

# A TALE OF TWO INQUESTS: A VULNERABILITY ANALYSIS OF CORONIAL INQUESTS IN TWO CASES OF ELDER NEGLECT

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## Abstract

This article analyses the findings of two 2018 Australian coronial inquests: the first into the death by neglect of Marcia Clark in the state of New South Wales,<sup>1</sup> the second the manslaughter of Janet Lois Mackozdi in Tasmania.<sup>2</sup> Applying vulnerability theory to the context-specific situation of a coronial inquest into the death of an older person who has been neglected, may help to inform safeguarding policies by highlighting a specific vulnerability or combinations of vulnerabilities that should trigger State intervention. This article seeks to explore whether vulnerability theory could therefore contribute to improvements in how the deaths of older people are investigated and reported by Coroners.

Part one of the paper outlines the existence and causes of extreme neglect leading to the death of older persons and views these situations through the lens of vulnerability theory. In the second part of the paper, two Australian coronial inquests into the deaths of older women are examined, to assess whether vulnerability theory might provide a useful framework for the application of Coronial powers and to suggest reforms to Australian Coronial law.

## I ELDER ABUSE AND NEGLECT AND CORONIAL POWERS

Elder abuse is currently a hot topic in Australia and has been the subject of many State and national inquiries.<sup>3</sup> A recently completed Australian Law Reform Commission Inquiry has been followed up with a Royal Commission into Aged Care,<sup>4</sup> prompted in part by a media investigation into abuse in the sector that included secretly filmed footage of care workers abusing elderly residents.<sup>5</sup> Whilst abuse in care should absolutely be investigated and exposed, the numbers of older people living in care as a percentage of the overall older

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<sup>1</sup> *Inquest into the Death of Marcia Clark*, NSW Coroners Court 30 May 2018, 2014/216538 (*Clark Inquest*)

<sup>2</sup> *Janet Lois Mackozdi*, (2018) TASCDC 274. (*Mackozdi Inquest*)

<sup>3</sup> Disability Services and Domestic and Family Violence Prevention Committee Communities, *Inquiry into the Adequacy of Existing Financial Protections for Queensland's Seniors* (Report 2, Parliament of Queensland, August 2015); NSW Ombudsman *Abuse and Neglect of Vulnerable Adults in NSW - The Need for Action* 2018 <[https://www.ombo.nsw.gov.au/\\_\\_data/assets/pdf\\_file/0003/62139/Abuse-and-neglect-of-vulnerable-adults-in-NSW-November-2018.pdf](https://www.ombo.nsw.gov.au/__data/assets/pdf_file/0003/62139/Abuse-and-neglect-of-vulnerable-adults-in-NSW-November-2018.pdf)>; Mike Clare, Barbara Black Blundell and Joseph Clare, *Examination of the Extent of Elder Abuse in Western Australia* (Crime Research Centre, The University of Western Australia, 2011); General Purpose Standing Committee No. 2, New South Wales Parliament, Legislative Council *Elder Abuse in New South Wales* (Report No. 44, , 2016); *Australian Law Reform Commission, Elder Abuse - A National Legal Response* (2017); Adam Dean, *Elder Abuse: Key Issues and Emerging Evidence* (Child Family Community Australia, 2019); *Rae Kaspiw, Rachel Carson and Helen Rhoades, Elder Abuse: Understanding Issues, Frameworks and Responses Australian Institute of Family Studies*, Research Report 35 (2016).

<sup>4</sup> Australian Law Reform Commission, *Elder Abuse - A National Legal Response* Report 131, (2017); *Royal Commission into Aged Care Quality and Safety* (8 October, 2018); Parliament of Western Australia, *Inquiry Into Elder Abuse* (13 September 2018).

<sup>5</sup> Australian Broadcasting Commission, “*Who Cares?*”, 4 Corners (17 September) 2018).

population is in decline.<sup>6</sup> Decades of policies aimed to encourage older Australians to ‘Age in Place’ has led to increasing numbers of people either living alone or being cared for by relatives. When those relatives themselves have special needs and are particularly vulnerable, or if they are motivated more by their own needs than concern for the older person, the conditions for abuse and/or neglect may blossom. These cases are notoriously difficult.

In Australia, tragic examples of self-neglect or neglect by a carer or family member leading to the death of an older person appear to be rare,<sup>7</sup> although previous examples of elder death following neglect at home have led to criminal charges in some situations.<sup>8</sup> When these deaths do occur, they inevitably raise fraught questions of responsibility: Should the State have done more to intervene? How do we ensure safeguarding of vulnerable older people whilst avoiding paternalism?<sup>9</sup> What is the threshold for intervention? The balancing act between an older person’s rights to make their own decisions and their right to be safeguarded from abuse is a difficult one.<sup>10</sup> Seldom does the inquiry into the cause of death extend to community and institutional responsibility or the contribution of our ageist systems. Applying vulnerability theory to these situations may help us to rethink their causes and highlight points of intervention.

### *A Reporting Deaths of the Aged*

In Australia, Coroner’s courts are state-based and exhibit some variations in the underlying legislation, and there is a knowledge gap in how Coroners investigate and report suspicious

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<sup>6</sup> Australian Institute of Health and Welfare, *People Using Aged Care* (2018) <[https://www.gen-agedcaredata.gov.au/www\\_aihngen/media/2017-Factsheets/People-using-aged-care-factsheet-2016%E2%80%9317.pdf](https://www.gen-agedcaredata.gov.au/www_aihngen/media/2017-Factsheets/People-using-aged-care-factsheet-2016%E2%80%9317.pdf)> (accessed 15 March 2019).

<sup>7</sup> Research in the United States suggests that death from neglect is under-reported. See for instance; *Laura Mosqueda and Aileen Wiglesworth, Coroner Investigations of Suspicious Elder Deaths* (US Department of Justice, 2012).

<sup>8</sup> See for instance *R v Miller* [2011] QCA 160 in which Agnieszka Alojza was charged with manslaughter for a failure to summon help for her mother. The Court in that instance acknowledged Agnieszka’s psychological impairment stemming in part from a deprived upbringing and difficult relationship with her mother but held that [13] ‘One may venture to think that in every case of neglect by a child of a parent, or of an elderly parent by a child, some psychological maladjustment will be present. Well adjusted, psychologically normal adults are unlikely to watch their children or their parents wither to the point of death. Such cases as there are show that ignorance and good intentions which might accompany psychological maladjustments, do not outweigh the need for general deterrence and denunciation.’ See also *R v Pryczak* [2011] VSC 219; *R v George* [2004] NSWCCA 247; *In the matter of an inquest into the death of Cynthia Thoresen* [2013] Coroner’s Court Brisbane 2009/3 (22 May 2013); *Re Inquest into the Death of Maria Carmel Niceforo* [2016] WACorC 202/2014.

<sup>9</sup> Wendy Lacey, ‘Neglectful to the Point of Cruelty?’ *Elder Abuse and the Rights of Older Persons in Australia* (2014) 36(1) *Sydney Law Review* 99, 104.

<sup>10</sup> See for instance the recent UK case, *Southend-On-Sea Borough Council v Meyers* [2019] EWHC 399 (Fam) (20 February 2019) in which the High Court ordered that a 98-year-old man should be prevented from returning to live with his son. See also the South Australian Supreme Court decision; *BC v The Public Advocate & Ors* (2018) SASC 193.

or unexpected deaths.<sup>11</sup> Concerningly, age can be a factor that prevents the reporting and investigation of suspicious or preventable deaths in New South Wales, where 72 is the arbitrary age above which a medical practitioner may choose to issue a death certificate rather than make a report to the Coroner.<sup>12</sup> This law may serve to help mask neglect through underreporting of deaths.

Because deaths by neglect occur in private, it can be difficult to determine the factors that contribute to the death and easy to blame the individual, family or carers, without consideration of institutional factors. As the NSW Ombudsman recently noted, while the state may lead the way in mandatory reporting of abuse in care homes, ‘there is horrendous abuse occurring in family homes....’<sup>13</sup> requiring an urgent imperative to introduce adult safeguarding measures and regulatory reform.<sup>14</sup>

It is for this reason that Coronial inquests take on significance. Coronial inquests can lay bare the failures of carers, the community or institutions that may cause, or fail to prevent an older person’s death.<sup>15</sup> Alternatively Coronial inquests may highlight the need for reforms in laws, policy or procedures.<sup>16</sup> Coroners exercise important powers to interrogate the causes of deaths and to recommend future action to prevent deaths.<sup>17</sup> Where a particular group of people may be at risk, Death Review Teams operating either inside the Coroner’s office or as part of multi-agency teams, may be formed to research and report upon the systemic and

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<sup>11</sup> David Studdert and Stephen Cordner, 'Impact of Coronial Investigations on Manner and Cause of Death Determinations in Australia, 2000-2007' (2010) 192(8) *Medical Journal of Australia* 444.

<sup>12</sup> *Coroners Act 2009* (NSW) s38 (2): (2) Despite subsection (1), a medical practitioner may give a certificate as to the cause of death of a person if the medical practitioner is of the opinion that the person:

- (a) was aged 72 years old or older, and
- (b) died in circumstances other than in any of the circumstances referred to in paragraphs (b)–(f) of the definition of reportable death in section 6 (1) or in section 23 or 24 (1), and
- (c) died after sustaining an injury from an accident, being an accident that was attributable to the age of that person, contributed substantially to the death of the person and was not caused by an act or omission by any other person.

<sup>13</sup> 'Abuse and Neglect of Vulnerable Adults in NSW - the Need for Action' (NSW Ombudsman, 2018) <[https://www.ombo.nsw.gov.au/\\_\\_data/assets/pdf\\_file/0003/62139/Abuse-and-neglect-of-vulnerable-adults-in-NSW-November-2018.pdf](https://www.ombo.nsw.gov.au/__data/assets/pdf_file/0003/62139/Abuse-and-neglect-of-vulnerable-adults-in-NSW-November-2018.pdf)>, Forward. (accessed 25 August 2019).

<sup>14</sup> *Ibid*, 34.

<sup>15</sup> Catherine Anne Sharp, Jennifer Sarah Schulz Moore and Mary-Louise McLaws, 'The Coroner’s Role in the Prevention of Elder Abuse: A Study of Australian Coroner’s Court Cases Involving Pressure Ulcers in Elders' (2018) 26(2) *Journal of Law and Medicine* 494, 500.

<sup>16</sup> *Ibid*; G Aitken et al, 'Coroners’ Recommendations for Prevention of Resident Deaths in Aged Care: The Role of Primary Care Providers' (2018) 47 *Australian Journal of General Practice* 315.

<sup>17</sup> *Coroners Act 2009* (NSW) s 82 (1) “A coroner (whether or not there is a jury) or a jury may make such recommendations as the coroner or jury considers necessary or desirable to make in relation to any matter connected with the death, suspected death, fire or explosion with which an inquest or inquiry is concerned.”

institutional causes of deaths,<sup>18</sup> though there is currently no systemic investigation of suspicious elder deaths in Australia. It is therefore vitally important that Coroners report on all potential causes of an elder's deaths, so that systemic causes can be identified and addressed.

### B *Vulnerability Theory*

Failures to report the causes of suspicious or preventable deaths in older people may occur because of ageism. Old age is often viewed paradigmatically as a life-stage characterised by declining physical and cognitive health and older people identified as a class or subject group in which their old age is equated with incapacity. The role of carers, the community and the state in contributing to the vulnerability of an older person may be ignored. Incapacity and death in old age may therefore be viewed as no more than inevitable, with little thought to the value of life in older age or to how premature deaths of the elderly may be prevented.

According to vulnerability theorist Martha Fineman, our lives are characterised by 'the inescapable interrelationship and interdependence that mark[s] human existence.'<sup>19</sup> This world view resonates in any discussion about elder neglect, because in old age, many of us will rely on others to meet some or all of our care needs. The sources of vulnerability for older people are varied. For some older people, cognitive or physical impairments can strain a person's usual family and social supports.<sup>20</sup> These disruptions to family can impact further on the older person's wellbeing.<sup>21</sup> A person who experiences impairment without any family support or within a family riven with conflict, is differently vulnerable to a person who is well supported. A person with an impairment who cannot afford high levels of care will be

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<sup>18</sup> See for instance the work of the Australian Domestic and Family Violence Death Review Network in Australia which was established in 2011 as an initiative of state and territory death review processes and is endorsed by all state and territory Coroners and the Western Australian Ombudsman: <[http://www.coroners.justice.nsw.gov.au/Pages/Publications/dv\\_annual\\_reports.aspx](http://www.coroners.justice.nsw.gov.au/Pages/Publications/dv_annual_reports.aspx)>. See also the Child Death Review Team: <<https://www.ombo.nsw.gov.au/what-we-do/coordinating-responsibilities/child-death-review-team>>.

<sup>19</sup> Martha Fineman, "'Elderly" as Vulnerable: Rethinking the Nature of Individual and Societal Responsibility' (2013) 20(2) *Elder Law Journal* 71, 71.

<sup>20</sup> Linda Lindsey Davis, 'Family Conflicts Around Dementia Home-Care' (1997) 15(1) *Families, Systems, & Health* 85; C. Peisah, H. Brodaty and C. Quadrio, 'Family Conflict in Dementia: Prodigal Sons and Black Sheep' (2006) 21(5) *International Journal of Geriatric Psychiatry* 485; Hilde Lindemann, 'Holding One Another (Well, Wrongly, Clumsily) In a Time of Dementia' (2009) 40(3-4) *Metaphilosophy* 416; Annika Kjallman Alm, Ove Hellzen and Karl-Gustaf Norgergh, 'Experiences of Family Relationships When a Family Member Has Dementia' (2014) *Open Journal of Nursing* .

<sup>21</sup> Sara Qualls, 'Therapy with Aging Families: Rationale, Opportunities and Challenges' (2000) 4(3) *Aging and Mental Health* 191, 191; Martha Fineman, 'The Vulnerable Subject and the Responsive State' (2010) 60 *Emory Law Journal* 251246 (2010) 268.

differently vulnerable than someone with good economic resources.<sup>22</sup> Even those with sufficient resources may be rendered more vulnerable if they live in a community that is not well serviced by the necessary health and social resources or institutions. Where an institution does not produce policies, procedures or training to respond to vulnerable older people, then that institution may further exacerbate the vulnerability of older people in their care.

### *C Sources of Vulnerability*

To be a useful lens of analysis, vulnerability theory must therefore be able to account for the different sources of vulnerability. This paper proceeds on the basis that the tripartite theory of vulnerability encompassing inherent, situational and pathogenic vulnerability as outlined by Rogers, Mackenzie and Dodds, is an appropriate framework to apply.<sup>23</sup>

First, vulnerability is considered at the inherent level, encompassing individual experiences associated with ageing, including the possibility of physical and cognitive impairment. However, if the analysis of vulnerability stopped at the individual inherent level, then any interventions to address that vulnerability would run the risk of pathologising the elderly person and focus the gaze of the law only on the impairments of any elderly victim of abuse or neglect.<sup>24</sup> Such an approach could also run the risk of assuming that the responsibility for caring for older people rests with their family. Placing the burden of responsibility for care of the vulnerable on families will render their needs invisible.<sup>25</sup> This is a particularly poignant observation considering the plight of Marcia Clark outlined in this paper. As will be seen, Marcia's daughter Nardia had mental health problems of her own and was not well equipped to deal with the difficulties of caring for an older person with dementia, yet her difficulties failed to trigger the necessary support from the community.

This leads us to consider further situational vulnerabilities. The situational context includes the level of support and resources at the disposal of an older client.<sup>26</sup> Resources include the

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<sup>22</sup> See for instance Frank Cooper, 'Always Already Suspect: Revising Vulnerability Theory' (2015) 93 *North Carolina Law Review* 1339, 1340.

<sup>23</sup> Wendy Rogers, Caitriona Mackenzie and Susan Dodds, 'Why Bioethics Needs a Concept of Vulnerability' (2012) 5(2) *International Journal of Feminist Approaches to Bioethics* 11; See also Caitriona Mackenzie and Wendy Rogers, 'Autonomy, vulnerability and capacity: a philosophical appraisal of the Mental Capacity Act' (2013) 9 *International Journal of Law in Context* 37.

<sup>24</sup> Jaime Lindsey, 'Developing Vulnerability: A Situational Response to the Abuse of Women with Mental Disabilities' (2016) 24(3) *Feminist Legal Studies* 295, 298.

<sup>25</sup> Titti Mattson and Mirjam Katzin, 'Vulnerability and Ageing' in Ann Numhauser-Henning (ed) *Elder Law: Evolving European Perspectives* (Edward Elgar Publishing 2017) 113, 131.

<sup>26</sup> Rogers, Mackenzie and Dodds (n 23) 24.

economic and information resources required to access and pay for services or professional care or assistance. Situational approaches to vulnerability highlight the link between impairment and elder abuse and posit other reasons why some people with disabilities are more vulnerable without characterising them as inevitably so.<sup>27</sup> Marcia Clark was situationally vulnerable because of her daughter's mental health problems and social isolation. In the Tasmanian case examined in this paper, Janet Mackodzie was vulnerable to abuse in part because she was denied professional care and assistance and was unable to access her own financial assets. Her daughter and son-in-law were able to control her finances for their own benefit, stole money from her and persuaded a probate clerk to transfer Janet's house to them.

A tripartite analysis extends beyond the overlapping inherent and situational causes of vulnerability to interrogate the pathogenic causes of vulnerability for older people experiencing neglect,<sup>28</sup> a concept that resonates with theories of institutional precariousness described in the human rights literature.<sup>29</sup> Institutions respond to and shape our experience of vulnerability and can either safeguard or expose the vulnerable subject to heightened risks.<sup>30</sup> At the pathogenic level, the way state-based regulators and professional bodies respond to, or fail to respond to neglect, creates another potential source of vulnerability for older people. In the cases examined below, medical and allied health staff failed to intervene effectively even when they had concerns about the care of these older women. The policies and procedures set up for doctors to prescribe medications enabled a 'hands-off' approach to their treatment. Finally, lax oversight by banking staff allowed Janet Mackodzi's daughter to deplete her savings, whilst a probate clerk failed in her duty to ensure that Janet was properly advised about transferring ownership of her property.

As outlined here, a tripartite theory of vulnerability calls attention to the multi-faceted dimensions of influence on a person's wellbeing, including personal, political and legal factors. In part two of this paper, the two inquests are compared through the lens of this vulnerability theory to interrogate the forms of vulnerability that cumulatively contributed to two tragic deaths. It will be suggested that an holistic approach to Coroner's investigations

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<sup>27</sup> Lindsey (n 24) 298.

<sup>28</sup> Rogers, Mackenzie and Dodds (n 23) 24.

<sup>29</sup> Bryan Turner, *Vulnerability and Human Rights* (Penn State University Press, 2006) 32.

<sup>30</sup> Susan Dodds, 'Dependence, Care, and Vulnerability' in Catriona Mackenzie, Wendy Rogers and Susan Dodds (eds), *Vulnerability: New Essays in Ethics and Feminist Philosophy* (Oxford University Press, 2013) 181, 198.

should include recommendations for institutional reforms when these are contributory factors to a preventable death.

## II INQUESTS IN TWO AUSTRALIAN STATES COMPARED

### *A NSW Inquest: Marcia Clarke*

In 2018, two Australian Coronial inquests investigated the circumstances that led to the death through neglect of an older woman. In NSW, an inquest was held into the death of Marcia Clark who died at Manning Base Hospital in 2014 after prolonged neglect and suffering.<sup>31</sup> Marcia had been living a relatively reclusive existence with her daughter Nardia and died seriously malnourished and with infected pressure sores.

Marcia's recent medical history outlining her inherent vulnerability is set out in paragraphs thirty-six to fifty-one of the Coroner's findings, including details of her dementia diagnosis, possible Parkinson's disease, a history of pressure sores and significant weight loss.<sup>32</sup> Marcia Clark also suffered from a debilitating mental illness throughout her adult life, described by the Deputy Coroner as a factor contributing to the difficulty that Marcia's daughter Nardia experienced in caring for her.<sup>33</sup>

Marcia Clark was found to have died due to 'the combined effects of severe malnutrition and infection.'<sup>34</sup> A description of the terrible pressure sores that Marcia Clark suffered, including a deep sacral pressure sore that had probably infected the underlying bone is rendered in the opening paragraphs.<sup>35</sup> However this clinical description belies the underlying situational and pathogenic vulnerabilities that together contributed to her death.

Marcia Clark's primary carer was her daughter Nardia, described as 'struggling to care for herself, much less being able to adequately care for her mother, an 83 year old bed bound woman.'<sup>36</sup> It is suggested that Nardia would likely have been suffering from carer's stress and noted that she herself sadly passed away two years later having disappeared in bushland.<sup>37</sup> There is little commentary on the role of other family members, although another daughter provided evidence to the inquest. What is known, is that Marcia Clark's doctor

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<sup>31</sup> *Clark Inquest* (n 1).

<sup>32</sup> *Ibid* 14-21.

<sup>33</sup> *Ibid* 16.

<sup>34</sup> *Ibid* 1.

<sup>35</sup> *Ibid* 5.

<sup>36</sup> *Ibid* 22.

<sup>37</sup> *Ibid* 26.

knew that Nardia was struggling to care for her mother, yet he was prescribing medications for Marcia without seeing her personally to check her health and wellbeing.<sup>38</sup>

It seems therefore that the stated ‘cause of death’ relates only to inherent vulnerability. ‘Cause of death’ is not defined in the legislation however, a vulnerability perspective on ‘cause of death’ might require that the broader circumstances contributing to a ‘reportable death’ should be considered ‘causal factors’. This could play a significant role in identifying and preventing elder abuse and neglect. Describing the ‘cause of death’ as malnutrition and infection in the case of Marcia Clark ignores the various acts and omissions that cumulatively led to her death.

### *B Tasmanian Inquest: Janet Mackozdi*

In Tasmania, the Coroner investigated the circumstances surrounding the death of Janet Lois Mackozdi, who died in 2010 from hyperthermia following a night where she was put to bed in a poorly insulated shipping container, on a property belonging to her daughter and son-in-law who were subsequently charged with Janet’s manslaughter.<sup>39</sup>

The Mackozdi inquest detailed Janet’s early history of thyroid problems, glaucoma and hypertension and her subsequent diagnosis of dementia and ‘decline in mental and physical functioning’.<sup>40</sup> There was evidence that Janet fractured her spine in a 2009 fall, thereafter requiring twenty-four hour care. As the Coroner described it, this led to ‘a complete dependence upon her daughter and family for all of her needs.’<sup>41</sup>

In the case of Janet Mackozdi, the Coroner accepted the findings of the autopsy pathologist that: ‘the cause of her death was hypothermia, with significant contributing factors being dementia of the Alzheimer’s type, frailty of advanced age and severe atherosclerotic and hypertensive cardiovascular disease.’<sup>42</sup> This recorded ‘cause of death’ for Janet Mackozdi excludes the fact that on the eve of her death, Janet was left by her daughter and son-in-law to

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<sup>38</sup> Ibid 37-51.

<sup>39</sup> *Mackozdi Inquest* (n 2).

<sup>40</sup> Ibid 50.

<sup>41</sup> Ibid.

<sup>42</sup> Ibi. 4.



spend the night in a shipping container in sub-zero temperatures. The stated ‘cause of death’ seems to gloss over Janet’s tragic circumstances.

Janet Mackozdi’s family situation was dire. Janet’s daughter and her husband (Jassy and Michael Anglin) failed in their care for Janet, although Jassy was a registered nurse and Michael a disability support worker. Medical professionals involved in caring for Janet during her lifetime gave evidence of their concerns that she was being cared for in the family home without outside assistance,<sup>43</sup> with one doctor stating that given the advanced state of Janet’s dementia, this should have raised ‘alarm bells.’<sup>44</sup> This raises serious questions about how Janet’s family were able to isolate her from all possible forms of assistance and why more was not done by those who were concerned for her welfare.

Staff who treated Janet Mackozdi in hospital following her spinal fracture were very concerned that her daughter was proposing to care for her at home when she had been assessed for high level care. Jassy Anglin told her doctor that she was struggling to care for her mother,<sup>45</sup> yet Jassy was supplied with medication for Janet without Janet attending doctor’s appointments or having home visits.<sup>46</sup>

Janet’s financial circumstances should also have raised alarm bells. There was evidence of financial abuse such that before her death, Jassy and Michael depleted all of Janet’s savings and assets. The Coroner found ‘Mr and Mrs Anglin spent a total of approximately \$350,000 of money belonging to Mrs Mackozdi.’<sup>47</sup> Yet the house where Janet died was described as ‘virtually uninhabitable’.<sup>48</sup> Some individuals or organisations either had, or should have had concerns about the way Janet’s funds or property were being used. Her Sydney-based financial adviser reported concerns about one account.<sup>49</sup> The Commonwealth Bank had allowed Mrs Mackozdi’s daughter to access her account through an Authority to Operate and did nothing to investigate a significant increase in the account activity that followed.<sup>50</sup> A law firm probate clerk witnessed a transfer of Mrs Mackozdi’s property to the daughter without assessing her ability to make legal decisions about such a transaction.<sup>51</sup> There were therefore

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<sup>43</sup> Ibid 106.

<sup>44</sup> Ibid.

<sup>45</sup> Ibid 89-91, 99.

<sup>46</sup> Ibid 99.

<sup>47</sup> Ibid 156.

<sup>48</sup> Ibid 112.

<sup>49</sup> Ibid 134.

<sup>50</sup> Ibid 136.

<sup>51</sup> Ibid 140.

opportunities for individuals or institutions to further investigate Janet's situation and to safeguard her from abuse.

### III A VULNERABILITY APPROACH TO REPORTABLE DEATHS

#### *A Situational Vulnerability and Reportable Deaths*

'Reportable deaths' are defined on a state by state basis, but generally include any sudden, suspicious or violent deaths.<sup>52</sup> Deaths that follow an operation must be reported, as must deaths that occur in a state facility and situations where the cause of death is unknown. As Middleton and Buist have observed, where the cause of death concerns the provision of health care, there is scant attention to situations where family, carers or medical practitioners *failed* to provide the necessary medical attention.<sup>53</sup> Lack of medical care was a key feature in both of these deaths.

Rogers, Mackenzie and Dodds define situational vulnerabilities as: 'vulnerability that is context-specific, and that is caused or exacerbated by the personal, social, political, economic, or environmental situation of a person or social group.'<sup>54</sup> Both inquests document the ways in which situational vulnerabilities contributed to the deaths. Significantly both women were cared for by family members who, for very different reasons, were ill-suited to the task and failed to provide appropriate care.

A further situational vulnerability of concern is that in both cases, medical practitioners or allied health workers did not consider it part of their role to follow up on concerns they had about the older women's health. Doctors were aware of the inherent physical and cognitive vulnerabilities of these women and alert to the risks they faced being cared for at home in their circumstances, yet nothing was done to check on either woman. Significant carer stress should trigger a welfare check and the offer of additional support services.

#### *B Pathogenic Vulnerability*

Rogers, Mackenzie and Dodds' taxonomy describes additional pathogenic vulnerabilities as those created through 'morally dysfunctional interpersonal and social relationships characterized by disrespect, prejudice, or abuse, or by socio-political situations characterized

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<sup>52</sup> *Coroners Act 2009* (NSW) s 6; *Coroners Act 1997* (Tas) s 13.

<sup>53</sup> Sarah Middleton and Michael Buist, 'The Coronial Reporting of Medical-Setting Deaths: A Legal Analysis of the Variation in Australian Jurisdictions' (2014) 37(3) *Melbourne University Law Review* 699, 701.

<sup>54</sup> Rogers, Mackenzie and Dodds, (n 23) 24.

by oppression, domination, repression, injustice, persecution, or political violence.<sup>55</sup> A lack of adequate institutional safeguarding strategies falls within this definition.

The ability to provide repeat supplies of prescription medications to a person who would otherwise experience a hardship if required to attend a doctor and collect the medication is an example of an institutional response to vulnerability. These inquests demonstrate the pathogenic vulnerability created through lax procedures for issuing repeat prescriptions. Allowing relatives to self-manage medications in these cases led to poorer health outcomes and reduced the opportunity for doctors to properly monitor the health progress of patients in their care.

In Janet Mackozdi's case, a failure by the Commonwealth Bank to monitor and investigate suspicious account activity is a further institutional failing that contributed to her vulnerability. The Australian Banking Association (ABA) suggests a number of institutional barriers to preventing financial abuse including the lack of an Australian authority with responsibility to accept and respond to reports of abuse, a lack of training for staff to assist them to identify when a customer lacks the decision-making ability to operate their account and the lack of a national register for enduring powers of attorney.<sup>56</sup> The ABA reports that 'Industry Guidelines and other tools are currently under review, awaiting a final decision of Government.'<sup>57</sup> This would suggest that government and banks are alert to the institutional weaknesses in responding to financial abuse but have been slow to act.

### *C Coronial Recommendations*

There are clear differences in the conclusions and recommendations of the two inquests, notwithstanding the very different circumstances of the families involved. In the NSW inquest, Deputy Coroner O'Sullivan addressed the shortcomings in medical record-keeping and interviewing by Marcia's doctor.<sup>58</sup> She noted that no person or agency who should have had concerns about the health of Marcia or her daughter made detailed enquiries and also noted the difficulties of obtaining a home based Aged Care Assessment, especially if resisted by the older person or carer.<sup>59</sup> Magistrate O'Sullivan also commented on the services offered by the Elder Abuse Helpline and the lack of a specialist investigatory body for elder abuse in

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<sup>55</sup> Ibid 25.

<sup>56</sup> Australian Banking Association, 'Vulnerable Customers' <https://www.ausbanking.org.au/policy/customers/vulnerable-customers/> (accessed 26 August 2019).

<sup>57</sup> Ibid.

<sup>58</sup> *Clark Inquest* (n 1) 50.

<sup>59</sup> Ibid, 60-64.

the State.<sup>60</sup> The Deputy Coroner touched on the Commonwealth responsibility for Aged Care funding, however declined to make specific recommendations for reforms in any of the areas that had drawn her criticism, finding:

Given the breadth of matters considered in the NSW Parliamentary Inquiry, the Government response to that Inquiry and the NSW Law Reform Commission proposal to amend the Guardianship Act 1987, there [was] no utility in this Court making further recommendations based upon this single case.<sup>61</sup>

By comparison, and possibly aided by the breadth of information provided to her as a result of the criminal investigation into the circumstances of Janet Mackozdi's death in addition to the fact that the Tasmanian legislation *requires* that recommendations be made,<sup>62</sup> Coroner McTaggart made several recommendations for reform in Tasmania. The recommendations were aimed at elder abuse prevention in the State and included legislative reform measures aimed to 'respond to abuse, neglect or exploitation'.<sup>63</sup> More broadly, the Coroner's recommendations addressed shortfalls in government resourcing of services.<sup>64</sup>

As Stu Marvel has written, '[T]he social institutions we construct are explicitly designed to mitigate our vulnerability and to provide us with resources and support as we move across the life course.'<sup>65</sup> Coroner's recommendations are one such institutional response to vulnerability, given that one of their key functions is to report on the causes of death and communicate any lessons to be learned to relevant community groups and government agencies.<sup>66</sup>

A key challenge for Coroners is that while they have access to a wide-range of evidence, there are no accepted guidelines on best practice recommendation formulation.<sup>67</sup> In Australia, not all Coroners in the state-based systems are compelled to provide recommendations to prevent future deaths, creating a frustration that they fail therefore to realise their preventative

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<sup>60</sup> Ibid, 52.

<sup>61</sup> Ibid, 65.

<sup>62</sup> *Coroners Act 1995* (Tas) s 28(2).

<sup>63</sup> *Mackozdi Inquest* (n 2) 197-200.

<sup>64</sup> Ibid 201.

<sup>65</sup> Stu Marvel, 'The Evolution of Plural Parentage: Applying Vulnerability Theory to Polygamy and Same-Sex Marriage' (2015) 64 *Emory Law Journal* 2047, 2065.

<sup>66</sup> Boronia Halstead, 'Coroners Recommendations Following Deaths in Custody', in Hugh Selby (ed), *The Inquest Handbook* (Federation Press 1998) 186-205.

<sup>67</sup> Ibid. See also Bill Mitchell, 'Identifying Institutional Elder Abuse in Australia Through Coronial and Other Death Review Processes' (2018) 18 *Macquarie Law Journal* .

functions.<sup>68</sup> The important preventative functions of the Coronial jurisdiction are not always given legislative expression.<sup>69</sup> This gap in the legislation creates vulnerability, as research has established that improving the frequency and detail of coronial recommendations may prevent future deaths of older people, with the nature of the recommendations influencing the uptake of necessary interventions.<sup>70</sup>

In New South Wales, one object of the Coroners Act is to *enable* (but not *compel*) the Coroner to make public health and safety recommendations arising from an inquest.<sup>71</sup> Should the NSW Coroner choose to make recommendations, any government agency or Ministry involved must respond to those recommendations within six months.<sup>72</sup> This can be compared to Tasmanian Coronial law where ‘A coroner *must*, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate.’<sup>73</sup>

#### D *The Vulnerability Approach*

In her article ‘Elderly as Vulnerable’, Fineman proposes that an antidote to the problem of exploitation or neglect of the elderly is enhanced laws identifying fiduciary duties for family or professionals such as banking staff and lawyers and presumably for doctors as well.<sup>74</sup> Such a solution is criticised by Nina Kohn as paternalistic.<sup>75</sup> Kohn argues that vulnerability theory is ill equipped to suggest ways to prioritise social welfare reforms.<sup>76</sup> However applying a tri-partite model of vulnerability may provide one such form of analysis.

Coronial Inquests are uniquely placed to investigate the worst cases of neglect and to interrogate layers of vulnerability. They should serve as a call to action. In each of these inquiries, witnesses expressed the view that it was up to an individual to seek out aged care

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<sup>68</sup> Rebecca Scott Bray and Greg Martin, ‘Exploring Fatal Facts: Current Issues in Coronial Law, Policy and Practice’ (2016) 12 *International Journal of Law in Context* 115, 135.

<sup>69</sup> Expressions of prevention in relation to recommendations exist in Qld: *Coroners Act* 2003 s 46(1)(c), SA: *Coroners Act* 2003 s 25(2); Tas: *Coroners Act* 1995 s 28(2).

<sup>70</sup> Lyndal Bugeja et al, ‘Frequency and Nature of Coroners’ Recommendations From Injury-related Deaths Among Nursing Home Residents: a Retrospective National Cross-sectional Study’ (2018) 24(6) *Injury Prevention* 412, 412.

<sup>71</sup> *Coroners Act* 2009 (NSW) s 3 (e).

<sup>72</sup> NSW Premier, ‘Responding to Coronial Recommendations’, Memorandum M2009-12, Department of Premier and Cabinet (6 April 2009).

<sup>73</sup> *Coroners Act* 1995 (Tas) s 28(2).

<sup>74</sup> Fineman (n 19) 94.

<sup>75</sup> Nina Kohn, ‘Vulnerability Theory and the Role of Government’ (2014) 26(1) *Yale Journal of Law and Feminism* 1, 11.

<sup>76</sup> *Ibid* 13.

services for themselves. This left the older person at the mercy of a caregiver who for different reasons had cause to actively retreat from services rather than seek them out.

Nina Kohn is right to be wary of paternalistic responses to the vulnerability of older people.<sup>77</sup> However consistent with a rights-based approach to elder abuse and neglect, the right to autonomy must be balanced with the need to safeguard people from abuse.<sup>78</sup> In these cases, increasing cognitive impairment meant that neither Marcia Clark nor Janet Mackozdi was able to make informed decisions about their health care needs and were unable to seek assistance. An inability to independently seek assistance might be a layer of vulnerability that could trigger at minimum a welfare check in circumstances where the carer has expressed that they are having difficulty coping.

In the Tasmanian case, the Coroner requested a specialist report from a multi-disciplinary group of academics based at the University of Tasmania known as PEAT (Preventing Elder Abuse Tasmania).<sup>79</sup> PEAT examined the available documents and identified those moments in Janet Mackozdi's life that could have served as 'red flags' for intervention, including: when she failed to attend follow-up appointments with medical practitioners; when the probate clerk failed to check that Janet knew she was transferring her house to her daughter; when hospitals identified her high level care needs and then discharged her without checking if those needs could be met; when the bank gave her daughter authority to operate her bank account; when Doctors identified that support was required but there was no take-up of that support; and when irregular and sometimes large withdrawals were made from her bank account.<sup>80</sup> The Coroner was particularly critical of the bank in this situation, due to their failure to identify whether Janet properly authorised her daughter's use of her account.

The Tasmanian inquest concluded with specific suggestions for reform to protect vulnerable older people from abuse, recommending the following reforms: an Elder Abuse Prevention Action Plan; creation of a body with specific powers to deal with elder abuse; and further resourcing of PEAT.

By contrast, the NSW Deputy Coroner recorded no utility in making recommendations. Applying the tri-partite vulnerability lens, it is arguable that Coronial inquests themselves

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<sup>77</sup> See also Lacey (n 9) 104.

<sup>78</sup> *Convention on the Rights of Persons with Disabilities*, opened for signature 13 December 2006, 2515 UNTS 3 (entered into force 3 May 2008), Art 12.

<sup>79</sup> *Mackozdi Inquest* (n 2) 180.

<sup>80</sup> *Ibid* 182.

might be a pathogenic cause of vulnerability if they identify the causes of abuse and potential remedies to that abuse, yet fail to make concrete recommendations.

### *E Tri-partite Vulnerability and Coronial Inquests*

Coronial inquests represent an important opportunity to interrogate the complex factors contributing to elder abuse and neglect and highlight the layers of vulnerability experienced by some older people with dementia. In one respect these two deaths share little in common. Marcia Clark's situation seems a tragic result of the joint mental health problems experienced by herself and her daughter that made it difficult for Nardia to seek assistance until it was too late. Janet Mackozdi on the other hand seems to have been denied help in an effort to isolate her from others and separate her from her wealth.

The two cases demonstrate the necessity for coordinated, state-sponsored safeguarding practices. As the Tasmanian Coroner found, there is a need for an agency that can investigate potential cases of neglect and prosecute abuse. This was also highlighted by the NSW Deputy Coroner who noted the limitations of current services including the Elder Abuse Helpline, the NSW Police and the Aged Care Assessment Teams. What is clear from these cases is that state inaction, lack of funding and lack of coordinated services contributes to the vulnerability of older people experiencing neglect.

The two Inquests were themselves an opportunity to provoke a response and contribute to the future prevention of neglect of older people through the formulation of specific recommendations. Prosecuting individuals for abuse or neglect will be too little, too late. Vulnerability theory points to this conclusion and the need to account for pathogenic vulnerabilities that look beyond the inherent and situational vulnerabilities of our elders.

The Tasmanian Coroner, subject to the requirement for mandatory recommendations, demonstrates how Coronial findings can address tri-partite sources of vulnerability and call on governments and communities to play a role in abuse prevention. The New South Wales legislation should be amended to provide a similarly clear mandate to the Coroner. Coronial reports could apply a tripartite model of vulnerability to systematically examine the layers of vulnerability that may contribute to the death of an older person and therefore extend our gaze beyond the inevitable physical decline of older age to interrogate the ways in which local communities and state institutions need to respond to older people at risk of abuse and neglect.

