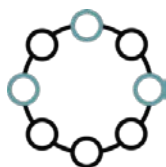




## Coronial recommendations: Fatal facts

A summary of cases and recommendations made  
between January and March 2014

Edition 40



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Coroners Court  
of Victoria



QUEENSLAND  
COURTS



CORONIAL SERVICES  
OF NEW ZEALAND  
*Parangō Ō te Āh Kaitiaki*



Coroner's Court  
of New South Wales



Coroners Court of  
Western Australia



MAGISTRATES COURT  
OF THE AUSTRALIAN CAPITAL TERRITORY



MAGISTRATES COURT of TASMANIA  
CORONIAL DIVISION



NORTHERN TERRITORY OF AUSTRALIA  
*Office of the Coroner*



Courts Administration Authority  
of South Australia

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## CORONERS' RECOMMENDATIONS

A coroner may make recommendations as part of their inquiry into a death.

Recommendations are made to help prevent similar deaths from occurring in the future.

The National Coronial Information System (NCIS) maintains a repository of information on deaths reported to a coroner in Australia and New Zealand. Subject to coronial approval, the NCIS publish summaries of Australian cases in which a coroner has made a recommendation.

*Coronial recommendations: Fatal facts* includes case summaries and recommendations for cases closed between January and March 2014.

Previous summaries and recommendations are available

at: <https://www.ncis.org.au/publications/fatal-facts/>

## AUSTRALIAN CAPITAL TERRITORY

The following cases summaries and recommendations relate to deaths reported to a coroner in the Australian Capital Territory.



## NEW SOUTH WALES

The following cases summaries and recommendations relate to deaths reported to a coroner in New South Wales.







## NORTHERN TERRITORY

The following cases summaries and recommendations relate to deaths reported to a coroner in the Northern Territory.





system did not and does not permit this. The Northern Territory Police Force cannot be criticised for this. I recommend that the Attorney General of this Territory look into this matter with a view to consulting with his colleagues interstate for the purpose of ameliorating the present system.

- **Recommendation 2: education regarding dangers of “ice”:** Those charged with undertaking public health campaigns in the area of illicit drugs ought to focus their attention, in particular, on advertising the dangers to young people of “ice”. As I have said this case serves as a salient example of its dangers.
- **Recommendation 3: GPS and bail:** After the abduction occurred a considerable amount of police time was expended looking for [the deceased] who had gone to ground. GPS (Global Positioning System) technology is now being employed in some jurisdictions for the purpose of monitoring the location of persons who are on bail. Presently, in the NT there is no lawful authority for a Magistrate or Judge to impose GPS tracking as a condition of bail. I recommend that the Attorney General and other relevant authorities look into the question of utilising this technology for the purpose of monitoring high risk persons whilst on bail, and if it is feasible, reforming the law in this regard to facilitate this.
- **Recommendation 4: urine samples:** The taking of urine samples in this case was overshadowed by an allegation, which I have found had merit, that [the deceased] was substituting the urine of others for his own so as to produce a false result. I recommend that when urine is taken that there be a specific signed note made by the person in charge of taking the sample that the sample has been taken from the person and that a note of that be placed on a form that is sent off to the relevant authorities.
- **Recommendation 5: drug counsellor notifications:** [the deceased’s] failure to follow up his appointment with the drug counsellor was not passed on to the police. As I have stated previously, I do not criticise the drug counsellor for this. However, I recommend that it be made clear to a drug counsellor when [they see] a person in circumstances such as [the deceased] whether there is a Court ordered obligation associated with the matter, in which case, I recommend that it be mandatory that a drug counsellor must notify the police OIC [Officer in Charge] of a failure to comply with any drug counselling condition of bail.

This *Fatal facts* summary has been produced by the National Coronial Information System and is released with the approval of the relevant State or Chief Coroner.

## QUEENSLAND

The following cases summaries and recommendations relate to deaths reported to a coroner in Queensland.



## TASMANIA

The following cases summaries and recommendations relate to deaths reported to a coroner in Tasmania.





## VICTORIA

The following cases summaries and recommendations relate to deaths reported to a coroner in Victoria.















## Coronial recommendations: Fatal facts

|                            |  |
|----------------------------|--|
| <b>Case number</b>         | VIC.2010.1092                                    |
| <b>Primary category</b>    | Natural cause death                              |
| <b>Fatal facts edition</b> | 40 – cases closed between January and March 2014 |

### Case summary

An adult female died from complications of an intra-abdominal haemorrhage during the third trimester of pregnancy.

The adult was taken to hospital due to abdominal pain, but discharged soon after as it was believed their condition had improved. The adult then suffered a seizure and was transported back to hospital but died shortly afterwards.

### Coronial findings

The coroner found that the death was from natural causes.

### Coronial recommendations

The coroner made the following recommendations related to this case:

- I adopt the recommendation of the Consultative Council on Obstetric and Paediatric Mortality and Morbidity that intra-abdominal haemorrhage (e.g. ruptured splenic artery aneurysm, ruptured liver) should be considered as part of the differential diagnosis when a pregnant woman presents with severe abdominal pain especially if she requires narcotic analgesia.

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## Coronial recommendations: Fatal facts

|                              |  |
|------------------------------|--|
| <b>Case number</b>           | VIC.2010.1112                                    |
| <b>Primary category</b>      | Law enforcement                                  |
| <b>Additional categories</b> | Intentional self-harm                            |
| <b>Fatal facts edition</b>   | 40 – cases closed between January and March 2014 |

### Case summary

An adult male took their own life by hanging whilst in police custody on remand. The adult had a history of self-harm and suicide attempts.

When placed in custody, the adult underwent a routine psychiatric evaluation which determined that they were at significant risk of suicide or self-harm. They were designated a P1<sup>1</sup> rating and were placed under observation but took their own life a few days later.

### Coronial findings

The coroner found that the death was due to intentional self-harm.

The coronial inquest focused on the custodial services' protocols and processes for responding to, and managing, the psychological needs of inmates and the associated risks.

### Coronial recommendations

The coroner made the following recommendations related to this case:

- Having regard to the greater pressure placed upon the system by the number of persons being held on remand and the numbers awaiting remand, while held in VICPOL [Victoria Police] cells, and having particular regard to the possible consequences of transferring prisoners through this system and out of [prison], who are suffering from severe mental illness (untreated) into non BDRP [Building Design Review Program] compliant cells at [prison] or elsewhere, and to the need for ongoing consultant supervision of the two nursing practitioners and others, I recommend that [prison services] seek the necessary additional funding to place one further full time equivalent psychiatric consultant, on part time duties at [prison]. Up to two consultants might share this work on a part time basis.

---

<sup>1</sup> Prisoners classified as P1 or P2 are required to be reviewed by a psychiatrist or psychiatric registrar to determine whether they should be referred on to a psychiatric registrar's out-patient list.

- Further, that these newly appointed psychiatrist(s) and both Nurse practitioners be specifically tasked under the direction of Consultant [physician], to review and medically manage all prisoners who are designated P1 or 2, floridly psychotic or not, this to occur and continue until such time as each such prisoner maybe be safely transferred out of [prison unit] and or BDRP compliant cells at [prison], into what remain as non BDRP compliant cells at [prison], and the reception unit at [prison], and elsewhere.
- I also adopt the two interim recommendations made during the inquest as follows:
  - I recommend that arrangements be made for [prison services] staff from the Director down, to visit and review the recent renovation of cells at the [prison], so that they are fully aware of the changes that have been made and the conditions in the cells, which have been made BDRP compliant, as opposed to conditions in cells which have not.
  - I further recommend that arrangements also be made for the same staff to visit the [prison] to inspect the [location] Reception Unit and thereby be made aware of the conditions in that place, so that they are fully informed about the unrenovated cells into which at risk prisoners maybe placed, dependent upon decisions that they are now called upon to recommend, about P and S<sup>2</sup> classification downgrading and transfer.
- The current P1 prisoner classification criteria be extended to specifically include those prisoners to be maintained at the AAU [Acute Assessment Unit], for pre-sentence or pre-trial psychiatric reports.
- The approach of remanding such prisoners referred to above exclusively to the AAU, be reviewed by the [prison unit] Director and the prison CEO, to determine whether such prisoners might be safely and conveniently detained in a BDRP compliant cell unit near to or adjacent to, but not necessarily within [prison unit] as currently defined.
- All P1 classified prisoners not covered by the category above, suffering from what is believed at admission screening, or release from a [prison unit] cell to be, '*a serious psychiatric condition, requiring immediate and or intensive care,*' be referred directly to the AAU for review, or in consultation with the CEO of [prison], to an adjacent BDRP compliant unit, to await detoxification and or available AAU cell space, in anticipation of a later review and provisional psychiatric diagnosis, by a nurse practitioner under a consultants supervision, or by a psychiatric registrar or above.
- That all P2 classified prisoners be referred as above, for medication review.
- That all [prison services] staff receives ongoing instruction from the [prison unit] Director and such others as she may invite, on all matters pertinent to admission screening and [prison unit] cell prisoner review. This instruction should be ongoing and planned with a view to ensuring that all mentally ill prisoners including those believed on admission to suffer from a serious mental illness (including a serious depressive illness), are classified

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<sup>2</sup> S classification refers to the level of risk of suicide of a prisoner

appropriately, and if P1 or P2 are then seen and reviewed in a time efficient manner as set out above. This instruction should also specifically include guidelines concerning the relevance of collateral information and its collection, and in consultation with the prison CEO, may also include advice given to admission prison and or SASH [suicide and self-harm trained] officers, concerning the collection of such information.

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## Coronial recommendations: Fatal facts

|                              |  |
|------------------------------|--|
| <b>Case number</b>           | VIC.2010.1988                                    |
| <b>Primary category</b>      | Transport and traffic related                    |
| <b>Additional categories</b> | Mental illness and health                        |
| <b>Fatal facts edition</b>   | 40 – cases closed between January and March 2014 |

### Case summary

An adult male died when they were struck by a motor vehicle. The adult had a long history of psychiatric illness and was a resident of a Supportive Residential Service.

They left the facility and were walking along the side of the road when they were struck by a vehicle and suffered multiple serious injuries. An ambulance was called and the adult was conveyed to hospital but was unable to be revived.

### Coronial findings

The coroner found that the death was unintentional.

The coronial investigation found that the deceased had previously gone missing from the facility which was not gated and residents were free to leave of their own volition.

### Coronial recommendations

The coroner made the following recommendations related to this case:

- At the time when [the deceased] went missing and at the time of his death the Supported Residential Services (Private Proprietors) Act 2010 and its accompanying Regulations were not in force. If the provisions had of been in force at the time the proprietors of [Supportive Residential Service] could have issued a 'Notice to Vacate' to [deceased] and the Department of Health would have been required to assess [deceased]'s needs and take appropriate action which in this case would have been to move him to a more secure facility.
- In my view, the current Act and its regulations are entirely appropriate and I therefore do not propose to make any further recommendations.

This *Fatal facts* summary has been produced by the National Coronial Information System and is released with the approval of the relevant State or Chief Coroner.



in any previous 24 hours and remains in the low dependency unit until when practicable, is reviewed by a consultant psychiatrist.

- To improve the safety of patients who are involuntary under the *Mental Health Act 1986* (Vic) and who are tobacco dependent and who do have approved leave, the [residential unit] should:
  - Review the available body of evidence-based guidelines regarding withdrawal from tobacco, including best practice in the assessment, prevention, and management of withdrawal symptoms.
  - Undertake a programme of education with the medical and nursing staff that addresses not only the administration of the rules of a smoke free environment, including staff and patient safety, but best practice in the assessment, prevention, and management of withdrawal symptoms from nicotine as a substance of addiction and prevent or manage the symptoms.
- To improve out of hours access for patients, the [residential unit] should install and ensure adequate signage proximate to the intercom at the front doors to the unit with sufficient information to guide patients who return after 9.00pm on both how to use it and how to contact staff.

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## Coronial recommendations: Fatal facts

|                              |  |
|------------------------------|--|
| <b>Case number</b>           | VIC.2011.3011                                    |
| <b>Primary category</b>      | Water related                                    |
| <b>Additional categories</b> | Drugs and alcohol                                |
| <b>Fatal facts edition</b>   | 40 – cases closed between January and March 2014 |

### Case summary

A young adult male drowned whilst attempting to swim across a river. They swam several metres from the bank before beginning to struggle in the water and disappeared from view. The young adult and their friends had been socialising and consuming alcohol at the time of the incident.

### Coronial findings

The coroner found that the death was unintentional.

As there had been a number of other drowning deaths in the area under similar circumstances, the coroner requested these incidents be reviewed.

### Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that Life Saving Victoria convene a meeting with the [local council] and Victoria Police to identify targeted drowning prevention interventions to prevent or deter alcohol-affected persons from entering the [river] within the [local council], particularly around [incident location area], where there appears to be a disproportionately high frequency of drownings.
- In light of the interest of the Australian Water Safety Council in preventing alcohol related drownings, and its interest in developing evidence based strategies to achieve this, I make the further recommendation that the Australian Water Safety Council consider whether the stretch of the [river] between the [two bridges] is an appropriate location to trial any interventions aimed at reducing alcohol-related unintentional drowning, given that there appears to be a disproportionately high frequency of drownings in this area.

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## Coronial recommendations: Fatal facts

|                              |  |
|------------------------------|--|
| <b>Case number</b>           | VIC.2012.704                                     |
| <b>Primary category</b>      | Water related                                    |
| <b>Additional categories</b> | Drugs and alcohol                                |
| <b>Fatal facts edition</b>   | 40 – cases closed between January and March 2014 |

### Case summary

A young adult male drowned whilst attempting to swim across a river. They were seen to struggle in the water, and were unable to be recovered despite their friends' rescue attempts. The deceased was subsequently located by emergency services. The group had been socialising and consuming alcohol at the time of the incident.

### Coronial findings

The coroner found that the death was unintentional.

As there had been a number of other drowning deaths in the area under similar circumstances, the coroner requested these incidents be reviewed.

### Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that Life Saving Victoria convene a meeting with the [local council] and Victoria Police to identify targeted drowning prevention interventions to prevent or deter alcohol-affected persons from entering the [river] within the [local council], particularly around [incident location area], where there appears to be a disproportionately high frequency of drownings.
- In light of the interest of the Australian Water Safety Council in preventing alcohol related drownings, and its interest in developing evidence based strategies to achieve this, I make the further recommendation that the Australian Water Safety Council consider whether the stretch of the [river] between the [two bridges] is an appropriate location to trial any interventions aimed at reducing alcohol-related unintentional drowning, given that there appears to be a disproportionately high frequency of drownings in this area.

This *Fatal facts* summary has been produced by the National Coronial Information System and is released with the approval of the relevant State or Chief Coroner.

## Coronial recommendations: Fatal facts

|                              |  |
|------------------------------|--|
| <b>Case number</b>           | VIC.2012.2413                                    |
| <b>Primary category</b>      | Transport and traffic related                    |
| <b>Additional categories</b> | Youth  |
| <b>Fatal facts edition</b>   | 40 – cases closed between January and March 2014 |

### Case summary

A young adult male died when they were struck by a train.

The young adult was walking along the railway tracks late at night and was listening to music through earphones. They were facing away from the train’s direction of travel so would not have been able to hear the train approaching.

### Coronial findings

The coroner found that the death was unintentional.

### Coronial recommendations

The coroner made the following recommendations related to this case:

- That rail authorities consider the development of a campaign similar to that developed by tram operators to remind pedestrians about dangers of rail track environs and in particular, the danger to pedestrians of distraction from earphones and other devices which may impede the ability to perceive or identify that a train is approaching.

This *Fatal facts* summary has been produced by the National Coronial Information System and is released with the approval of the relevant State or Chief Coroner.

## Coronial recommendations: Fatal facts

|                              |  |
|------------------------------|--|
| <b>Case number</b>           | VIC.2012.3924                                    |
| <b>Primary category</b>      | Intentional self-harm                            |
| <b>Additional categories</b> | Transport and traffic related                    |
| <b>Fatal facts edition</b>   | 40 – cases closed between January and March 2014 |

### Case summary

An adult male died when they stepped into the path of a train at a pedestrian crossing. The adult had a history of mental illness and had previously exhibited suicidal ideation.

### Coronial findings

The coroner found that the death was due to intentional self-harm.

Despite not contributing directly to this death, the coroner found that the pedestrian crossing had scope for improvement.

### Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that consideration be given to making the pedestrian railway crossing at [location] active through the provision of pedestrian gates and audible tones.

This *Fatal facts* summary has been produced by the National Coronial Information System and is released with the approval of the relevant State or Chief Coroner.

## Coronial recommendations: Fatal facts

|                              |  |
|------------------------------|--|
| <b>Case number</b>           | VIC.2014.863                                     |
| <b>Primary category</b>      | Law enforcement                                  |
| <b>Additional categories</b> | Intentional self-harm/Mental illness and health  |
| <b>Fatal facts edition</b>   | 40 – cases closed between January and March 2014 |

### Case summary

An adult male took their own life whilst in custody at an immigration detention centre. They had previously attempted suicide whilst in the custody of police.

Whilst at the detention centre, the adult underwent multiple mental health assessments, but did not disclose any mental health issues or previous self-harm attempts. The assessments did not raise concern for their mental health.

### Coronial findings

The coroner found that the death was due to intentional self-harm.

The coronial investigation found conflicting information as to whether police notified the operators of the detention centre of the previous suicide attempt when transferring custody of the deceased.

### Coronial recommendations

The coroner made the following recommendations related to this case:

Department of Immigration and Border Protection, [security services], [health care service] and police:

- To promote the safety and wellbeing of immigration detainees, I recommend that appropriate representatives of the Department of Immigration and Border Protection, [security services] and Victoria Police meet to discuss and develop a coordinated transfer of custody process which ensures that all relevant information held by one agency is conveyed contemporaneously with the detainee when transferred.
- To ensure the efficacy of any interagency coordinated transfer process, I recommend that the Department of Immigration and Border Protection, [security services] and Victoria Police each independently ensure that any necessary internal policies and procedures are effectively developed and implemented.
- To ensure the efficacy of any interagency coordinated transfer process that is developed, I recommend that Department of Immigration and Border Protection, [security services]

and Victoria Police each ensure that their employees are aware and appropriately trained in the aspects of the process pertaining to them.

[Security services] and the Department of Immigration and Border Protection

- I recommend that [security services] and the Department of Immigration and Border Protection collaborate to amend the Self Harm Assessment Interview to require all detainees to be specifically questioned about their mental health and suicide and self-harm history, to ensure that any relevant information is elicited and recorded at the earliest available opportunity and appropriately actioned.

[Health care service]

- To increase the safety of detainees, I recommend that the Department of Immigration and Border Protection, [security services] and [health care service] meet to consider the feasibility of, and options around, developing a system whereby qualified mental health practitioners are able to observe and interact with detainees within the common areas of the [immigration detention centre], particularly during periods of higher suicide and self-harm risk such as when first detained or when informed about deportation or when identified as someone who is at risk.

This *Fatal facts* summary has been produced by the National Coronial Information System and is released with the approval of the relevant State or Chief Coroner.

## WESTERN AUSTRALIA

The following cases summaries and recommendations relate to deaths reported to a coroner in Western Australia.

## Coronial recommendations: Fatal facts

|                            |  |
|----------------------------|--|
| <b>Case number</b>         | WA.2010.485                                      |
| <b>Primary category</b>    | Work related                                     |
| <b>Fatal facts edition</b> | 40 – cases closed between January and March 2014 |

### Case summary

A middle aged male died in a workplace mining incident. The adult died when the loader they were operating fell down a vertical void between levels of the mine. The void was not protected by physical barriers.

### Coronial findings

The coroner found that the death was unintentional.

### Coronial recommendations

The coroner made the following recommendations related to this case:

- That, wherever possible, mine operators manage the hazard of open holes in mines by designing, constructing and locating physical hard barriers so as to prevent equipment from having access to the edge of such open holes, and that the barriers be used in conjunction with lower level access control systems such as signage, demarcation and lockable barriers controlled by persons in authority.

This *Fatal facts* summary has been produced by the National Coronial Information System and is released with the approval of the relevant State or Chief Coroner.



# Coronial recommendations: Fatal facts

|                            |  |
|----------------------------|--|
| <b>Case number</b>         | WA.2013.109                                      |
| <b>Primary category</b>    | Water related                                    |
| <b>Fatal facts edition</b> | 40 – cases closed between January and March 2014 |

### Case summary

A young adult male died when they fell from a reef into the ocean while fishing. Despite a significant rescue operation, their body was never recovered. The conditions were known to be dangerous in this area.

Fisheries officers gave the young person and their friend information about the rules and regulations of fishing in the area before they went out onto the reef. This did not include a wave or weather hazard warning.

### Coronial findings

The coroner found that the death was unintentional.

### Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that Surf Life Saving, local government and Fisheries work together to maximise individual safety concerns alongside desirable fisheries management.

This *Fatal facts* summary has been produced by the National Coronial Information System and is released with the approval of the relevant State or Chief Coroner.

## Coronial recommendations: Fatal facts

|                            |  |
|----------------------------|--|
| <b>Case number</b>         | WA.2013.1031                                     |
| <b>Primary category</b>    | Geographic                                       |
| <b>Fatal facts edition</b> | 40 – cases closed between January and March 2014 |

### Case summary

A middle aged male disappeared from a campsite while prospecting with a friend in a remote area. Despite an extensive search and rescue operation, the adult was not seen alive again and their body was never found.

### Coronial findings

The coroner made an open finding as to the circumstances of the death, but determined that he died sometime in the month following his disappearance.

### Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend WAPOL [Western Australia Police] consider ongoing negotiation with the Department of Mines and Petroleum in educating prospective prospectors of the benefits of carrying a personal location beacon when travelling in remote Australia.

This *Fatal facts* summary has been produced by the National Coronial Information System and is released with the approval of the relevant State or Chief Coroner.

## APPENDIX A: FATAL FACTS WEB TOOL CATEGORY TAGS

| Category                | Description  |
|-------------------------|--|
| Adverse medical effects | Adverse after effects from a recent medical or surgical treatment, failure to comply with medical advice.  |
| Aged care               | Incidents that occurred in an aged care or assisted living facility or residence including a retirement village.   |
| Animal                  | Incidents where an animal was involved in the cause of death.  |
| Child and infant death  | Any case involving a child or infant - 12 years old and under.   |
| Domestic incident       | Fatal incident that occurred as a result of domestic injury or event.  |
| Drugs and alcohol       | Death where drugs or alcohol or both were a primary or secondary cause of death.   |
| Electrocution           | Cases where electrocution is the primary cause of death.   |
| Falls                   | Incidents where a fall was involved in the circumstances or cause of death.  |
| Fire related            | Incidents where a fire was involved in the circumstances or cause of death.  |
| Geographic              | Cases where the geographic region is significant to the cause of death, for example remote location.   |
| Homicide and assault    | Includes interpersonal violence and family domestic violence.  |
| Indigenous              | Cases related to a specific demographic group.   |
| Intentional self-harm   | Cases determined intentional self-harm (ISH) by coronial investigation   |
| Law enforcement         | Includes police pursuit, death in custody, parole issues, pending or previous court cases including family court, restraining order and coronial investigation procedures. |
| Leisure activity        | Any leisure activity that directly influence the circumstances including holiday.  |

## National Coronial Information System

| Category                      | Description  |
|-------------------------------|--|
| Location                      | Cases where the location of either the incident or the discovery of the body is of significance, does not refer to geographic location.  |
| Mental illness and health     | Incidents where the existence of mental illness issues were involved in the circumstance on death, both diagnosed and anecdotal. Please note mental health is included as a contributing factor to death at the discretion of the coroner. |
| Misadventure                  | Risk taking behaviour such as train-surfing, unintentional drug overdose.  |
| Natural cause death           | Cases where the death is due to natural causes.  |
| Older persons                 | Cases related to a specific demographic group or where the age of a person was a factor in the death.  |
| Physical health               | Cases where the existing physical health of the person contributed but were not necessarily cause the death.   |
| Sports related                | Cases where a sports incident significantly impacted the cause of death.   |
| Transport and traffic related | Cases involving road, water and air vehicle incidents, motorised or naturally powered. Also includes cases where pedestrians are impacted by transport vehicles.   |
| Water related                 | Includes swimming, scuba, snorkelling, boating, fishing and all water related activity in both a recreational or commercial context.   |
| Weather related               | Cases where the environmental conditions such as heatwave or storm conditions were significant to the cause of death.  |
| Work related                  | Includes cases where work is related to the death and also where unemployment is significant.  |
| Weapon                        | Cases where the involvement of a weapon is significant.  |
| Youth                         | Cases related to a specific demographic group.   |