Media Release

Coroners Court of Victoria

Monday 4 August 2025

State Coroner renews calls for better protections for vulnerable adults

Victorian State Coroner Judge John Cain has renewed calls for better protections for adults at risk of abuse and neglect following the deaths of three people while in the care of their families.

In all three investigations, His Honour found that the Victorian adult safeguarding system – the framework for investigating and co-ordinating services to protect the rights of vulnerable adults – was fragmented and the lack of clear referral pathways imposed significant barriers for at-risk adults and their families to access vital support.

On 11 November 2020, YTR, a 78-year-old woman who had a range of medical issues including undiagnosed lymphoma, type 2 diabetes and a history of schizophrenia, died in hospital. She had been admitted for complications arising from prolonged immobility and malnutrition developed while under the care of her adult son.

Judge Cain noted that YTR's deteriorating health was largely invisible until her hospital admission. His Honour stated that if a family member or YTR's general practitioner "…*wanted to raise concerns about YTR's wellbeing, there was no specific agency that they could contact. Similarly, when YTR first presented to hospital, clinicians queried whether they should contact police or the Victorian Civil and Administrative Tribunal (VCAT).*"

On 16 November 2020, 50-year-old William Heddergott was found deceased by a council worker in the home he shared with his mother who had fatally asphyxiated and bludgeoned him before she attempted suicide.

Prior to his death, William had a National Disability Insurance Scheme (NDIS) plan in place to support his daily living. His NDIS support worker had previously identified serious issues with William's treatment by his mother. She discussed the matter with others involved in his care and investigated avenues to report her concerns but, without a clear path forward, no action was taken.

On 9 August 2022, MHT, an 86-year-old man, died in hospital from injuries sustained in an assault by his adult son. MHT had a history of perpetrating family violence and was in the care of his wife following a diagnosis of Alzheimer's and vascular dementia. When his wife suffered a stroke and later died, MHT's family encountered significant difficulties trying to transfer his guardianship to another family member. Following his wife's funeral, MHT was fatally assaulted by his son.

Prior to his death, MHT's granddaughter contacted several organisations, including VCAT and the Office of the Public Advocate (OPA) seeking assistance in taking guardianship over him. The family also raised concerns with MHT's general practitioner, Victoria Police, Dementia Support Australia and Carer Gateway – a support organisation for carers. In her statement to the Court, MHT's granddaughter said the family felt helpless.

This is the second time Judge Cain has called for a legislative adult safeguarding framework in Victoria. In March 2025, Judge Cain made 10 recommendations directed to the Victorian Government and OPA following the death of a 78-year-old woman who experienced prolonged neglect while in the care of her son.

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In response to the previous recommendations, the Department of Families, Fairness and Housing (DFFH) advised of current adult safeguarding initiatives and agreed to take the coronial findings into consideration. DFFH noted the Victorian Government is working with the Disability Reform Ministerial Council to consider reform options in response to the Disability Royal Commission, established in 2019 – which also recommended the introduction of adult safeguarding legislation.

In the three new findings, His Honour commented on the DFFH response: *"I do not view any of these initiatives as a substitute for the above recommendations…at-risk adults, particularly those 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."*

His Honour has subsequently reiterated six of the ten prior recommendations, including:

- That the Victorian Government implement, as a priority, 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.

- That adequate funding be allocated to facilitate the creation of an appropriate agency and that any such agency is empowered to work cooperatively with other service providers to facilitate the timely provision of, or changes to, the support services provided to at-risk adults.

In the finding into the death of William Heddergott, His Honour noted that neither the NDIS providers nor the mental health professionals responsible for his care were adequately trained to respond to reports of family violence. His Honour recommends:

- That DFFH engage with the Commonwealth Government in relation to the prescription of Commonwealth Government entities such as the National Disability Insurance Agency (NDIA) and the NDIS Quality and Safeguards Commission as Information Share Entities (ISEs) under the Family Violence Information Sharing Scheme (FVISS) and in respect of the Multi Agency Risk Assessment and Management Framework (MARAM).

- That the Psychology Board of Australia, the Australian Psychological Society and the Royal Australian and New Zealand College of Psychiatrists work to implement mandatory family violence training and CPD for Australian psychiatrists.

The findings can be accessed here:

- Finding into the death of YTR
- Finding into the death of William Heddergott
- Finding into the death of MHT

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