that, Victoria Police sighted both CWQ and JYT on 11 January 2016. At that time, police spoke to CWQ and JYT via their flyscreen front door, and both said they were "*fine*" and wanted to be left alone. Police attempted various other welfare checks after this occasion, however, were unable to sight either CWQ or JYT.

Systemic issues

61. From a review of the various services involved with CWQ and his sister, it is clear that various attempts were made over several years to engage with the pair and link them with support services, however these were largely declined. There was some collaboration between organisations, however 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.

Adult safeguarding explanation

62. Broadly, adult safeguarding means protecting the rights of adults to live in safety, free from abuse and neglect.[6] 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.[7] At-risk adults are defined as people aged 18-years-old and over, who:

    a) have care and support needs;[8] and

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

[6] 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)>.

[7] 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)>.

[8] 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.[9]

63. Adult safeguarding is important because people with a disability are more likely to experience violence, abuse, and neglect than people without a disability,[10] often from people on whom they depend 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]

64. 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.[14] A specialised response to reports of abuse and neglect of at-risk adults is therefore required.

65. 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

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[9] 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).

[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 <National Elder Abuse Prevalence Study: Final Report (aifs.gov.au)>.

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

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

d) facilitating decision-making support for at-risk adults

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

f) reporting the abuse to the police

g) applying for an intervention order in relation to the person allegedly causing harm to the at-risk adult[15].

Victoria's adult safeguarding provisions

66. 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'.[16]

67. 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.[17] 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.[18]

68. 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.'[19] This complex system also makes it 'very difficult for third parties who are concerned about an at-risk adult experiencing abuse to know

[15] 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.
[16] OPA, *Line of Sight: Refocussing Victoria's Adult Safeguarding Laws and Practices* (Review, 18 August 2022) 13.
[17] Ibid 47.
[18] Ibid 48
[19] 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.[20]

69. 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.[21]

Adult safeguarding in relation to CWQ and JYT

70. CWQ may have met the criteria for an adult safeguarding response, given that he had complex needs for care and support relating to his mental health, he was at risk of self-neglect and his needs for care and support may have prevented him from accessing the support required to address this risk. Similarly, JYT appeared to have her own complex needs for care and support and may not have had the capacity to provide CWQ with the level of care and support that he required.

71. Safeguarding responses can be initiated when there are concerns for neglect or self-neglect. As noted above, multiple services held concerns for CWQ's welfare which indicated that he may have been at risk of harm due to self-neglect. Available records suggested that CWQ relied on his sister for many years prior to his passing, however she was likely unable to meet these needs. She appeared to be acutely mentally unwell when police located CWQ's remains, and it is unclear how long she was experiencing this condition.

72. Victoria Police, DFFH and ST all held significant concerns for CWQ's health and safety over several years. These concerns appear to have escalated in the months prior to the discovery of his remains, with ST requesting multiple welfare checks, and DFFH attempting to access the home on several occasions. ST also sought support for CWQ via GenU. However, they were unable to take further action when CWQ did not answer the door to GenU staff in May 2022.

73. If an adult safeguarding agency/mechanism were available, any of the above agencies could have made a report regarding CWQ. I note that CWQ appeared to be a very private person who was diagnosed with multiple mental health conditions that manifested in a distrust of

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

[21] 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.

services. However, I also note the circumstances in which he passed, particularly where JYT continued to live at the property with his remains, potentially for several months, until police located the remains. This indicates that both parties may have suffered in the period proximate to CWQ's death. An adult safeguarding mechanism may have been able to investigate CWQ's risk of self-neglect, and to coordinate with services to assess risk and implement multi-disciplinary risk management strategies.

Previous adult safeguarding cases and discussion

74. CWQ's case is not the first case before this Court where an adult safeguarding mechanism/response may have been beneficial. Former State Coroner, Judge Cain, extensively canvassed the issue of adult safeguarding in several findings handed down in 2025, including the deaths of CFT[22], William Heddergott[23], MHT[24], YTR[25], DRF[26], JZA[27], JNY[28], TBL[29]

75. In Judge Cain's finding into the death of CFT, his Honour recommended (amongst other recommendations):

> 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,*

[22] Finding into death without inquest – CFT (COR 2020 4205).
[23] Finding into death without inquest – William Heddergott (COR 2020 6253).
[24] Finding into death without inquest – MHT (COR 2022 4511).
[25] Finding into death without inquest – YTR (COR 2020 6157).
[26] Finding into death without inquest – DRF (COR 2022 0022).
[27] Finding into death without inquest – JZA (COR 2022 4946).
[28] Finding into death without inquest – JNY (COR 2023 3518).
[29] Finding into death without inquest – TBL (COR 2023 3101).

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.*[30]

76. In response to his Honour's recommendations in CFT, the Department of Families, Fairness and Housing (**DFFH**) advised that it had taken all of 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.

77. 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.

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

79. I remain concerned that that without a comprehensive adult safeguarding framework in Victoria, vulnerable adults such as CWQ (and their carers/families/professionals) have no centralised avenue to seek advice or raise concerns. In my recent finding into the death of JZA, I reiterated Judge Cain's recommendations 4 to 10.[31]

80. 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

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

the Victorian Auditor-General's Office (**VAGO**) report, *Guardianship and Decision-Making for Vulnerable Adults*, which was tabled in May 2024. The VAGO report made 10 recommendations to the OPA and three recommendations to the OPA and DJCS jointly. The recommendations included improving the OPA's documentation, how it engages with clients, its training and guidance for staff, how it collects and uses data, and its planning and oversight. These recommendations have been accepted or accepted in principle, and implementation is underway.

81. 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.

82. 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).

83. DFFH also responded to my recommendations in JZA by reiterating the response[32] it provided to Judge Cain's finding into the death of CFT. Since DFFH's response to CFT, it further advised that the Victorian Government introduced the Social Services Regulation Amendment (Child Safety, Complaints and Workers Regulation) Bill 2025 into Parliament. The Bill sought to increase protections for children and people with disability and to merge the functions of the Victorian Disability Worker Commission and Disability Services Commissioner with the Social Services Regulator, simplifying disability regulation and creating a 'one stop shop' for users of state-funded disability services.

84. 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

[32] DFFH's response to recommendations, 2 June 2025, https://www.coronerscourt.vic.gov.au/sites/default/files/2025-07/2020%204205%20Response%20to%20recommendations%20from%20DDFH_CFT.pdf.

(i.e., the NDIS) or those who do not receive any state-funded disability services, such as CWQ. 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.

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

Procedural fairness responses

86. As a matter of procedural fairness, the Court wrote to DFFH, ST and JYT, to provide them with an opportunity to respond to potentially adverse comments within the finding.

87. DFFH advised that on the basis that my finding intended to discuss the topic of adult safeguarding, in line with other recent findings, they did not wish to file any submissions. ST similarly advised that it also did not wish to file a response.

88. Finally, the Court wrote to JYT at her last known address and invited her to contact the Court and/or file a response to the potentially adverse comments. JYT did not file a response.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was CWQ born [redacted];

    b) the death occurred between early-August 2022 and 28 December 2022 at [redacted], from unascertained causes; and

    c) the death occurred in the circumstances described above.

I convey my sincere condolences to CWQ's family for their loss.

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

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:

JYT, senior next of kin

Barwon Health

Department of Families, Fairness and Housing

Department of Justice and Community Safety

Department of Premier and Cabinet

State Trustees

The Hon. Lizzie Blandthorn, Minister for Disability

Sergeant Darcy Spence, Coronial Investigator

Signature:

Judge Liberty Sanger, State Coroner

Date: 09 June 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.