IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 006253

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	Judge John Cain, State Coroner
Deceased:	William Charles Heddergott
Date of birth:	10 August 1970
Date of death:	Between 14 and 16 November 2020
Cause of death:	1(a) Plastic bag asphyxia in the setting of ethanol intoxication and blunt force head injuries
Place of death:	7 Palmyra Court, Greensborough, Victoria, 3088
Keywords:	Family violence; adult safeguarding; disability; mental illness

INTRODUCTION

1. On 16 November 2020, William Charles Heddergott was 50 years old when he was found deceased by a council worker who was performing a 'Meals on Wheels' delivery. William's mother, Erica Heddergott, pleaded guilty to William's murder in 2021, and was sentenced by the Supreme Court of Victoria to 15 years' imprisonment, with a non-parole period of 10 years. She was 81 years old at the time of the fatal incident.

Erica's background

2. Erica was born in Germany in 1939 and moved to Australia in the 1940s. She worked as a nurse, married and had two sons – William and Andrew. Erica's husband suffered a stroke in about 2005 and moved into a care home.

3. Erica's medical history included anxiety, self-described obsessive-compulsive traits, and insomnia. In 2016, Erica was referred by her general practitioner (**GP**) to a psychologist, to whom she reported experiencing persistent high levels of stress and worry in relation to William. Erica also noted social anxiety stemming from a stutter. The psychologist considered that Erica met the criteria for avoidant personality disorder, however Erica ceased seeing the psychologist in 2017 before the psychologist could share this diagnosis with her.

4. In 2017, Erica was diagnosed with a meningioma (malignant tumour that was not growing in size). She reported feeling ongoing dizziness and malaise due to the tumour. The tumour was not expected to reduce Erica's lifespan, however Erica believed that she was dying from it. She also believed that William would be unable to look after himself if she died.

William's background

5. William lived with his mother for the majority of his life, other than for a few months during 2018-2019 when he lived at Chatswood Terrace, a supported accommodation facility. As a younger man, William worked in aged care, however, was unemployed and was receiving a disability support pension at the time of the fatal incident.

6. William had a significant history of mental health diagnoses, including social anxiety disorder, general anxiety disorder, depression, obsessive compulsive disorder (**OCD**), adjustment disorder, and alcohol abuse syndrome not reaching the level of dependence. Erica noted that William had a stutter, however this was not documented by any of the clinicians working with

William. William also had difficulties with sleep and was diagnosed with a mild intellectual disability in 1998.

7. The NDIS approved a support plan for William in August 2017, which included funding to support and improve his daily living as well as increased social and community participation. Smarter Connections became William's care provider in July 2019. They initially provided three hours of support, twice per week, and assisted William with daily activities such as laundry, cleaning, accessing the community, and accompanying him to the shops.

Erica and William's relationship

8. Erica's brother, Peter Zapf, told investigating police that Erica was controlling and psychologically abusive towards William, commencing in William's childhood. Peter alleged that Erica "*suffered Manchausen (sic) by proxy with William all her life*", controlled every aspect of his life, and introduced him to drugs and alcohol.

9. Erica's nephew (Peter's son), similarly told police that Erica introduced William to drugs, regularly purchased him alcohol, did not want William to have a job. While William had a driver's licence, he did not drive because Erica did not approve.

10. In the years prior to William's passing, Erica expressed to multiple people that she was very stressed due to William's care needs and that William would be unable to care for himself when she died. William's medical and other records suggest that William was not as dependent upon Erica as she described. One counsellor stated that William was "*an intelligent person that was socially awkward and lacked confidence*". William's counsellor and support worker both suspected that Erica had Munchausen syndrome by proxy in relation to William.

THE CORONIAL INVESTIGATION

11. William'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.

12. 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.

13. 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.

14. Victoria Police assigned Detective Senior Constable Aaron Price to be the Coronial Investigator for the investigation of William'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.

15. This finding draws on the totality of the coronial investigation into the death of William Charles Heddergott 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

16. On 19 November 2020, William Charles Heddergott, born 10 August 1970, was visually identified by his sister-in-law, Joanne Heddergott.

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

Medical cause of death

18. Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 17 November 2020 and provided a written report of his findings dated 1 February 2021.

19. The post-mortem examination revealed a mildly enlarged heart (515 grams), both arms were bound with a dressing gown cord, ragged scalp lacerations, intact larynx and no other

[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.

significant injuries or internal pathology. The two areas of lacerations to the head did not cause internal cerebral bleeding or a skull fracture.

20. Toxicological analysis of post-mortem blood samples identified the presence of ethanol (0.18 g/100mL in the blood; 0.23 g/100mL in vitreous humour), a clonazepam metabolite and alprazolam. Toxicological analysis of post-mortem hair samples revealed the presence of clonazepam and its metabolite, and diazepam, and its metabolite.

21. Dr Bedford provided an opinion that the medical cause of death was *1(a) plastic bag asphyxia in the setting of ethanol intoxication and blunt force head injuries.*

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

Events in the year prior to the fatal incident

23. William permanently left Chatswood Terrace in 2020 in order to live with Erica. He told his treating clinicians that he planned to return to Chatswood Terrace on several occasions, despite experiencing some issues while living there.

24. From February to November 2020, William consulted with a psychiatrist, a counsellor, and two psychologists. Some of these clinicians noted concerns about Erica's treatment of William, however these concerns did not prompt further investigation or referrals.

25. Due to the COVID-19 related restrictions in Victoria, Smarter Connections reduced William's hours of support from three hours, twice per week, to three hours once per week.

26. William's support worker observed that William appeared to be "*going downhill*" from September 2020. From 28 September 2020 to 16 November 2020, Erica or William cancelled seven of the eight scheduled appointments with their Smarter Connections support worker.

27. In late-2020, Erica attempted to take William's superannuation funds out of his account. When she was unable to withdraw these funds, Erica applied to change the beneficiary of William's account. Erica updated William's funeral plans, reportedly gave away her possessions and prepared her will.

Circumstances in which the death occurred

28. On 12 November 2020, Erica and William cancelled his scheduled support worker session. William attended an appointment with his psychiatrist; however, it is not clear what was discussed during the session.

29. William's movements from 14 to 16 November 2020 are unknown. On 16 November 2020, council worker, Rosalie, attended Erica and William's home to make a Meals on Wheels delivery. Rosalie observed a key was in the front door, so she called out to Erica. After receiving no response, Rosalie entered the house and located a handwritten note from Erica on the kitchen table that was entitled 'Farewell'. The letter was dated 14 November 2020, gave thanks to Erica's family and friends, and appeared to evince Erica's intention to end her life. Rosalie became concerned after reading the note, so she searched for Erica and William.

30. Rosalie located Erica on the floor of the living room, conscious but unable to speak. Rosalie called 000, despite Erica indicating that she did not want an ambulance. While on the phone, Rosalie located William lying on the couch with a plastic bag over his head. On the floor under the couch, Rosalie observed an axe with the head covered in a blood-stained beanie, which had been duct-taped to the axe. The 000 call-taker instructed Rosalie to remove the plastic bag from William's head, however it was secured tightly around his neck and Rosalie could only pull it up under his nose.

31. Erica was transported to the Austin Hospital by paramedics where she was treated for inhalation of vomit. Erica reported that she had attempted to take her own life by consuming an overdose of sleeping pills and she later made a full recovery.

Criminal proceedings

32. Erica pleaded guilty to William's murder. For the purposes of her guilty plea, Erica was assessed by a consultant psychiatrist who noted that she did not suffer from hallucinatory phenomena, thought disorder, psychosis, or depressive psychosis, but Erica's evaluation of William's health was "*an exaggeration of delusional proportions, a belief [she continues] to cling to and it is not open to rational discussion*". The psychiatrist opined that Erica was caught up in a "*circumscribed delusional disorder*" and her distorted emotional expression "*is at least consistent with late onset schizophrenia rather than just a delusional disorder*".

33. The psychiatrist opined that there may have been a prospect of a mental impairment defence, however Erica chose not to pursue same. She was sentenced to 15 years' imprisonment, with a non-parole period of 10 years.

FURTHER INVESTIGATIONS AND CPU REVIEW

34. As the relationship between William and Erica meets the definition of a "*family member*" pursuant to the *Family Violence Protection Act 2008* (Vic), I requested that the Coroner's Prevention Unit (**CPU**)[2] examine the circumstances of William's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**)[3].

35. I make observations concerning service engagement with William and Erica as they arise from the coronial investigation into his 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 William's death.

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

Private psychiatrist – Dr Simon Croke

37. William was treated by private psychiatrist, Dr Simone Croke, from 2004 until the days prior to the fatal incident. The records available to the Court suggest that Dr Croke was aware that William was frustrated with his mother's level of involvement in his care, however, he may have been unaware of the family violence perpetrated by Erica against William.

38. William's Medicare records indicate that he had 12 appointments with Dr Croke in 2020, with the last appointment occurring on 12 November 2020. Dr Croke's medical records do not contain progress/case notes for 11 of these 12 appointments. When the Court contacted Dr Croke to request the missing records, he responded by providing further records which did not contain the missing 2020 progress notes. In a letter to the Court, Dr Croke did not address the missing progress notes, however stated that William's 2020 appointments "*were mostly*

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

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

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

checks that his overall state was stable, that there were no crises and that medication prescription was ongoing". Dr Croke further noted that "*there was no mentions (sic) of his mother beyond an occasional repeating of the longstanding frustration that she was a very anxious person who was over concerned about his welfare*".

39. I note the Australian Health Practitioner Regulation Agency (**AHPRA**)'s code of conduct which states "*maintaining clear and accurate medical records is essential for the continuing good care of patients*". The code of conduct additionally states that good medical practice involves keeping accurate, up to date and legible records that report relevant details of clinical history, clinical findings, investigations, information given to patients, medication, and other management in a form that can be understood by other health practitioners. Similarly, the Royal Australian and New Zealand College of Psychiatrists **(RANZCP)** Code of Ethics states that "*psychiatrists shall maintain legible, accurate, comprehensive and up-to-date records for the purposes of optimal treatment, potential access by patients, communication with colleagues, and medico-legal and statutory requirements*".

40. There is no evidence to suggest that Dr Croke's record-keeping played any role in William's passing. However, it may be indicative of other issues with the quality of the service and care provided to William. Without the 2020 records, it is not possible to determine whether Dr Croke missed any opportunities for preventative intervention.

41. As a matter of procedural fairness, Dr Croke was provided with an opportunity to respond to the above observations. Dr Croke stated that he "*wish[ed] to apologize for [his] failure to provide the complete record as was required.*" He advised that he searched his previous records to see if William's records were accidentally misfiled, however could not locate any additional records. Dr Croke noted that he has since made significant improvements in his record keeping and storage practices, including the use of artificial intelligence, and stated that he is confident that such errors will not occur again in the future. Dr Croke reiterated that at no time during his consultations with William was there any suggestion or concern of aggression from Erica and he did not believe William was at risk of harm.

42. In circumstances where Dr Croke has advised he has updated his record-keeping practices and software; I am satisfied that further recommendations are not required.

GP clinic, NDIS and Chatsworth Terrace

43. There were no issues identified with William's contact with any of these services.

Smarter Connections

44. As noted above, Smarter Connections were William's NDIS care provider from July 2019 until his death and provided assistance with his activities of daily living. Smarter Connections advised the Court that Erica "*had her own requirements of a support worker*" and that "*if she did not like the worker, then they were removed from the service, irrespective of Will's preferences*". Consequently, Smarter Connections sent a total of 10 support workers to William during their period of engagement with him.

45. The Smarter Connections worker allocated to William from December 2019 to October 2020 identified significant concerns in relation to Erica's treatment of her son and made the following comments:

    a) She believed Erica had Munchausen's Syndrome by proxy in relation to William.

    b) William was extremely nervous around Erica and "*never said so much as boo to her*".

    c) On one occasion, Erica asked the support worker to get her a gun and William shouted, "*Mum don't you start this again*".

    d) Erica was controlling and demeaning towards her son and put him down when the support worker complimented him.

    e) Erica castigated William for forgetting to purchase items at the supermarket and would claim to have put these items on the shopping list when she had not actually done so.

    f) Erica was controlling over William's care to the extent that other professionals had told her not to speak on his behalf.

46. On 7 April 2020, William's counsellor from Personal Freedom asked to speak to the support worker to get further information about William's relationship with his mother because William "*did not seem anything like his Mother was describing*". The counsellor and support worker discussed their mutual suspicion that Erica had Munchausen's Syndrome, but agreed there was nothing they could do other than continuing to work and assist William, because Erica did not have a formal diagnosis. From this time onwards, William's support worker described having "*real concerns about Will and his mother's actions towards him*".

47. In August or September 2020, William's support worker investigated avenues where she could report her concerns about Erica's treatment of William. In a statement, the support worker said:

> *When I was trying to find out where I could report this sort of behaviour I Couldn't [sic] find anywhere to do it. Everything was geared towards reporting this sort of behaviour directed towards children but not between adults. I just got frustrated and ended up called [sic]…my supervisor.*

48. The support worker's supervisor stated that "*it was a sad situation*" but believed there was nothing they could do about it and that "*the best course of action was just to continue supporting Will as best [they] could*".

49. On 14 September 2020, while William was sleeping, Erica asked the support worker to assist her with contacting his superannuation provider to enquire about taking his funds out of his account. The support worker reported that this was "*not right*" and made audio recordings of the conversation with the superannuation provider as "*proof of Erica's unfitness to look after Will*".

50. Upon a review of the available Smarter Connections records, the service contact with William was largely appropriate. However, I identified two areas of possible non-compliance with internal policies and procedures. These are outlined in further detail below.

William's autonomy

51. Smarter Connection's policies and procedures emphasise the importance of client autonomy and require that clients are involved in making decisions about all aspects of the support services they receive. Upon a review of the available records, there is no evidence to suggest that Smarter Connections staff spoke to William about Erica's level of involvement in his care, or about any of the other concerns they identified about her behaviour. This appears to be a breach of Smarter Connections' policies and procedures. There is no evidence to suggest that this would have prevented William's death, however I am of the view that it represents a missed opportunity to promote William's autonomy and potentially explore the challenging relationship between the pair.

52. In response, Smarter Connections stated that William was always consulted about his support services and was involved in the decision-making process. He was involved in the signing of the service agreement, which outlined the level of supports and engagement he was to receive.

Smarter Connections stated that William "*never indicated to our office that he did not wish for his mother to be involved, as he would sometimes prefer us to speak to his mother*" and that at times, William "*would try to defer this tasks [sic] to his mother*". Smarter Connections concluded that William therefore *did* have independent control over the supports and services he received.

53. I accept that while William was able to sign his service agreement without input from Erica, I am not satisfied that his autonomy was always respected or preferred. For example, in the statement from Smarter Connections' manager, Laurie Alonzo, he noted that "*Whilst Will was easy-going and enjoyed the company of many of our workers, Erika had her own requirements of a support worker. If she did not like the worker, then they were removed from the service, irrespective of Will's preferences*". Similarly, in a case note dated 7 October 2019, a carer noted "*Erica did not like Alex [support worker] as she was too young and she would prefer them to be older and they prompt Will to do his tasks*". It appears this support worker was removed from William's service, as the next file note one week later indicates a different case worker was allocated. There is no discussion or reference to Will's opinion of Alex and the decision appears to have been made solely on the basis of Erica's request.

54. When Smarter Connections was given the opportunity to respond to these additional concerns, it stated that it did not wish to provide a response to same.

Response to family violence

55. William's support worker correctly identified that Erica was perpetrating abusive and controlling behaviour against William. The support worker raised these concerns with her supervisor and discussed them with William's counsellor, however neither the support worker, not her supervisor, spoke to William directly about their concerns or offered him a referral to specialist family violence services.

56. Smarter Connections policy states that staff who identify that a client is experiencing family violence should speak to the client about whether they are willing to receive assistance and refer them to a specialist family violence service for a full assessment, if they consent. If the client does not consent to a referral, the staff member should inform the client "*about the help that is available, and monitor the situation closely*". I am of the view that the failure to make these enquiries with William and offer referrals represents a missed opportunity to engage William with supports which may have been able to further assess and manage the risk that Erica posed to William. However, there is no evidence before me to suggest that this deviation

from Smarter Connections policy represents a prevention opportunity or that it caused or contributed to William's death.

57. In response to the above concerns, Smarter Connections stated that the concerns were "*taken from a police statement made by one support worker. A statement made after the incident, with the benefit of hindsight and at a highly emotional time*". Smarter Connections referred to a particular former employee, 'Rebecca', and strongly stated that no concerns were ever raised by Rebecca or any of the other support workers.

58. The Court does not have a statement from Rebecca. However, a different carer from Smarter Connections noted the concerns as summarised above (at paragraph 45). I accept that her statement was made after William's passing, however the carer clearly described specific incidents and even recorded Erica on her phone during one conversation that she felt was particularly troubling. These recordings were passed onto police as part of their criminal investigation. There is no evidence before me to suggest that this carer's statement or concerns were fabricated. William's Personal Freedom records noted an incident in April 2020 in which a Smarter Connections carer spoke to the Personal Freedom counsellor about her concerns that Erica had undiagnosed Munchausen's by proxy.

59. The case notes from Smarter Connections are scant (totalling one page only). There are 13 entries from 26 August 2019 to 12 November 2020, and they do not appear to cover every interaction that Smarter Connections had with William. For example, there are no notes between 5 May 2020 and 24 September 2020. It is therefore possible (indeed, likely) that the carer did not record their concerns on William's file note, as there appears to be many missing records. The absence of a record about these concerns does not equate to an absence of those concerns.

60. When Smarter Connections was given the opportunity to respond to these additional concerns, as above, it stated that it did not wish to provide a response to same. I commend the support worker for escalating her concerns and providing a candid statement to the Court, which was of great benefit to my investigation.

Disability workers' response to family violence

61. I note that the ability for NDIS providers such as Smarter Connections to adequately respond to family violence is negatively impacted by a lack of family violence training for disability service workers. The Victorian Royal Commission into Family Violence (**RCFV**)

recommended that the Victorian Government fund training and education programs for disability workers, and that all disability workers complete certified training in identifying family violence. Following these recommendations, the Victorian Government trained the (then) Department of Health and Human Services' (**DHHS**) disability workforce to recognise and respond to family violence, and funded family violence training delivered through the vocational education and training system. However, this is not mandatory for all disability workers and as of April 2023, Smarter Connections advised that they do not require disability support workers to have any training in family violence, nor do they offer any family violence training to staff.

62. The Victorian Government has also funded training on Victoria's family violence risk assessment framework, the Multi Agency Risk Assessment and Management Framework (**MARAM**) for disability workers employed by organisations which are prescribed under the MARAM. However, most disability support work is now funded by the NDIS, which is not prescribed under the MARAM.

63. I also note that NDIS providers are not prescribed under the Family Violence Information Sharing Scheme (**FVISS**). The FVISS underpins the MARAM and provides a mechanism for prescribed organisations to request and share information for family violence risk assessment and protection purposes. Prescription under the FVISS can improve information sharing practices between professionals who support people with disabilities, for example, by providing guidance on when and how to seek consent before sharing family violence related information.

64. The NDIS Participant Safeguarding Policy was released in 2023 but does not indicate that disability support workers will receive family violence training, nor does it reference the MARAM. This policy recommends that critical incidents involving people with a disability in home or community settings be reported by NDIS providers to the National Disability Abuse and Neglect Hotline. The hotline provides information on relevant support services but does not provide a safeguarding response.

65. I note the recent recommendation by the Office of the Public Advocate (**OPA**) that the Victorian Government negotiate 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 FVISS and in respect of the MARAM. This case is a timely reminder

of the potential benefits associated with prescribing disability support workers under the MARAM. I therefore intend to make a recommendation to that end.

Private psychologist

66. William attended three appointments with a private psychologist between September and October 2020. During these appointments, William described Erica perpetrating controlling and psychologically abusive behaviour towards him. During his first appointment, William explained that Erica was his "*only friend*" and that she was controlling and placing a lot of pressure on him.

67. During his second appointment, William disclosed that Erica was "*quite negative*" towards him, that she fixated on things that he had not done and told him "*he can't do things*" and that he "*should be worried*". William reported that he was unable to stand up for himself and his support worker regularly stepped in. He also disclosed that Erica "*comes up with terrible things late at night*".

68. During his final appointment, William told the psychologist that his mother was "*acting like she only had months to live*". He disclosed that Erica yelled at him if he did anything wrong, that she did not listen to him, and that she would become nasty when she felt dizzy.

69. On 2 November 2020, Erica called the clinic and cancelled William's next scheduled appointment. The receptionist confirmed the cancellation with William, who declined a telephone appointment and did not reschedule the appointment. The reason for cancellation was not recorded.

70. It appears that the psychologist's response to William's disclosure of family violence was insufficient and suggests that they may lack an understanding of family violence. Like disability workers, private psychologists are not prescribed under the MARAM and are therefore not legally required to align their practice with the MARAM. However, complying with the MARAM is still best practice for these professionals. The MARAM directs professionals to undertake family violence screening when they identify indicators of family violence, and to take further actions as required. These further actions may include family violence risk assessments, secondary consultation with a specialist family violence service and/or a referral to relevant services. William's psychologist did not undertake any of these steps, which represents a missed opportunity to assess and manage the family violence risk posed by Erica.

71. As discussed in my Finding into the death of Fatima Batool[5] and my Finding into the death of Alicia Little,[6] an opportunity exists to upskill private psychologists and psychiatrists on how to identify and appropriately respond to family violence disclosures. In my Finding into the death of Samantha Fraser, I recommended:

> *That measures be taken by the APS and RANZCP to introduce family violence mandatory CPD for registered psychologists and psychiatrists to provide for an occupation-specific level of family violence understanding and referrals for further support where a patient/client is identified as experiencing or suspected to be experiencing family violence.*

72. The Australian Psychological Society (**APS**) responded to this recommendation and advised that it was not the appropriate body to implement such a recommendation. It suggested that the Psychology Board of Australia would be the most appropriate body to respond. RANZCP have not responded to date.

73. I note that the Royal Australian College of General Practitioners (**RACGP**) now offer a *Family Violence GP Education Program (Victoria)* to assist GPs in identifying and responding to family violence. Given that people experiencing family violence are likely to disclose their experiences to psychologists/psychiatrists, it would be prudent for those clinicians to have a similar training program or CPD available to them. I therefore intend to make a recommendation to that effect.

Adult safeguarding

74. The issue of adult safeguarding was extensively discussed in my recent finding into the death of CFT[7], and appears to be a relevant issue in the present case. In William's case, professionals and carers who were concerned about William's welfare did not have a clear referral pathway to raise concerns about Erica's behaviour or escalate their concerns. William's support worker raised her concerns with her supervisor and spoke to William's counsellor, but was unable to identify a service to which she could report her concerns.

[5] Finding into death without inquest – Fatima Batool (COR 2018 3266).
[6] Finding into death with inquest – Alicia Little (COR 2017 6543).
[7] Finding into death without inquest – CFT (COR 2020 4205).

75. Broadly, adult safeguarding means protecting the rights of adults to live in safety, free from abuse and neglect.[8] 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.[9] At-risk adults are defined as people aged 18-years-old and over, who:

a) have care and support needs;[10] and

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

c) are unable to protect themselves from the abuse or neglect because of their care and support needs.[11]

76. Adult safeguarding is important because people with a disability are more likely to experience violence, abuse, and neglect than people without a disability,[12] often from people on whom they depend for care and support.[13] 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%,[14] with those experiencing poor physical or psychological health and higher levels of social isolation more likely to experience abuse.[15]

77. 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

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[8] 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)>.

[9] 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)>.

[10] 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)>.

[11] 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).

[12] 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.

[13] *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* (Final Report, September 2023) vol 11, 25.

[14] 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)>.

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

addressing abuse perpetrated by people they are dependent on for care and support.[16] A specialised response to reports of abuse and neglect of at-risk adults is therefore required.

78. In this case, William would have likely met the criteria for an adult safeguarding response, given that:

    a) He had needs for care and support related to his mental health.

    b) He was experiencing abuse from Erica.

    c) His needs for care and support likely prevented him from protecting himself from Erica's abuse.

79. In William's case, none of the agencies involved with him appeared to be equipped to adequately respond to the abuse that Erica was perpetrating against him for the following reasons:

    a) The abuse was perpetrated in private accommodation where abuse of people with a disability is significantly under-reported, and which is not subject to the oversight of the Office of the Public Advocate (**OPA**) through Victoria's Community Visitors Program.

    b) Although William may have required support with decision-making, the extent of this need may not have met the threshold for an investigation by the OPA under their limited role in adult safeguarding. The OPA has powers to advocate for the human rights and interests of people with a disability, however this is not required, nor is the OPA funded to provide this advocacy following reports of abuse and neglect of at-risk adults.

    c) The abuse witnessed by and disclosed to support services did not involve clear criminality and Victoria Police responses in such cases are generally limited to offering referrals to other agencies. Victoria Police may have offered a Family Violence Intervention Order (**FVIO**) to prevent Erica from having contact or communication with William, however an FVIO, on its own, is an insufficient response to abuse of an at-risk adult.

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

d) The NDIS Quality and Safeguards Commission was unlikely to have taken any action against Erica's interference with William's care, as they have declined to take any action where matters concerning alleged interference with NDIS supports have been referred in the past.

e) The NDIS and NDIS-funded providers are not prescribed under the MARAM or the FVISS, so their obligation to identify, assess and manage family violence risk is limited.

f) Specialist family violence services do not have a statutory safeguarding function, nor the associated powers required to carry one out.

80. As in the matter of CFT, I am of the view that William's case is another example of a situation where an adult safeguarding agency could have been beneficial. The professionals and family members who had concerns for William could have raised these with the agency and received guidance and advice. If William's situation met the requisite threshold for a safeguarding response, the agency could have taken the lead as the coordinator. This also provides a simpler and more streamlined response and eliminates confusion in situations where multiple carers and clinicians are involved.

81. An adult safeguarding response which involved actions commonly taken in other jurisdictions could have benefitted William by:

a) Providing an accessible service.

b) Speaking directly with William about his experience of abuse and his preferred way forward.

c) Convening a multi-agency meeting to put a safety plan in place.

d) Addressing the issues William experienced at Chatsworth Terrace to enable him to return there should he wish to.

e) Addressing issues relating to Erica interference in William's care and support.

f) Considering William's mental capacity to make decisions relating to the safeguarding process and facilitating decision making support if appropriate.

82. A referral to a safeguarding agency could have been made by William's treating clinicians (GP, psychologist, psychiatrist), or more likely, his support worker at Smarter Connections.

FINDINGS AND CONCLUSION

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

a) the identity of the deceased was William Charles Heddergott, born 10 August 1970;

b) the death occurred between 14 and 16 November 2020 at 7 Palmyra Court, Greensborough, Victoria, 3088, from *1(a) plastic bag asphyxia in the setting of ethanol intoxication and blunt force head injuries*; and

c) the death occurred in the circumstances described above.

COMMENTS

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

1. I endorse recommendations 4 to 10, made in my Finding into the death of CFT[17], namely:

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 William'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, with police, healthcare entities, government departments, the Office of the Public Advocate and any other agencies involved.

[17] Finding into death without inquest – CFT (COR 2020 4205).

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.*[18]

2. In response to my finding into CFT's death, the Department of Families, Fairness and Housing (**DFFH**) responded to advise that it has taken all of the above 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.

3. In their response, DFFH also listed various initiatives which are funded by the Victorian Government, and which are aimed at preventing and responding to elder abuse. I do not view any of these initiatives as a substitute for the above recommendations, which have been made and supported by the ALRC, the OPA and the Disability Royal Commission over the course of several years. 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.

4. Finally, DFFH referred to the new Social Services Regulator as a new initiative to reduce the risk to vulnerable adults with care and support needs, however this body only covers state-funded disability services. In this case, William was receiving NDIS funding, not state funding, so the Social Services Regulator is unlikely to have made a difference here.

RECOMMENDATIONS

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

(i) That the **Department of Families, Fairness and Housing** 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

[18] Finding into death without inquest – CFT (COR 2020 004205).

Family Violence Information Sharing Scheme (**FVISS**) and in respect of the Multi Agency Risk Assessment and Management Framework (**MARAM**).

(ii) That the **Psychology Board of Australia** work with the **Australian Psychological Society** to implement mandatory family violence training and CPD for Australian psychiatrists.

(iii) That the **Royal Australian and New Zealand College of Psychiatrists** work with the **Medical Board of Australia** to implement mandatory family violence training and CPD for Australian psychiatrists.

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

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Andrew Heddergott, Senior Next of Kin

Australian Psychological Society

Commonwealth Government

Department of Families, Fairness and Housing

Medical Board of Australia

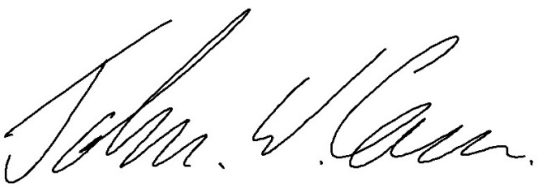
Office of the Public Advocate

Psychology Board of Australia

Royal Australian and New Zealand College of Psychiatrists

Detective Senior Constable Aaron Price, Coronial Investigator

Signature:



Judge John Cain
State Coroner
Date: 30 July 2025

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.