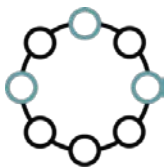




Coronial recommendations: Fatal facts

A summary of cases and recommendations made
between April and June 2014

Edition 41



NATIONAL CORONIAL INFORMATION SYSTEM

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ACKNOWLEDGMENTS

The NCIS is funded by all State/Territory Justice Departments, New Zealand Ministry of Health, Commonwealth Department of Health, Commonwealth Department of Infrastructure, Regional Development and Cities, Australian Competition and Consumer Commission, the Australian Institute of Criminology and Safe Work Australia. Coronial data has been provided by each State and Territory Coroner's Office in Australia and New Zealand. Additional codes are provided by the Australian Bureau of Statistics (ABS) and Safe Work Australia. We gratefully acknowledge their support.



Coroners Court
of Victoria



QUEENSLAND
COURTS



CORONIAL SERVICES
OF NEW ZEALAND

Parangō Ō te Āh Kōwhiri



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 April and June 2014.

Previous summaries and recommendations are available

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

AUSTRALIAN CAPITAL TERRITORY CASES

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

Coronial recommendations: Fatal facts

Case number	ACT.2011.208
Primary category	Adverse medical effects
Fatal Facts edition	41 – cases closed between April and June 2014

Case summary

A middle aged female died in hospital shortly after requiring emergency life support.

The adult complained of breathlessness during a medical procedure and a Medical Emergency Team (MET) call was activated. Responding staff had difficulty intubating the adult and they were significantly oxygen-deprived for a period of time. The adult suffered neurological damage and their family decided to withdraw treatment.

Coronial findings

The coroner found that the death was due to complications of medical or surgical care. The coroner found that the environment in which the MET call was being conducted was somewhat chaotic. The procedure was complicated by the number of people present, the noise levels, a lack of assertive management by doctors and poor communication.

Coronial recommendations

The coroner made the following recommendations related to this case:

That the person responsible for the medical emergency team and ICU [Intensive Care Unit] outreach services at the [location] Hospital consider implementing the following:

- A requirement that all staff who are responsible for MET [Medical Emergency Team] pagers, or are required or authorised to attend MET calls, be required to complete a document indicating that they have read and are familiar with MET call policies and procedures and have familiarised themselves with the equipment available on the MET trolley, to be completed annually;
- Amending paragraph 7 of the "Responders roles and responsibilities" document to incorporate at point 1, under the heading "Key points of communication", the following recommended form of introduction on arrival at a medical emergency:
"my name is.....; I am the (indicate role); I have (x) years/months experience in this role; who is in charge of this response?/I am in charge of this response."

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

Coronial recommendations: Fatal facts

Case number	ACT.2013.74
Primary category	Intentional self-harm
Additional categories	Mental illness and health
Fatal Facts edition	41 – cases closed between April and June 2014

Case summary

An older adult male took their own life by hanging. They had previously attempted suicide.

They were a voluntary patient on the Medical Assessment and Planning Unit [MAPU] of a hospital whilst waiting to be admitted to a specialised psychiatric unit. They absconded from the ward and their body was located in a park a week later.

Coronial findings

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

The coroner found the clinical handover of the patient was inadequate, including insufficient communication of the high risk of absconding or self-harm. The coroner also found that the security levels on the ward and procedure for responding to patients who had absconded could be improved.

Coronial recommendations

The coroner made the following recommendations related to this case:

- ACT [Australian Capital Territory] Health should give consideration to requiring a review of the handover protocol by Clinical Handover Standards Group which might consider requiring staff to review at least the basic handover sheet, which would highlight any particular risk issues, before commencing clinical duties.
- ACT Health should give consideration to the development of a Standard Operating Procedure [SOP] and report form in relation to patients who abscond from wards in the hospital, which would assist in guiding staff in relation to gathering information and informing appropriate personnel in a timely and accurate manner.
- ACT Health should give consideration to securing or monitoring access to, and egress from, wards other than dedicated psychiatric wards which accommodate mobile patients suffering psychological or mental illness.
- ACT Health should give consideration to amending the "Mental Health, Justice Health and Alcohol and Drug Services Access and Acute Mental Health Service SOP, the

Suicidal Behaviour: Treatment and care of consumers who display suicidal behaviour” document in order to address the particular circumstances of patients with psychological or psychiatric conditions housed in other than psychiatric units, for example, the Medical Assessment and Planning Unit [MAPU].

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NEW SOUTH WALES

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

Coronial recommendations: Fatal facts

Case number	NSW.2004.6337
Primary category	Homicide and assault
Additional categories	Law enforcement
Fatal Facts edition	41 – cases closed between April and June 2014

Case summary

An adult female went missing in circumstances that indicated they were abducted. Their body was never found.

Coronial findings

The coroner was unable to determine the cause of the deceased's fatal injuries.

The coronial investigation found significant deficiencies in the initial police investigation that affected the ability of police to conclude who was responsible for her disappearance and death.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the Minister of Police and Justice of NSW [New South Wales]
and To the Attorney General of NSW

- Consideration be given to the NSW Government offering a substantial monetary reward for information leading to the conviction of any person or persons for the abduction and murder of [deceased person]. The sum should not in my view be less than \$500,000;
- That consideration be given to implementing measures to achieve a closer liaison between the Missing Persons Unit and the Homicide Squad in relation to long term missing person cases.

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Coronial recommendations: Fatal facts

Case number	NSW.2009.408
Primary category	Adverse medical effects
Additional categories	Natural cause death
Fatal Facts edition	41 – cases closed between April and June 2014

Case summary

A young adult male died due to an undiagnosed brain cyst. The young adult had been experiencing headaches for several months and was eventually admitted to hospital. They required a brain CT scan; however, this hospital did not have a CT scanner. The young adult was transported to another hospital where their symptoms were misdiagnosed and they were discharged.

Soon after returning home, they suffered a catastrophic brain event. The young adult was non-responsive and an ambulance was called. Despite emergency treatment, their injuries were fatal.

Coronial findings

The coroner found that the death was due to complications of medical or surgical care.

The coroner was unable to say whether the deceased could have been saved had they been correctly diagnosed, however, they were sent away from the hospital before their condition was properly investigated.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend to the Minister for Health, the Royal Australasian College of Surgeons and the Neurosurgical Society of Australasia that they consider implementing a scheme for organising regular short-form neurosurgical skills training for general surgeons operating in NSW [New South Wales] regional centres.

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Coronial recommendations: Fatal facts

Case number	NSW.2010.646
Primary category	Aged care
Additional categories	Falls/ Older persons
Fatal Facts edition	41 – cases closed between April and June 2014

Case summary

An older adult male fell from a balcony at the aged care facility where they lived. Staff located them lying on the ground and noticed that the balcony railings above were missing.

Coronial findings

The coroner found that the death was unintentional. The majority of the external handrails and balustrades in the complex had been in urgent need of repair for some time.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the NSW [New South Wales] Minister for Planning

- I recommend that the Minister consider implementing a process whereby Aged Care Facilities operating within NSW are required to provide Safety Certificates on an ongoing basis in relation to the structural integrity of their balconies & balustrades. Any such requirement should be at least every 3 years and should contain reference to any deficiencies identified in the safety of those balustrades and the time period required to rectify such deficiencies. I also recommend that if this recommendation is implemented that the Minister's office inform in writing the Commonwealth Minister of Social Services and the Aged Care Quality Agency of any such requirement.

To Commonwealth Minister for Social Services

- I recommend that the Australian Aged Care Quality Agency require Aged Care Providers to provide evidence of the compliance with [the first recommendation] at the time of reaccreditation if such recommendation is implemented by the NSW Ministry for Planning.

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Coronial recommendations: Fatal facts

Case number	NSW.2010.1654
Primary category	Adverse medical effects
Additional categories	Drugs and alcohol
Fatal Facts edition	41 – cases closed between April and June 2014

Case summary

A young male died from cardio-respiratory arrest due to mixed drug toxicity. They were a patient at an acute adult mental health clinic when they overdosed on prescription and non-prescription medication.

Nursing staff located the patient unconscious and not breathing in bed. Resuscitation was attempted whilst they were still in bed and emergency services were contacted. Ambulance officers transported the patient to hospital where they were declared deceased.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the response of nursing staff was sub-optimal and they were inadequately trained to respond to a critical incident like rendering emergency resuscitation.

Coronial recommendations

The coroner made the following recommendations related to this case:

Recommendation 1 - Review of resuscitation training

- Having regard to the illnesses suffered by some of the patients of the [clinic] and the treatment regularly provided to them, there is an elevated risk of cardio-respiratory arrest occurring among that population so that ready access to advanced life support is essential in my view. Accordingly, I recommend that [health service] review the level of training currently provided to the staff at the clinic, the manner in which it is provided and the frequency with which it is refreshed to ensure that at all times there are staff on the premises who can adequately respond to foreseeable emergencies when they occur.

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Coronial recommendations: Fatal facts

Case number	The coroner held a joint investigation into the following deaths which resulted from similar incidents: NSW.2011.532, NSW.2011.2271, NSW.2012.1130
Primary category	Drugs and alcohol
Additional categories	Natural cause death
Fatal Facts edition	41 – cases closed between April and June 2014

Case summary - NSW.2011.532

A young male died of natural causes in the context of mixed drug toxicity. They suffered severe back pain and were abusing prescription medication.

Prior to their death they obtained dangerous quantities of prescription medication from numerous different doctors.

Coronial findings

The coroner found that the death was due to natural causes.

The coroner found the death highlighted the need for a real-time prescribing system.

Case summary - NSW.2011.2271

An adult female died as a result of an unintentional consequence of ingesting a lethal combination of prescription drugs.

They obtained escalating quantities of prescription medication from the same medical centre and pharmacy.

Coronial findings

The coroner found that the death was unintentional.

The coroner found the death highlighted the need for education and training of general practitioners and pharmacists on identifying and appropriately treating patients with addiction to the medication which they are being prescribed.

Case summary - NSW.2012.1130

An adult male died as a result of ingesting a lethal combination of prescription drugs.

Coronial findings

The coroner found that the death was unintentional.

The coroner found the death demonstrated the vital contribution that real time prescribing would make to the protection of individuals and society against the harms and costs of the abuse of prescription medication.

Coronial recommendations

The coroner made the following recommendations related to these cases:

To the Secretary of the Australian Government Department of Health and Aging

- I recommend that all benzodiazepines should be moved to Schedule 8 of the Standards for the Uniform Scheduling of Medicines and Poisons.

To the NSW [New South Wales] Minister for Health

- I recommend that the New South Wales Department of Health consider steps to be taken to implement a real-time web based prescription monitoring program available to, at least, pharmacists and general practitioners within 12 months, that:
 - records the dispensing of all Schedule 8 poisons in New South Wales;
 - provides real-time prescription information to all prescribers and dispensers throughout New South Wales; and
 - facilitates the New South Wales Department of Health to monitor the dispensing of these medications and identify behaviours of concern, with an expected completion date of 36 months.
- I recommend that the New South Wales Department of Health consider including all benzodiazepines within the program set out above.
- I recommend that the New South Wales Department of Health consider what if any additional steps can be taken to educate pharmacists and general practitioners on the ability to report inappropriate prescribing to the Pharmaceutical Services Unit, Ministry of Health (NSW), on means of identification of inappropriate prescribing, and on the authority requirements when prescribing schedule 8 drugs.
- I recommend that New South Wales Department of Health consider:
 - imposing a requirement that a doctor should not commence prescribing a schedule 8 drug or a benzodiazepine to a patient without making enquiries to verify the patient's prescribing history, or if not practicable, such supply should be limited to that which is necessary until the prescribing history can be obtained; and
 - expanding the restrictions on the prescribing of schedule 8 drugs in sections 27 to 29 of the *Poisons and Therapeutic Goods Act 1966* to also cover a list of restricted drugs of dependence.

To the CEO of the Pharmacy Guild of Australia

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- I recommend that the Pharmacy Guild of Australia consider preparing de-identified case studies involving misuse of prescription medications with a view to providing continuing education to pharmacists in identifying and responding to prescription shopping and/or drug dependency.
- I recommend that the Pharmacy Guild of Australia, the Pharmaceutical Society of Australia and the Royal Australian College of General Practitioners liaise with a view to:
 - promoting the use of staged supply and other means to reduce the risk of the misuse of prescription medication;
 - promoting the use of supervised administration of medication in a pharmacy; and
 - developing education modules on lawful options available to respond to suspected misuse of prescription medications.

To the President of the Royal Australian College of General Practitioners

- I recommend that the Royal Australian College of General Practitioners consider developing a short 1-2 page clinical guideline for use by general practitioners regarding:
 - The management of chronic non-cancer pain;
 - The prescription of benzodiazepines;
 - The prescription of opioids;
 - The circumstances in which the use of private and/or repeat prescriptions may be appropriate; and
 - Available resources including the Drug and Alcohol Specialist Advisory Service and the form to authorise the release of personal Medicare and Pharmaceutical Benefits Scheme claims information to a third party.
- I recommend that the Royal Australian College of General Practitioners consider developing a clinical governance framework for General Practices and General Practitioners to address the rising problem of prescription drug abuse in Australia.
- I recommend that the Royal Australian College of General Practitioners and the National Coronial Information System (NCIS) liaise to consider how to facilitate sharing of information on the NCIS database in relation to deaths linked to the abuse of prescription medication.
- I recommend that the Royal Australian College of General Practitioners consider including within its continuing professional development requirements for general practitioners:
 - A requirement that all general practitioners who prescribe Schedule 8 poisons and/or benzodiazepines, be required to attend an unit of skills training within 3 years (or within 3 years of qualification) dealing with pain management, drug dependency and the proper prescribing of opioids and benzodiazepines, and including, once it is completed, the guideline referred to above; and
 - An education module which addresses sharing of information about patients, including the legal constraints upon this; and

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- Use of de-identified case studies in these education modules, and liaise with the Pharmacy Guild of Australia in relation to these.
- I recommend that the Royal Australian College of General Practitioners and the Australian Medicare Local Alliance (with those entities seeking to involve such national bodies as they consider appropriate in the circumstances) consider establishing a program, available on a non-mandatory basis for members of the Royal Australian College of General Practitioners, for establishing local forums to be attended by general practitioners, and to invite also pharmacists and other specialists or hospital services, to identify problems of doctor shopping within that area and to establish channels of communication to deal with the problem.

To the Minister for the Australian Government Department of Health and Aging

- I recommend that the Minister together with the Chief Executive Officer of Medicare:
 - consider working with the Pharmaceutical Society of Australia, the Pharmacy Guild and other relevant peak bodies to facilitate access to the prescription hotline by pharmacists and to promote the use of the prescription hotline by pharmacists;
 - consider adopting mechanisms to make it compulsory for all medical prescribers to be registered under the Prescription Shopping Program (administered by the Department of Human Services on behalf of the Department of Health (Cth));
 - consider the efficacy of the Prescription Shopping Program (administered by the Department of Human Services on behalf of the Department of Health (Cth)) and consider what, if any, means might be adopted to assist in ensuring that the system is used by practitioners and that it enables prompt identification of the abuse of prescription medications having regard to the issues arising in these matters.

To the Secretary Australian Government Department of Health and Aging and the Minister of the New South Wales Department of Health

- I recommend that the Commonwealth Department of Health and Aging and the New South Wales Department of Health (through the PBS) consider imposing a requirement that a general practitioner should not, other than in exceptional circumstances, prescribe long term anti-depressant and/or anti-psychotic medication to a patient without seeking advice and/or input from a psychiatrist, who should if relevant, be the patient's treating psychiatrist.

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Coronial recommendations: Fatal facts

Case number	NSW.2011.5238
Primary category	Law enforcement
Additional categories	Transport and traffic related/ Drugs and alcohol
Fatal Facts edition	41 – cases closed between April and June 2014

Case summary

A young adult male sustained fatal injuries when the motorcycle they were riding was involved in a head-on collision with another vehicle. They were being pursued at speed by police at the time. Alcohol and cannabis were detected in deceased's blood post-mortem.

Coronial findings

The coroner found that the death was due to legal intervention.

The coroner opined that due to their operational nature and close proximity to the issue, state police cannot objectively analyse and develop appropriate policy around police pursuits. The coroner recommended independent review into pursuit policy in an effort to reduce the number of casualties in high-speed pursuits.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the Minister for Police

- I recommend that the NSWPF [New South Wales Police Force] Safe Driving Policy (SDP) in respect of police pursuits be reviewed by a panel of independent experts appointed by the Minister in the light of Australian and international experience and research with a view to establishing best practice for the New South Wales Police Force.
- I recommend that such a review address the following issues (at least):
 - What are the bases in practice on which pursuits are currently commenced or not commenced? Are they appropriate?
 - How should the factors relating to the commencement of pursuits be ranked or weighted?
 - In what way(s) can the decision-making process for officers on the streets be simplified?
 - Are pursuits *in practice* a traffic law enforcement tactic of "last resort"? If not, why not?

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- If so, what alternatives are routinely employed before pursuits are commenced? What practical alternatives are there to pursuits?
- What are the costs and benefits of a policy mandating that a pursuit only be commenced or maintained when there is immediate danger to the safety of others if the suspect is not apprehended at the time?
- What are the costs and benefits of the SDP specifying a list of offences which, absent other factors, would not justify the commencement of a high-speed pursuit?
- What are the costs and benefits of pursuing vehicles driven by persons reasonably suspected of being under the influence of drugs or alcohol?
- What are the costs and benefits of pursuing suspected stolen vehicles?
- What are the costs and benefits of pursuing stolen vehicles believed to be carrying persons suspected of more serious crimes than stealing a motor vehicle or taking and driving a motor vehicle?
- What are the costs and benefits of introducing specific (possibly temporary) categories of situation in which pursuits ought be terminated or temporarily suspended (eg, if the suspect exceeds a particular speed; approaches an operational school zone; or approaches a known traffic “black spot” that would significantly increase the risk of a high-speed pursuit)?
- Because motorcyclists are more vulnerable to death or injury in pursuits than persons in other types of vehicles, should they be treated as a special case (ie, high-risk) under the SDP?
- In the NSWPF Safe Driving Policy is risk to suspected offenders taken into account as a factor in the decisions whether to commence, continue or terminate a pursuit? If so, how is that manifested? If not, why is it not and ought it be?
- If it is taken into account in the SDP, is it also taken into account in practice by the NSWPF? If not, why not? If so, how does this manifest itself in the conduct of pursuits?
- When is a police vehicle “part of a convoy” in a pursuit? Is it part of a convoy if it is following two pursuing vehicles at above the speed limit in “urgent duty” mode? Are the SDP guidelines sufficiently clear on this point?
- How should the SDP be reviewed periodically? Internally only? Externally only? A combination of both methods?
- Are there any technological improvements to NSWPF vehicles that could enhance the safety of high-speed often by the NSWPF as an alternative to pursuits?
- Are the penalties for s 39 offences sufficiently severe? Are prosecutors informing sentencing courts that s 39 is a measure intended to reduce the number of police pursuits?
- What categories of statistics kept by the NSWPF concerning pursuits? What additional statistics ought be recorded to enable an appropriate understanding of NSWPF pursuit practice, the behaviour of pursued drivers and accurate cost-benefit analysis of pursuit policy?

- How does the NSWPF's practice compare with that of other Australian and comparable international police forces?
- Ought a more restrictive SDP be introduced in pursuits or be used to reduce the number of pursuits? Would introduction of such technologies be feasible, practicable and cost-effective?
- To what extent is s.39 of the Law Enforcement (Powers and Responsibilities) Act used as an alternative to pursuits for traffic offences? Ought it be used more NSW?
- Whether or not such a review is undertaken, I recommend that the current SDP be amended to eliminate the ambiguities identified in these findings and to clarify the SDP generally.
- I recommend that, pending any review, the SDP make specific reference to the risk to the suspected offender (and any passengers in the suspect vehicle) as a major factor in the decision whether to commence, maintain or terminate a pursuit.
- I recommend that, pending any review, the vulnerability of motorcyclists also be considered a major factor in the pursuit decision-making process.
- I recommend that, pending any review, the SDP make specific reference to the high rate of casualties resulting from high-speed pursuits and that police training also emphasise this.
- I recommend that, pending any review, the wording of the principle in the SDP that police officers should engage in pursuits "when the gravity and seriousness of the circumstances require such action" to be amended to read "when the gravity and seriousness of the circumstances indicate such action"
- I recommend that, pending any review, Guideline 1 in the SDP be amended by the replacement of the phrase "the need to immediately apprehend the offender" with the phrase "the desirability of immediately apprehending the offender".
- I recommend that, pending any review, that the NSWPF collect data identifying the specific type of offence or suspected offence that gave rise to the decision to commence a pursuit.
- I recommend that the NSWPF publish in its annual reports a full account of the number of pursuits commenced and terminated, the results of those pursuits, the reasons the pursuits were commenced and the number and types of casualties occasioned during the pursuits.
- I recommend that, pending any review, urgent consideration be given to restricting high-speed pursuits to cases in which a serious offence (other than fail to stop as directed) is reasonably suspected of having been committed by the pursued driver or a person in the pursued vehicle AND (b) that person is unidentified OR there is no immediate prospect of locating him or her unless apprehended urgently. (For the purpose of this recommendation, consideration ought be given to defining "high-speed pursuit" as a pursuit in which a speed of 45kph or more over the prevailing speed limit is reached during the course of the pursuit by either the pursued vehicle or the police pursuit vehicle(s).)

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- In the alternative to the previous recommendation, I recommend that, pending any review, urgent consideration be given to prohibiting high-speed pursuits for traffic offences that do not under NSW law make the offending driver liable to having his or her licence suspended or to disqualification from holding a licence.
- I recommend that, pending any review, urgent consideration be given to placing a time-limit of two minutes on high-speed pursuits unless there are compelling reasons to extend the pursuit for a further period.
- In any event, I recommend that, pending any review, urgent consideration be given to placing a time-limit of two minutes on high-speed pursuits in urban areas and five minutes in rural and regional areas outside towns unless there are compelling reasons to extend the pursuit for a further period.

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Coronial recommendations: Fatal facts

Case number	NSW.2012.3496
Primary category	Intentional self-harm
Additional categories	Law enforcement
Fatal Facts edition	41 – cases closed between April and June 2014

Case summary

An adult male took their own life by hanging while in custody on remand. The adult had no known history of previous mental illness.

Whilst on remand, their mental health was regularly assessed. They were initially assessed as being at risk of self-harm but this risk appeared to have dissipated. At the time of their death, the adult was living in a private, 'one-out' cell.

Coronial findings

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

Corrective Services and Justice Health were independent services at the time of this death. A multidisciplinary team used records from both services to inform decisions about inmates' mental health and associated risks. Corrective Services, however, ultimately determined the placement of inmates in cells, including whether they had private or shared cells. The coroner's recommendations focused on addressing the issues posed by this service arrangement and how to improve its efficiency and effectiveness.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the Ministers for Health and for Corrective Services:

- I recommend that, given the overlap of the psychological, mental health and medical disciplines (if a patient / inmate is to be treated holistically) these services to be managed by Justice Health.
- Alternatively, I recommend that the current process of working towards developing guidelines for the sharing of patient information and an efficient system or method of sharing relevant patient information continue with all practical speed.
- I also recommend that the working party or the two relevant departments consider the longer term issue of merging or transferring Corrective Services psychological staff into Justice Health.

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- I recommend that Justice Health nurses be required to have undergone suitable mental health training before they are permitted to conduct mental health assessments.
- I recommend that decisions by Justice Health staff concerning Health Problem Notification Forms relating to 'green cards'¹ not be made without access to all relevant patient records.
- I recommend that where practicable a custodial patient who is being assessed psychologically or psychiatrically at intervals be assessed by the same clinician over that time to both build a therapeutic relationship with the patient but also to better comprehend any subtle (but significant) changes in the patient's mental status.

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¹ A 'green card' is a card placed in a slot outside an inmate's cell identifying him as a person who must be accommodated 'two-out' for safety – usually medical – reasons. (A cell-mate can raise the 'knock-up' alarm if the inmate becomes ill or threatens to do something harmful to himself. The cell-mate may also be a companion or 'buddy' for the inmate on the 'green card'.)

Coronial recommendations: Fatal facts

Case number	NSW.2012.4288
Primary category	Intentional self-harm
Additional categories	Law enforcement/ Mental illness and health
Fatal Facts edition	41 – cases closed between April and June 2014

Case summary

A middle aged adult male took their own life in the course of a police operation. The adult had a significant history of mental health issues requiring several scheduled admissions to hospital by both police and paramedics.

They were conveyed to hospital by police two days before their death but left the hospital by unknown means. Police attended the adult's property and observed them on the balcony. By the time police reached the balcony, the adult had sustained fatal injuries.

Coronial findings

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

Coronial recommendations

The coroner made the following recommendations related to this case:

To Minister for Health

- I recommend that the Mental Health Act be amended to provide specifically for a mechanism for revoking schedules (and discharging scheduled patients) together with short reasons for such decisions being recorded.

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Coronial recommendations: Fatal facts

Case number	NSW.2012.4375
Primary category	Work related
Fatal Facts edition	41 – cases closed between April and June 2014

Case summary

A middle aged adult male died when a trailer they were repairing accidentally came into contact with them, causing fatal internal injuries.

The adult was attempting to connect a crane to a trailer when the trailer lurched forward and fell off its support and onto the ground.

Coronial findings

The coroner found that the death was unintentional.

The coronial investigation found the accident may have been avoided had there been a different locking device on the trailer.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That [name], Deputy Prime Minister, Minister for Infrastructure and Regional Development consider the implementation of suitable Australian Design Rules requiring the placement /affixing of some form of locking device on the landing legs on semi-trailers and timber Jinkers, similar to that involved in this accident, which are not currently covered by a specific Australian Design Rule.
- That [name] , New South Wales Minister for Roads and Freight consider possible amendments to current registration requirements for semi-trailers and timber Jinkers, similar to that involved in this accident which would mandate some form of locking device on the landing legs on such semitrailers and timber Jinkers prior to their registration in New South Wales.
- That [name] Chief Executive Officer of Work Cover Authority of New South Wales consider the issue of a Safety Alert regarding the risks associated with the repairs of trailers similar to that involved in this matter especially highlighting the risk associated with the lack of a locking mechanism on the landing legs of such trailers during their repair.
- That A/CEO of Safework Australia [name] consider the issue of a Safety Alert (or its equivalent if such power is available to her) regarding the risks associated with the

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repairs of trailers similar to that involved in this matter especially highlighting the risk associated with the lack of a locking mechanism on the landing legs of such trailers during their repair.

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Coronial recommendations: Fatal facts

Case number	NSW.2013.777
Primary category	Drugs and alcohol
Additional categories	Law enforcement
Fatal Facts edition	41 – cases closed between April and June 2014

Case summary

An adult female died due to a heroin overdose while in custody. The adult was serving a sentence for drug-related offences and was a long-term drug user.

Coronial findings

The coroner found that the death was unintentional.

The coronial investigation found that the cell the deceased shared with another prisoner was not searched before lockdown, or monitored during the course of the night.

Coronial recommendations

The coroner made the following recommendations related to this case:

To: The Commissioner of Corrective Services:

- That consideration should be given to the implementation of random searches of cells at, or shortly after, the afternoon lockdown with particular attention being given to cells occupied by inmates that are known, or reasonably suspected, to be users of illicit substances whilst in custody.

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

Coronial recommendations: Fatal facts

Case number	NSW.2013.1345
Primary category	Mental illness and health
Fatal Facts edition	41 – cases closed between April and June 2014

Case summary

An adult female died when they asphyxiated on food. The adult was a resident of a group home run by the state for persons with disabilities.

They were known to be at high risk of choking and had a tendency to place large volumes of food in their mouth. The adult choked when they quickly ingested a large quantity of food and despite the efforts of staff and paramedics to render assistance, died at the scene.

Coronial findings

The coroner found that the death was unintentional.

The coroner found there was no internal investigation into the incident to identify other related or critical issues in the home that may have needed to be addressed to avoid a similar incident from occurring.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the Minister for Disability

- That a system be implemented to ensure that there is a comprehensive and documented investigation and review of systems following the death of or serious injury to a resident at the [location] group home.

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

NORTHERN TERRITORY

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

Coronial recommendations: Fatal facts

Case number	NT.2012.105
Primary category	Transport and traffic related
Additional categories	Fire related/Physical health
Fatal Facts edition	41 – cases closed between April and June 2014

Case summary

An adult male died of fire-related injuries sustained in a motor vehicle collision. Their vehicle was struck by another vehicle, causing the fuel tank to rupture and a fire that engulfed the vehicle.

Coronial findings

The coroner found that the death was unintentional.

The driver of the other vehicle had caused other motor vehicle collisions prior to this fatal incident. The driver had a medical condition that impeded their ability to drive a motor vehicle safely and had their license suspended a few years prior. They had recently been granted a conditional licence to drive.

The coroner found numerous failings in the system that led to the driver of the other vehicle's licence being reinstated.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That a Review Panel be set up for the purpose of rendering expert advice to the Registrar of Motor Vehicle regarding the fitness to drive of applicants for a driver's license who suffer from health problems.
- A legislative system be put in place that fully supports the operation of such a Review Panel.
- That the Review Panel be comprised of members of the MVR [Motor Vehicle Registry], the NT [Northern Territory] Police, the Department of Health and the medical profession. The proposed categories of medical specialists available to sit on the panel ought to include neurologists, cardiologists, rehabilitation specialists, geriatric specialists, alcohol and drug specialists, ophthalmologists and endocrinologists.
- That the decision making power of the Review Panel be determined by a process of referrals.

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- That such a Review Panel be for the purpose of complex cases involving fitness to drive issues and that it not be for all such decisions that are made in this area.
- That the present system of mandatory reporting by health professionals of health issues pertaining to fitness to drive a motor vehicle continue and be run in tandem with the Review Panel.
- That a system be put in place whereby such a Review Panel would have available to it all medical and police information relevant to the assessment of an applicant for a driver's license.
- That the Review Panel be initially trialled with a view to it being a permanent body.
- That all efforts be made to ensure that such a Review Panel be a practical and efficient body that is subject to a minimum of administrative complexity.
- That a system be put in place whereby any NT police officer must draw to the attention of the Registrar of Motor Vehicles any person who that officer believes, on reasonable grounds, to be a serious danger to other road users (as a consequence of physical health/mental health issues suffered by that person), if that person is granted a driver's license, or that person continues to hold a driver's license.
- That when a medical practitioner who notifies the Registrar of Motor Vehicles that a person is physically or mentally incapable of driving a motor vehicle with safety to the public, or is physically or mentally unfit to be licensed (pursuant to section 11 of the NT Motor Vehicle Act), section 11 of the NT Motor Vehicle Act be amended by adding words to the effect that any health professional who makes such a notification, incurs no civil or criminal liability in carrying out his or her duty under the Act. This is intended to be consistent with Section 148 (3) of the South Australian Motor Vehicles Act 1959.
- That occupational therapists/physiotherapists no longer be a registered person capable of making an assessment pursuant to s 11 of the NT Motor Vehicle Act that a person is not mentally or physically capable of driving a motor vehicle safely or is physically or mentally unfit to be licensed.

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

SOUTH AUSTRALIA

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

Coronial recommendations: Fatal facts

Case number	SA.2010.1454
Primary category	Adverse medical effects
Additional categories	Drugs and alcohol/ Older persons/ Falls
Fatal Facts edition	41 – cases closed between April and June 2014

Case summary

An older adult female died after being administered excessive amounts of analgesic medication whilst in hospital. The adult had a terminal illness, had recently suffered a fall and was experiencing worsening pain. They were considered a palliative patient.

Nursing staff administered analgesic medication via spinal catheter (intrathecal administration), as authorised by the treating doctor. Despite efforts to counteract the excessive dose, the adult's condition continued to deteriorate until their death.

Coronial findings

The coroner found that the death was due to complications of medical or surgical care.

The coroner found that, unlike in a surgical environment, the deceased's vital functions were not being monitored at the time of drug administration.

Coronial recommendations

The coroner made the following recommendations related to this case:

- The only other matter that requires consideration is the need for better monitoring following intrathecal bolus administration of analgesic medication. In this regard the Court recommends that the General Manager of the [hospital] draw to the attention of all clinical staff the need to closely monitor the vital signs of a patient to whom such analgesia has been administered.

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

TASMANIA

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

Coronial recommendations: Fatal facts

Case number	TAS.2009.363
Primary category	Work related
Fatal Facts edition	41 – cases closed between April and June 2014

Case summary

A middle aged male died in a work related incident. The adult was attempting to repair a mobile elevating work platform (EWP or 'cherry picker') when the EWP unexpectedly moved causing them to be crushed. Rescue efforts commenced immediately and the adult was transported to hospital but their condition did not improve.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that current regulations required a High Risk Work licence to operate a EWP. However, should an individual be repairing, rather than operating the machine, the licence was not required. The coroner also found the deceased contributed to their own death by not completing all the required safety steps before using the EWP.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that consideration be given to reviewing the regulatory requirements for a High Risk Work licence to operate boom-type elevating work platforms, so that such a licence is required for all persons operating such plant and regardless of the length of the boom.
- I recommend that there be a review of the current ability of WST [WorkSafe Tasmania] to maintain a system of audit to assess whether the "competent person" has properly inspected registered plant, and to ensure that unsafe registered plant is not in service. I am informed that current resourcing to undertake this vital safety task is inadequate.
- I recommend that there be a review of the current ability of WST to assess and audit determinations by PCBU's ["Person Conducting a Business or Undertaking] of "competent persons" on a regular basis, given that such system underpins the safety of both registered and unregistered plant in this State. I am informed that current resourcing to undertake this vital safety task is inadequate.
- I recommend that [company] review its vehicle entry procedures on an ongoing basis to ensure that there is an effective system of detecting defective vehicles and equipment.

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- I recommend that [company] give priority to ensuring prompt distribution of every new version of its Site Conditions; and to ongoing education of its contractors with regards its safety policies.

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Coronial recommendations: Fatal facts

Case number	TAS.2013.108
Primary category	Adverse medical effects
Additional categories	Natural cause death/ Older persons
Fatal Facts edition	41 – cases closed between April and June 2014

Case summary

An older adult female died of heart related illness whilst in hospital.

The adult experienced serious health problems towards the end of their life and was discharged from hospital on two occasions without correct diagnosis. Whilst in hospital, they also gained a significant amount of weight due to fluid retention.

Coronial findings

The coroner found that the death was due to natural causes.

The coroner found the adult did not receive optimal care from the hospital, which failed to diagnose their condition and commence effective treatment. Whilst this misdiagnosis did not directly contribute to the cause of death, the coroner found that it denied the adult a less stressful existence during her later months.

Coronial recommendations

The coroner made the following recommendations related to this case:

- It is my recommendation that the [hospital] give consideration to [doctor]'s comments concerning the management of [the deceased]'s fluid retention. Her death is the second case in recent times where bleeding complications have been associated with the insertion of pleural drainage catheters in patients who appear to have little to gain from the procedure.

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VICTORIA

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

Coronial recommendations: Fatal facts

Case number	The coroner held a joint investigation into the following deaths which resulted from similar incidents: VIC.2002.3802, VIC.2003.2069
Primary category	Child and infant death
Additional categories	Natural cause death
Fatal Facts edition	41 – cases closed between April and June 2014

Case summary

Two male children from the same family died on separate occasions; one from respiratory complications and another from unascertained causes. In both instances, the mother located the child unresponsive in their bed and immediately called emergency services.

Coronial findings

The coroner found that one death was due to natural causes and the other due to unascertained causes. The coronial investigation found that the children's mother had presented them both for medical attention numerous times throughout their lives. The coroner made comments and recommendations addressing the state's healthcare system.

Coronial recommendations

The coroner made the following recommendations related to these cases:

Medicare reporting system and multiple presentations

- As part of the police investigation, the then State Coroner requested that police also investigate:
 - the current system of reporting medical consultations in Victoria; and
 - whether any safeguards are possible to prevent multiple medical presentations of a child from going undetected in the future.
- The police investigation into the [family name] sibling deaths identified that a Medicare system enabling recognition of significant numbers of presentations to medical practitioners may have provided an opportunity for the health professionals to investigate [deceased's mother]'s over-presenting of her children. Such a system may have alerted medical professionals that there was a problem within the family that required further testing, including genetic, metabolic or otherwise.
- Apart from identifying a need for further investigation or family support, a program that identifies multiple medical presentations may cause a medical practitioner to form a belief that a child is in need of protection. Victorian medical practitioners are now

obliged to report any suspicious activity which creates in them a belief of reasonable grounds that a child is in need of protection to the Department of Human Services.

- The basic framework and infrastructure is already in place to allow a similar program to be created to enable the identification of persons who present on multiple occasions at general practitioners and various health professionals. However, two issues would constrain Medicare's ability to create such a program, being:
 - the inability of the system to capture data from within public hospital facilities, as they do not technically bill against Medicare (because they are funded by the State governments); and
 - legislative amendment would be required relating to privacy considerations and information dissemination beyond the primary purpose for which it was obtained.
- The first constraint could be overcome by hospitals scanning or storing patients' Medicare details and registering hospital visits with Medicare. This may require further consideration of changes to the centralised computer/recording programs and implementation costs would surely follow.
- The second constraint comes under the public and private medical sectors' regulatory instruments. The Health Privacy Principles within the *Health Records Act 2001* (Vic) regulate use or disclosure of personal and health information for purposes other than the primary purpose for which it was collected. However, several specific categories allow for dissemination of medical information in limited situations and a new category could be included to cover cases of multiple presentations of children within a limited time period. Alternatively, the system need not identify details of treatments or identifying medical information other than frequency of attendances.
- If health professionals could easily access the number and frequency of previous presentations of a child, they could make reasonable and appropriate inquiries to inform themselves of the child's circumstances. This could potentially benefit the welfare of children with an undiagnosed problem within the family requiring further testing, or children at risk.

Pursuant to section 72(2) of the Coroners Act 2008, I make the following recommendations connected with the death:

- if it has not already occurred, that the [deceased]'s family consider consulting specialist genetic services for diagnostic, family health, and/or disease prevention advice; and
- that the Minister for Health consider improvements in the way data regarding presentation for medical care can be accessed/shared by medical professionals to assist with patient evaluation and care, and that this consideration takes into account the Comments [...] above.

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Coronial recommendations: Fatal facts

Case number	The coroner held a joint investigation into the following deaths which resulted from the same incident: VIC.2005.2434, VIC.2005.2435, VIC.2005.2436
Primary category	Transport and traffic related
Additional categories	Weather related/ Work related
Fatal Facts edition	41 – cases closed between April and June 2014

Case summary

Three middle aged females died when an aircraft containing two passengers and a pilot crashed.

The pilot had been warned of extreme weather conditions at the arrival destination. Despite these warnings, the pilot attempted to land but the aircraft crashed into trees and was engulfed by fire. The crash site was located a few days later and an investigation took place.

Coronial findings

The coroner found that the death was unintentional.

The coroner determined that the crash could have been avoided had the pilot heeded warnings about the extreme weather. The coroner made a recommendation about the investigation process.

Coronial recommendations

The coroner made the following recommendations related to these cases:

- I recommend that the ATSB [Australian Transport Safety Bureau] undertake review of the merits of and its capacity to utilise video recording at all fatal aircraft accident investigations and that such video recording should incorporate the scene and the accident investigation.

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

Coronial recommendations: Fatal facts

Case number	VIC.2006.1089
Primary category	Law enforcement
Additional categories	Homicide and assault / Weapon
Fatal Facts edition	41 – cases closed between April and June 2014

Case summary

An adult male was fatally injured while in custody on remand awaiting trial. The adult suffered multiple serious penetrating wounds when they were assaulted by another inmate. Despite efforts to stop the loss of blood, the adult died shortly after the incident.

Coronial findings

The coroner found that the death was due to assault.

The coronial inquest focused on communication between medical/nursing staff and prison staff and how communication coming into the prison is managed.

Coronial recommendations

The coroner made the following recommendations related to this case:

- All telephone calls to [location] Prison reception should be recorded, with the option to cease recording upon transfer to particular extensions within the prison. The method used for recording and noting phone calls should be a matter for the [prison].
- [Correctional health service] should regularly review its policies and procedures in relation to communications with [custodial services]. It should assess the implementation of those procedures as part of such a review. [Correctional health service] should train each new staff member on commencement, and all staff on a regular basis.
- [Custodial services] and [correctional health service] should jointly prepare a short, easy to use pro forma or similar to record the transfer of critical information regarding a prisoner's wellbeing or prisoner requests which could not be immediately be attended to (such as a request to speak to a supervisor).

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Coronial recommendations: Fatal facts

Case number	VIC.2006.4590
Primary category	Drugs and alcohol
Fatal Facts edition	41 – cases closed between April and June 2014

Case summary

An adult female died of pneumonia as a result of a combination of prescription medications and cannabis. They had a complex medical history with multiple co-morbidities.

Coronial findings

The coroner found that the death was unintentional.

The coroner found there was no formal case management or coordination of care established for the adult and the communication and prescribing between medical practitioners for their conditions was sub-optimal.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the Secretary of the Victorian Department of Health commit to a timeline for implementation of real-time prescription monitoring in Victoria, to reduce the harms and deaths associated with longstanding systemic health issues including poor coordination of care and inappropriate prescribing and dispensing. This timeline should include a goal that all Victorian prescribers and dispensers have access to real time prescription monitoring capacity within 12 months from the date I publish this finding.

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

Coronial recommendations: Fatal facts

Case number	VIC.2011.2904
Primary category	Transport and traffic related
Additional categories	Physical health/ Older persons
Fatal Facts edition	41 – cases closed between April and June 2014

Case summary

An older adult female died in a motor vehicle incident in which they were a passenger. The driver experienced an epileptic seizure causing the car to run off the road.

Coronial findings

The coroner found that the death was unintentional.

The coronial investigation revealed that despite regularly suffering from seizures, neither the driver nor their treating clinicians notified road authorities of their condition.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Secretary, Department of Transport, Planning and Local Infrastructure amend the Road Safety (Drivers) Regulations 2009 to include a statutory obligation for reporting by medical practitioners of patients immediately upon diagnosis with epilepsy.
- That the Secretary, Department of Transport, Planning and Local Infrastructure consider further amending the Road Safety (Drivers) Regulations 2009 to include a statutory obligation for reporting by medical practitioners of patients previously diagnosed with epilepsy.
- That VicRoads and the Royal Australian College of General Practitioners educate and encourage medical practitioners to inform patients of the patients' legal obligations to report relevant medical conditions to VicRoads.
- That VicRoads and the Royal Australian College of General Practitioners educate medical practitioners as to their rights and obligations to report patients' relevant medical conditions to VicRoads.
- That VicRoads conduct a campaign educating drivers and medical practitioners about drivers' continuing obligation to report possible medical conditions and/or changes to their medical conditions, including on renewal of all classes of licences. This campaign should also emphasise road safety implications of driving with certain medical conditions.

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- That VicRoads include a section in all licence renewal forms requesting drivers to provide information of any medical conditions they have or medications they are taking which may affect their driving.
- That the Secretary, Department of Transport, Planning and Local Infrastructure give consideration given to increasing the penalty for drivers who breach their legal obligation under the Road Safety (Drivers) Regulations 2009 by failing to report to VicRoads any injury or illness which may impair their driving, including possible licence suspension.

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Coronial recommendations: Fatal facts

Case number	VIC.2011.3127
Primary category	Drugs and alcohol
Additional categories	Mental illness and health
Fatal Facts edition	41 – cases closed between April and June 2014

Case summary

An adult female died of a drug overdose. The adult was an involuntary patient at a psychiatric unit. They were admitted to the psychiatric facility after they suddenly ceased taking their methadone (as per their methadone maintenance program) and their condition deteriorated. Whilst in the facility, alongside other medications, the adult's methadone was re-instated and the quantity was increased daily.

Coronial findings

The coroner found that the death was unintentional. The coroner found the criteria for re-introducing methadone treatment was not sufficiently demonstrated and expressed concern over the combination of medications the deceased was administered.

Coronial recommendations

The coroner made the following recommendations related to this case:

- To increase the safety of patients in the [hospital] Psychiatric Unit, the training program for the safe use of opioid therapies should be referenced to the 2013 Department of Health Policy for maintenance pharmacotherapy for opioid dependence, and the 2003 National clinical guidelines and procedures for the use of methadone in the maintenance treatment of opioid dependence. Specifically, the training program should address the knowledge and skills of medical and nursing staff regarding:
 - Informed consent and patient information
 - Safe prescribing of methadone *pro re nata* (PRN)
 - Appropriate monitoring of patients prescribed methadone or alternate pharmacotherapies, especially the level of sedation
 - Specific education of the 2011 [location] *Mental Health Alcohol and Other Drug Withdrawal Practice Guidelines*

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Coronial recommendations: Fatal facts

Case number	VIC.2011.4899
Primary category	Transport and traffic related
Additional categories	Child and infant death
Fatal Facts edition	41 – cases closed between April and June 2014

Case summary

A male child collided with a vehicle while riding their bike in a caravan park. The driver of the vehicle was driving slowly and safely but their view of the child was obscured by a parked vehicle. The deceased was not wearing a helmet or being supervised by an adult at the time.

Coronial findings

The coroner found that the death was unintentional.

Coronial recommendations

The coroner made the following recommendations related to this case:

- The Victorian Caravan Parks Association Incorporated (Vicparks) and the Department of Transport, Planning and Local Infrastructure should consider consulting with relevant road design experts to develop guidance on appropriate design principles for roads in Victorian caravan parks. The guidance should identify the specific contexts within which caravan park roads are situated and used (ie road sharing between cars, pedestrians and cyclists; tent and temporary dwellings proximal to roads; historical practice or parking at campsites; road design principles that might appropriately address these contexts to achieve the optimum balance between the needs and the safety of all road users and examples of practical design solutions that demonstrate how these principles can be executed. A tool for auditing road design in existing and new caravan parks could be formulated as part of this process.
- That Vicparks work with caravan park proprietors to reinforce to residents the importance of maintaining adult supervision of children who are resident in caravan parks, during all activities. This should include reinforcing the need to wear bike helmets within caravan parks and should also consider prohibiting or restricting children from riding or playing in high vehicle use areas within caravan parks.

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

Coronial recommendations: Fatal facts

Case number	VIC.2012.1383
Primary category	Intentional self-harm
Additional categories	Drugs and alcohol
Fatal Facts edition	41 – cases closed between April and June 2014

Case summary

A middle aged female overdosed on her prescription medication, including propranolol. They had previously attempted suicide by overdose.

Coronial findings

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

The deceased's doctor originally prescribed propranolol to treat a medical condition. The coroner found that a warning or precaution of about the involvement of propranolol in suicidal activity was not currently in the standard Australian information resources on propranolol prescribing.

The coroner also repeated recommendations made in another matter for a real-time prescription monitoring system.

Coronial recommendations

The coroner made the following recommendations related to this case:

The Therapeutic Goods Administration (TGA) is the main conduit through which prescribing precautions are disseminated and incorporated into standard Australian prescribing references. I recommend that the TGA consider issuing an alert to prescribers and advise exercising caution when prescribing Propranolol to patients at risk of self-harm, particularly self-harm by overdose.

Possible countermeasures for prescribers could include:

- if clinically appropriate, a beta-blocker that is safer in overdose could be substituted for Propranolol.
- scripts could be provided for small quantities of Propranolol, to reduce the amount of Propranolol to which the patient has access at once.

The reasoning behind [the second point above] is that at present, Propranolol packets contain 100 tablets, and up to five repeats can be included in a single script, providing

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patients access to up to 600 Propranolol tablets at once - that is, a sufficient quantity for an overdose. For patients who are at risk of self-harm by overdose, providing a script for 50 or 20 tablets at a time with no repeats would inhibit the patient's ability to access fatally large quantities of Propranolol at one time.

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Coronial recommendations: Fatal facts

Case number	VIC.2012.2175
Primary category	Drugs and alcohol
Additional categories	Law enforcement
Fatal Facts edition	41 – cases closed between April and June 2014

Case summary

An adult male died of mixed drug toxicity in an accidental overdose. They had a long history of illegal substance abuse and had recently been released on parole from prison.

Either side of the adult's imprisonment, they received methadone prescribed by their doctor as part of opioid replacement therapy. They also received a prescription from another doctor for benzodiazepines.

Coronial findings

The coroner found that the death was unintentional.

The coroner called into question the doctor's decision to continue prescribing methadone at the same dosage so close to the deceased's release from prison, given the known risk of overdosing for recent parolees. The coroner also found the ability for prescribers to ensure patients are not prescription shopping is reduced without a real-time prescription monitoring program.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I have identified some potential issues with the medical treatment [the deceased] received after he was released from [correctional centre]. These issues in turn suggest some potential opportunities for prevention.
- [Doctor] provided a script that enabled [the deceased] to access five takeaway methadone doses per week, two days after his release from prison. [The deceased] was not in stable accommodation (he was staying at a hotel with his mother) and it is not clear whether [doctor] attempted to assess any other measures of stability to support a decision for such a high level of takeaway dosing. His clinical decision could be referred for critical evaluation to Drugs and Poisons Regulation at the Victorian Department of Health.

- Separate from the question as to whether or not [doctor] exercised appropriate clinical judgement, I have identified that the Victorian policy for provision of opioid replacement therapy contains no guidance on safe treatment of recently paroled clients. Given that recent parolees are particularly at risk of overdose death, this would appear to be a significant oversight, especially since the circumstances of [the deceased]'s death are not unique, have happened before, and without specific attention, could occur again.
- I recognise that the complexity and exigency of primary health care necessitate some latitude in patient treatment. It would be difficult, if not impossible, to develop specific prescribing guidelines applicable to all permutations and combinations of patient presentation. However, I think it preferable that basic general guidance material adopts a more considered and cautious approach aimed at harm reduction.
- I recommend that the Victorian Department of Health amend the January 2013 *Policy for Maintenance Pharmacotherapy for Opioid Dependence*, to incorporate explicit advice on managing vulnerable opioid replacement patients including those recently paroled from prison, to reduce the likelihood a newly paroled client will overdose on methadone. The amended policy should indicate that a client transferred from prison to a community-based service should be treated in the same way as a new patient commencing treatment, and should not be provided takeaway doses until medical, psychological and social stability in the community is established.
- The rescheduling of alprazolam from a Schedule 4 benzodiazepine to a Schedule 8 benzodiazepine took effect on 1 February 2014. While I welcome the decision to reschedule alprazolam, I recognise the ongoing risks that all other benzodiazepines pose to the community, as reflected in the continuing trend of deaths associated with benzodiazepines, particularly diazepam, and particularly in combination with methadone-related deaths. I accordingly recommend all other benzodiazepines should also be rescheduled to Schedule 8 because they present the same risks as alprazolam.
- Nearly two years after the Victorian Department of Health indicated it was engaging with the Commonwealth on its Electronic Recording and Reporting of Controlled Drugs initiative, Victoria is still without a real-time prescription monitoring system to assist in addressing the harms and deaths associated with pharmaceutical drug misuse and inappropriate prescribing and dispensing of pharmaceutical drugs. There is no question that the current prescribing system, and therefore the ease of obtaining inappropriate access and/or amounts of drugs, lacks sufficient rigour. In a previous coronial matter, [another coroner] expressed concern that if the Victorian Department of Health relies on the Commonwealth to deliver a national real-time prescription monitoring system, it might be "waiting for an extended period or even indefinitely while preventable harms and deaths from prescription shopping continue to occur". At that time, then Acting Secretary for the Victorian Department of Health [name] rejected [another coroner]'s concerns. I note however, that the current state of affairs is unchanged while the same problem remains, illustrated by [doctor]'s observations that a real-time prescription

monitoring system would have enabled [them] to identify other drugs [the deceased] had received from other doctors and to treat him accordingly.

- I therefore recommend that the Victorian Department of Health explore options for implementing a Victorian-based real-time prescription monitoring system to prevent ongoing harms and deaths associated with pharmaceutical drug misuse and inappropriate prescribing and dispensing of pharmaceutical drugs.
- As there is practically no discernable publically available information regarding the status of the ERRCD [Electronic Recording and Reporting of Controlled Drugs] initiative and Victorian progress towards implementing real-time prescription monitoring, I recommend that within three months, the Victorian Department of Health should create a page on its website regarding real-time prescription monitoring, the ERRCD system and other related topics. The page should provide up-to-date information regarding the planning and implementation of this crucial public health initiative. Transparent, continuous disclosure of progress would assist a broad range of stakeholders, including peak medical and pharmacy bodies, Coroners and the Victorian public.

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

Coronial recommendations: Fatal facts

Case number	VIC.2012.2915
Primary category	Homicide and assault
Additional categories	Weapon / Work related
Fatal Facts edition	41 – cases closed between April and June 2014

Case summary

A middle aged male died when they were stabbed by an assailant who was not known to them.

The deceased was working as a taxi driver and collected the offender as a 'street hail' fare. Witnesses heard the taxi collide with a fence and saw the driver lying on the road. Emergency services arrived but were unable to revive them.

Coronial findings

The coroner found that the death was due to assault.

The coronial investigation found that the deceased was not using a driver protection screen in their taxi vehicle on the night of the incident.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the Taxi Services Commission make driver protection screens mandatory for use in all taxis operating between the hours of 10.00pm and 5.00am.

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

Coronial recommendations: Fatal facts

Case number	VIC.2012.4013
Primary category	Transport and traffic related
Additional categories	Fire related
Fatal Facts edition	41 – cases closed between April and June 2014

Case summary

An adult male died from burns sustained when their car caught fire during, or after, a single motor vehicle collision.

The adult had been driving at high speed when they lost control of his vehicle. The force of the impact caused the vehicle to rotate onto its side, rupturing the fuel lines and causing the fire.

Coronial findings

The coroner found that the death was unintentional.

Police investigations found that the vehicle may not have been fitted with a functioning fuel cut-off system. Such systems are activated in the event of a collision, reducing the risk or severity of a fire. At the time of the incident, there were no regulations requiring fuel cut-off systems for vehicles currently in force in Australia.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Secretary of the Commonwealth Department of Infrastructure and Regional Development investigate whether the Australian Design Rules should be amended to include a standard for fire retardant materials in interiors of motor vehicles manufactured in or imported into Australia, to reduce the likelihood of death from effects of fire following a motor vehicle collision.
- Although [the deceased's] vehicle was fitted with a fuel cut-off system, the investigation identified that there is no Australian Standard or regulation requiring this safety feature for vehicles currently in force in Australia. I therefore recommend that the Secretary of the Commonwealth Department of Infrastructure and Regional Development investigate whether the Australian Design Rules should be amended to include a standard for fuel cut-off systems in motor vehicles manufactured in or

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imported into Australia, to reduce the likelihood of death from effects of fire following a motor vehicle collision.

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Coronial recommendations: Fatal facts

Case number	VIC.2012.4191
Primary category	Drugs and alcohol
Fatal Facts edition	41 – cases closed between April and June 2014

Case summary

An adult female died of combined drug toxicity by way of inadvertent or accidental overdose.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the deceased had likely been abusing anaesthetic drugs over a significant period of time. The deceased took the drugs from their workplace where they were readily accessible with no accountability and small volume theft was unnoticed.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Victorian Department of Health consult with the [hospital] Department of Anaesthesia and Pain Management regarding their response to the death of [the deceased], in particular the changes in place that reduce/regulate access to general anaesthetics and neuromuscular blocking agents.
- That the Victorian Department of Health consult with Victorian hospitals regarding Victorian overdose deaths from misuse of neuromuscular blocking agents and/or general anaesthetic agents, and seek their advice on whether any further measures could be put in place to reduce misuse of these agents.

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Coronial recommendations: Fatal facts

Case number	VIC.2012.4352
Primary category	Work related
Fatal Facts edition	41 – cases closed between April and June 2014

Case summary

An adult male died when they were struck by a falling branch. The incident occurred in the immediate vicinity of trees waiting to be felled. The adult was operating a stump grinder at the time and was not wearing protective headgear.

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 consideration be given to the creation of legislation as follows:

- A statutory requirement that all persons involved in the falling and clearing of trees including stump grinding and any other functions requiring the person to be within close proximity to trees to wear an appropriate helmet at all times.
- A prohibition or directing, allowing or permitting a person to carry any such work whilst alone.

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Coronial recommendations: Fatal facts

Case number	VIC.2013.993
Primary category	Sports related
Additional categories	Transport and traffic related
Fatal Facts edition	41 – cases closed between April and June 2014

Case summary

An adult male died from a penetrating neck injury sustained in a motorcycle incident.

The adult was riding their motorcycle along dirt trails with another person when they collided with a fallen tree branch. The branch penetrated their neck and the adult was thrown from their motorcycle.

By the time they were able to reach emergency services for assistance, the adult was in a critical condition. They was transported to hospital where they were pronounced deceased.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that a previous Inquiry by the Parliament of Victoria Road Safety Committee required the Committee to consider the trends in off-road riding crashes and investigate the responsibilities of road safety agencies in relation to off-road riding.

The coroner noted an absence of initiatives that specifically targeted off-road riding, and a number of public health and safety gains to be made by promoting off-road riding safety.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the road safety agencies, particularly VicRoads, the Transport Accident Commission and the Department of Sustainability and the Environment, consider the Road Safety Committee's findings and adopt the recommendations set out in its report.

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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.

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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.