Coronial recommendations: Fatal facts

A summary of cases and recommendations made between July and September 2014

Edition 42
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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 Coronal 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 July and September 2014.

Previous summaries and recommendations are available at: https://www.ncis.org.au/publications/fatal-facts/
NEW SOUTH WALES
The following cases summaries and recommendations relate to deaths reported to a coroner in New South Wales.
Coronial recommendations: Fatal facts

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<thead>
<tr>
<th>Case number</th>
<th>NSW.2007.538</th>
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<tbody>
<tr>
<td>Primary category</td>
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<td>Fatal facts edition</td>
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</table>

Case summary

A young adult male disappeared in suspicious circumstances.

The young person had been charged with a criminal offence and was due to stand trial some months later. They had received threats from their co-accused. The young person was last seen leaving their workplace.

Coronial findings

The coroner was unable to determine the circumstances of the death.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that this case be referred to the Unsolved Homicide Unit of the New South Wales Police Force for further investigation.
Coronial recommendations: Fatal facts

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<thead>
<tr>
<th>Case number</th>
<th>NSW.2009.1122</th>
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<tbody>
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</table>

Case summary
A middle aged male died as a result of stab wounds in an assault.
They were found unconscious by fire brigade officers after a fire broke out in their home and were found to have sustained fatal injuries.

Coronial findings
The coroner found that the death was due to assault.
The coroner found that the fatal injuries were inflicted by a person or persons unknown.

Coronial recommendations
The coroner made the following recommendations related to this case:

- Refer to Unsolved Homicide Team at Homicide Squad.

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Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>NSW.2009.3866</th>
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<td>Fatal facts edition</td>
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</table>

Case summary
An adult female disappeared, presumed deceased as their body was never recovered.
They had left a note to their husband and parents detailing their leaving and moving on with their life.

Coronial findings
The coroner was unable to determine the circumstances of the death.

Coronial recommendations
The coroner made the following recommendations related to this case:

- Refer to Unsolved Homicide - Complete Report on Handwriting on notes

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Coronial recommendations: Fatal facts

Case summary

A male child died from natural causes in a hospital setting. The child was admitted to hospital after a cardiorespiratory arrest caused catastrophic brain injury.

The child suffered from morbid obesity and obstructive sleep apnoea, for which they had previously been hospitalised. They were often unable to attend school due to their health issues. The child’s parents had been given a treatment plan to adhere to but were non-compliant with the regime and the child’s condition continued to worsen.

At the time of the child’s on going health issues, both parents were using illicit drugs.

Coronial findings

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

The coroner found that the parents’ failure to appreciate the seriousness of the child’s ill health may have been contributed to by their drug abuse at the time of the child’s treatment.

The coroner found that child protection intervention should have been engaged but were not due to a lack of:

- communication between areas of health within the hospital and lack of engagement and follow up of Child Protection Team at [the hospital].
- communication between Health and Community Services.
- understanding by health staff of Community Services processes.
- understanding by Community Services staff of the child’s medical condition due inadequate records and a failure to share and seek appropriate information so the full risks to the child were not properly identified and followed up.

Department of Education staff at the child’s school failed to inquire whether they were receiving medical treatment to address their school attendance requirements.
Coronial recommendations

The coroner made the following recommendations related to this case:

- Consideration be given to the establishment of a Weight Management Unit within the [hospital] for the treatment of children with eating disorders including serious obesity.
- That sections 7 and 10 of the Ministry of Health Policy regarding Neglect and Responses to Neglect be amended so that child protection issues are properly identified and responded to.
- Consideration be given to the establishment of a formalised and administratively supported Child Protection Unit at the [hospital].
- That the D-G [Director General] Ministry of Health and the D-G Family & Community Services give consideration to entering into an arrangement under s27 A(2) of the Children and Young Persons (Care and Protection) Act 1998 so that a formalised system involving Alternative Reporting Arrangements can be introduced to the [hospital]
  - That if such an arrangement is made:
    - the D-G Ministry of Health designate persons or a class of persons who are members of the Child Protection Team at [the Hospital] as “assessment officers” for the purposes of 27A(3) and (6);
    - the Child Protection Team at [the hospital] be structured, funded, and administered to carry out the functions under s27 A;
    - the Child Protection Team be identified as a “Unit” capable of employing seconded child protection officers in the employ of Community Services;
    - the Child Protection Team have its own office space so that clinicians, medical staff, members of the public and other agencies identify the place where the Unit exists;
    - that Policy Procedure and Guidelines be developed in line with Child Protection Team carrying out the reporting duties under s27 A;
    - that Director Health liaises with Director Communities, to develop mutually acceptable procedures for the introduction and evaluation and improvement of a system of alternative reporting by [the hospital].
Coronial recommendations: Fatal facts

<table>
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<tr>
<th>Case number</th>
<th>NSW.2010.4658</th>
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<tbody>
<tr>
<td>Primary category</td>
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<tr>
<td>Fatal facts edition</td>
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</tr>
</tbody>
</table>

Case summary

A young adult male died as a result of multiple gunshot wounds in an assault. The victim was ambushed at home by a number of assailants.

Coronial findings

The coroner found that the death was due to assault.

Coronial recommendations

The coroner made the following recommendations related to this case:

- Refer to Unsolved Homicide Team at Homicide Squad.

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<th>NSW.2011.3151</th>
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<tr>
<td>Primary category</td>
<td>Natural cause death</td>
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<tr>
<td>Additional categories</td>
<td>Mental illness and health, Drugs and alcohol</td>
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<tr>
<td>Fatal facts edition</td>
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</table>

Case summary

An adult female died while being treated in a hospital facility as a long-term patient. They were prescribed clozapine as they suffered from a treatment-resistant psychiatric condition. They were found unconscious in the treatment facility and could not be revived.

Coronial findings

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

Toxicological testing identified elevated levels of clozapine. The coronial investigation revealed that clozapine was kept in locked cupboards at the treatment facility, and all residents were administered their doses in the presence of nurses. There was no evidence of any irregularity in the quantities of clozapine used or supplied in the days leading up to the adult’s death, and no evidence of hoarding of the drug.

An independent expert report concluded that the elevated levels of clozapine were most likely due to post-mortem changes.

The coroner concluded that it was therefore unlikely that the cause of death was acute clozapine toxicity. The coroner found that the most probable cause of death was cardiac illness.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the Minister for Health:

- I recommend that, in relation to hospital deaths reported to coroners, the NSW [New South Wales] Forensic and Analytical Health Service consider methods of improving routine communication between forensic pathologists conducting post mortem investigations and the patient’s treating clinicians. This would be with a view to forensic pathologists being given as complete a relevant history as is practicable in a timely manner.
fashion so as to enable as accurate a post mortem diagnosis as is reasonably possible to be given.

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Coronial recommendations: Fatal facts

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<th>NSW.2011.3774</th>
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<td>Work related</td>
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<td>Fatal facts edition</td>
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</table>

Case summary

A middle aged adult male died in a workplace accident when a wheel from a vehicle they were working on exploded.

Toxicological testing identified amphetamines at a level that may have affected the adult’s mental processes in relation to their work.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult failed to deflate the tyre as per the specifications before removing the nuts holding the wheel rim assembly together. Failure to deflate the tyre pressure resulted in an avoidable accident.

The adult had been made aware of the risk associated with explosion of the tyre and had been shown correct practices in the technique. The adult had successfully completed this task on several occasions prior to the incident.

The coroner found that quantity of methamphetamine found in the blood samples of the adult were enough to have an intoxicating effect and explain their failure to deflate the tyre.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the Minister responsible for the WorkCover Authority of New South Wales and to the Chief Executive Officer of the WorkCover Authority of New South Wales:

- The Minister and the Chief Executive Officer give urgent consideration to referring the regulation of requirements for the identification, safe demounting, inspection, testing, maintenance and safe mounting of split rim and multi-piece pneumatic tyre and wheel assemblies for rubber pneumatic tyred industrial machinery and industrial vehicles to the relevant officer and/ or standards committee of Standards Australia with a view to the development of a standard designed to regulate the identification, safe demounting,
inspection, testing, maintenance and safe mounting of split rim and multi-piece pneumatic tyre and wheel assemblies.

To the Minister responsible for the WorkCover Authority of New South Wales and to the Chief Executive Officer of the WorkCover Authority of New South Wales:

• The Minister and the Chief Executive Officer give urgent consideration to referring the regulation of requirements for the identification, safe demounting, inspection, testing, maintenance and mounting of split rim and multi-piece pneumatic tyre and wheel assemblies for rubber pneumatic tyred industrial machinery and industrial vehicles to the relevant officer and/or committee of Safe Work Australia with a view to the development of Model Code of Practice designed to regulate the identification, safe demounting, inspection, testing, maintenance and safe mounting of split rim and multi-piece pneumatic tyre and wheel assemblies.

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Case summary

An adult male died during the course of work when they were trying to rescue an injured person. They worked as a specialised paramedic within a specialty casualty access team.

The adult was trying to rescue an injured person from a cliff edge when they and the injured person fell from the cliff.

Coronial findings

The coroner found that the death was unintentional.

The coroner was unable to determine why the deceased fell from the cliff edge.

Coronial recommendations

The coroner made the following recommendations related to this case:

To: The Minister for Infrastructure and Regional Development (Cth); The Chief Executive Officer, Australian Maritime Safety Authority (AMSA); The Minister for Police and Emergency Services (NSW); and The Commissioner of the NSW Police Force.

I recommend to the Minister for Infrastructure and Regional Development (Cth), the Chief Executive Officer of Australian Maritime Safety Authority (AMSA), the Minister for Police and Emergency Services (NSW) and the Commissioner of Police, New South Wales Police Force, that:

- The Australian Maritime Safety Authority in conjunction with the New South Wales Police Force develop a paper in relation the early transfer of coordination of LandSAR operations from Australian Maritime Safety Authority to the New South Wales Police Force to be taken to the next meeting of the National Search and Rescue Council.
- The Australian Maritime Safety Authority in conjunction with the New South Wales Police Force review their joint arrangements in relation to the prompt exchange of data relevant to search and rescue incidents.
To: The Minister of Police and Emergency Services, the Chairman of the State Rescue Board of New South Wales and the Commissioner of the New South Wales Police Force.

- I recommend to the Minister for Police and Emergency Services, the Chairman of the State Rescue Board of New South Wales and the Commissioner of the New South Wales Police Force that a review be conducted of the status of emergency services helicopter winching operations for the purpose of clarifying whether the conduct of such operations constitutes "rescue" within the meaning of the State Emergency and Rescue Management Act, 1989 (NSW).

To: The Minister of Police and Emergency Services, the Minister for Health, the Director General of the Ministry of Health, the Commissioner of the NSW Police Force, and The Chief Executive of NSW Ambulance Service.

I recommend to the Minister of Police and Emergency Services, the Minister for Health, the Commissioner of the NSW Police Force and the Chief executive of NSW Ambulance Service that:

- The review of the operation of the Memorandum of Understanding (MOU) signed 21 October 2013 between the Commissioner of Police and the Commissioner of New South Wales Ambulance be completed. The review should include consideration of arrangements with respect to inter-agency communications regarding the tasking and conduct of missions performed under the MOU.

To: The Minister of Health and the Chief Executive of New South Wales Ambulance Service:

I recommend to the Minister of Health and the Chief Executive of New South Wales Ambulance Service that:

- The roll out of the NSW Ambulance Aeromedical Integrated Risk Management Framework be completed;
- The helicopter winch simulator, including the introduction of mission simulation, be completed as soon as reasonably practicable;
- The Enhanced Helicopter Paramedic Helmet System project and that the trial of the proto-type enhanced paramedic helmet be completed as soon as practicable;
- A review of the position of SOT /Specialty Casual Access Team (SCAT) Activation Officer, including consideration of the following matters, be undertaken:
  - incorporation of the position of SOT /SCAT Activation Officer into the Aeromedical Operations Control Centre;
  - training of the SOT/SCAT Activation Officer in SCAT land-based operations and the operational role of helicopter paramedics;
  - and the provision of protocols and training to SOT/ SCAT Activation Officers in relation to the planning and conduct of helicopter beacon response and helicopter rescue operations.
• The revision of the SCAT paramedic training materials be completed;
• Regular, on-going SCAT paramedic training be scheduled.

To: The Minister of Health, the Chief Executive Officer of New South Wales Ambulance Service and the Chief Executive, Lloyd Helicopters Pty Ltd ACN: 007 916 912 trading as CHC Helicopters (Australia):

I recommend to the Minister of Health, the Commissioner of New South Wales Ambulance Service and the Managing Director, Lloyd Helicopters Pty Ltd ACN: 007 916 912 trading as CHC Helicopters (Australia):

• Training in relation to changes in NSW Ambulance Control & Command procedures relevant to the conduct of NSW Ambulance Service Aeromedical helicopter operations be provided to all NSW Ambulance paramedics1 medical crew, aircrew and pilots engaged in the provision of NSW Ambulance Service Aeromedical helicopter services.
• CHC and NSW Ambulance reinstate the Combined situational and/ or scenario based training for SCAT and Air Crew to the annual basis originally envisaged.

To: the Managing Director, Lloyd Helicopters Pty Ltd trading as CHC Australia

I recommend to the Managing Director Lloyd Helicopters Pty Ltd trading CHC Australia [CHC]

• CHC conduct a review of the Hi Line Procedure set out the CHC Operations Manual with a view to developing a comprehensive standard operating procedure governing the use of the Hi Line Procedure in the course of winching operations conducted overland.
• CHC review current rescue helicopter crew training schedules including but not limited to the re-introduction of annual integrated, holistic, scenario-based crew training.
• CHC conduct a review of cabin staff training documentation for the purpose of ensuring that the cabin staff training documentation accurately reflects the information, instructions and procedures contained in CHC's current Operations Manual, including current Flight Staff Instructions.
• CHC conduct a review of the company’s policy in relation to video footage captured on the winching cameras as installed and to be installed on CHC rescue helicopters with a view to ensuring that the video obtained in the course of winching operations is available to be used and is used in on-going, rescue training.
Coronial recommendations: Fatal facts

<table>
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<th>Case number</th>
<th>The coroner held a joint investigation into the following deaths which resulted from similar incidents: NSW.2012.2397, NSW.2013.3516</th>
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**Case summary – NSW.2012.2397**

An adult female took their own life using a weapon at a shooting range.

They attended a supervised program designed for unlicensed shooters to use a firearm. While participating in the program, they turned their assigned weapon on themselves.

**Coronial findings**

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

The coroner found that the shooting range provided an adequate safety briefing for the program to prevent accidental shooting.

The coroner noted that the *Firearms Act 1996* (NSW) required unlicensed shooters to be under direct supervision, but that ‘direct supervision’ is not defined by the act.

The coroner found that the adult was under direct supervision at the time of their death.

**Case summary – NSW.2013.3516**

A middle aged male took their own life by using a weapon at a shooting range.

They were suffering from complex medical conditions at the time of the incident. They attended a supervised program designed for unlicensed shooters to use a firearm. While participating in the program, they turned their assigned weapon on themselves.

**Coronial findings**

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

The coroner found that the shooting range provided an adequate safety briefing for the program to prevent accidental shooting.
The coroner noted that the *Firearms Act 1996* (NSW) required unlicensed shooters to be under direct supervision, but that there was ambiguity surrounding the definition of ‘direct supervision’.

The coroner found that the middle aged male was not under direct supervision at the time of their death.

**Coronial recommendations**

The coroner made the following recommendations related to these cases:

To The Minister of Sport and Recreation:

- That consideration be given, in consultation with any relevant stakeholders, to amending the term “direct supervision” in section 6B(1) of the *Firearms Act 1996* (NSW) and clause 110(6) of the *Firearms Regulations 1996* (NSW) to “direct, personal and exclusive supervision” which is consistent with section 53(6) of the *Weapons Act 1900* (QLD).
Coronial recommendations: Fatal facts

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Case summary
A middle aged female died while undergoing a cardiac procedure. During the procedure, a major blood vessel was unintentionally damaged, resulting in fatal injuries.

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

The coroner concluded that the injury could not have been foreseen prior to the operation commencing. It was noted that this procedure should have ideally been performed in a hybrid operating theatre, with emergency surgeons on hand, as there was a delay in transferring her to emergency surgery.

Coronial recommendations
The coroner made the following recommendations related to this case:

I recommend to the Minister for Health that the department of cardiology at [the hospital], in consultation with the NSW [New South Wales] Ministry of Health and the Cardiac Society of Australia and New Zealand, consider introducing a specific form of written consent for lead extraction procedures which include the following:

- The pertinent elements of the planned procedure and all reasonable alternatives.
- The percentage risk of major and minor complications.
- A statement (including [the hospital]'s rates of extractions and outcomes) that lead 3 extractions can be potentially life-threatening.
- A statement of the proceduralist's personal level of experience in lead extractions and outcomes.
- The emergency procedures in place should a complication arise.
- Insofar as is reasonably practicable, I recommend that the patient's consent be obtained in the presence of a family member or friend.

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Coronial recommendations: Fatal facts

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</table>

Case summary

A young female died by hanging at their home.

They were attending a mental health service and seeing their school counsellor at the time of their death.

Coronial findings

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

The coroner found that there were systemic issues with their case management at the mental health service. This resulted in the clinicians not receiving appropriate information to provide suitable support to the young person. The coroner noted that significant changes had been implemented at the mental health service following the incident.

The coroner found that there was a breakdown in communication between the school and the mental health service, resulting in gaps in the young person’s treatment and recognition of their deteriorating mental state.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the NSW [New South Wales] Minister for Education (Education) and to the Chief Executive of the [local health district]:

- Education and [local health district] to jointly develop a document to be distributed to employees (including those in mental [local health district] services) supporting children and young people which clearly explains the legal basis for exchanging information about children and young people in NSW under Chapter 16A of the Children and Young Persons (Care and Protection) Act 1998 (Chapter 16A). This should address:

  - the kind of information that could be exchanged – for example [local health district] could provide information on children and young people presenting with suicidal
ideation and Education could provide information about school attendance, behaviours and academic progress of these children and young people
  - the circumstances in which consent is not required in order to exchange information
  - that privacy law, professional etiquette or ethics will not prevent the exchange of information for the purposes of Chapter 16A.

- Education and [local health district] to identify and regularly maintain key contact points in a school or local [local health district] district and notify each other of those contacts. This will include “after-hours” and school holiday contact points.
- [Local health district] to notify the appropriate contact at Education where [local health district] is aware that a specific government school student is expressing current suicidal ideation. This includes but is not limited to circumstances where a student is released from hospital after a suicide attempt. [Local health district] should provide sufficient information to Education to enable Education to begin planning for the student’s support/revise existing support plans.
- Education to continue to provide information to a nominated contact at [local health district] about a student’s progress at school where it is aware a child or young person is the subject of intervention by [local health district] for suicidal ideation. This should include academic progress but also information about the student’s presenting behaviours, wellbeing, and school attendance.
- Each agency consider the need for a cross-agency case management meeting to support collaborative and integrated planning with and for the student and family (where appropriate).
- Each agency to explore the potential for joint professional development designed to enhance an interagency response in support of children and young people expressing suicidal ideation.

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Coronial recommendations: Fatal facts

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<tr>
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Case summary

A young male was swimming in a rock pool during rough ocean conditions. A large wave struck the rock pool and caused him to strike his head and lose consciousness. He was swept out to sea and subsequently drowned.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the signage stating the pool was closed due to dangerous conditions was not effective either in bringing attention to the pool’s closure or in adequately conveying the risks of using the pool in dangerous conditions.

Coronial recommendations

The coroner made the following recommendations related to this case:

- In the circumstances I propose to make a recommendation to the [council] in accordance with Section 82 of the Act that a safety review be undertaken of the [rock pool] with particular consideration being given to the inherent risks associated with the use of the pool by the public, the effectiveness of the methods used to inform the public of the risks associated with the use of the pool during certain weather conditions, the methods adopted in order to protect the public from such risks and whether there are any structural modifications to the pool that might mitigate the risks posed to the public by adverse weather conditions.

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Coronial recommendations: Fatal facts

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<th>Case number</th>
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<td>Primary category</td>
<td>Transport and traffic related</td>
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<td>Fatal facts edition</td>
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Case summary

An adult female died when they lost control of their vehicle and collided with a tree. They were using their mobile phone at the time of the crash.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult was answering a phone call immediately before the crash, and momentary inattention caused them to drive slightly off the road. They lost control when they overcorrected their steering.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the Minister for Roads:

- I recommend that, if one has not been recently conducted, a safety audit of the [road] be carried out by Roads and Maritime Services and that any deficiencies be rectified.
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.2012.76
---|---
Primary category | Adverse medical effects
Additional categories | Natural cause death
Fatal facts edition | 42 – cases closed between July and September 2014

Case summary
A young adult male passed away from bacterial meningitis. They attended a local medical clinic several times in the week preceding their death with symptoms of being unwell.

Coronial findings
The coroner found that the death was due to natural causes. The corner found there was a delay in prescribing the deceased with antibiotics due to a breakdown of communication between doctors.

Coronial recommendations
The coroner made the following recommendations related to this case:

To the NT [Northern Territory] Department of Health

- Review the role out of tele-health facilities in the Northern Territory to ensure that staff in remote clinics have access to facilities and are trained in their use, and that the Duty Medical Officer emergency and other relevant specialists are being made available for the service, and are trained in it use.
- Encourage changes in the Central Australian Rural Practitioners Association Standard Treatment Manual so that:
  - The sections on recognizing and treating meningitis are referenced to sections on headache, neck stiffness and fever;
  - The Manual is made more explicit about commencement of treatment for meningitis, noting the imperative to avoid delay if diagnosis is suspected.
  - The Manual should explicitly state at what point a Medical Officer must be notified of a condition and, in the case of meningitis the presence of new headache and fever alone should be a trigger for Medical Officer referral.
• All clinical staff to undergo regular training and up-skilling within their scope of practice, with training to highlight conditions that they are unlikely to encounter in routine practice, and the need to obtain, and document expert advice in those circumstances.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>NT.2013.4</th>
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</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Child and infant death</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>42 – cases closed between July and September 2014</td>
</tr>
</tbody>
</table>

Case summary

A female child died from unknown causes, though the pathologist determined the child was chronically malnourished.

The child was born eight weeks premature and was considered small for their age, however experienced continuous growth up until death. The child was in foster care for a period of less than a week before death. The foster carer noted that the child was difficult to feed and had bowel issues. The foster carer had difficulties with the hip brace that was fitted to the child.

Coronial findings

The coroner was unable to determine the circumstances of the death.

The coroner concluded that on or about the penultimate day/night of the child’s death, the child’s health declined rapidly. The coroner found that the foster parent was extremely experienced and of the highest quality.

Following the death, a local doctor encouraged implementing a system in the town whereby clinical nurses experienced in paediatric issues would be available by telephone or in person to attend health enquiries raised by a foster carer looking after young infants. The coroner found that the Department of Health and Department of Children and Families were receptive to exploring this initiative.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I strongly recommend that the Departments of Health and Department of Children and Families work together with foster care agencies to achieve a workable protocol and practice in this regard.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>NT.2013.143</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Transport and traffic related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>42 – cases closed between July and September 2014</td>
</tr>
</tbody>
</table>

Case summary

An adult male died when their motorcycle collided with a vehicle. The adult attempted to overtake the vehicle as it was turning onto an unmarked road.

Coronial findings

The coroner found that the death was unintentional.

The coroner noted that the driver of the vehicle had correctly indicated, and had right of way on the road. The coroner also noted that the absence of road markings or signage indicating a turn off was the main factor in why the collision occurred.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the NT Government immediately commission a traffic survey to determine the use of the [area] as a recreational area, and if it is to be used, that further measures are taken to warn riders and drivers on the [road] that a turn off is ahead, including measures such as a sign to indicate the turn off, a slip lane and reduction of the speed limit in the relevant area.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>NT.2013.214</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Leisure activity</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Water related, Weather related, Transport and traffic related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>42 – cases closed between July and September 2014</td>
</tr>
</tbody>
</table>

Case summary

A middle aged adult female drowned when they were thrown from a houseboat that capsized during a violent storm.

At the time the storm struck, the adult was standing on the upper deck of one of two houseboats. The houseboats had their anchors down at the front to face into the weather. However, the houseboats were tied together at the bows, resulting in them being side-on to the storm.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the houseboats being tied together at the bows did not give them the best chance of surviving the storm. However, it was noted that by the time the wind increased, the boats were crashing together and there was no safe opportunity to separate them.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that a safety and operational instruction be provided to those that hire houseboats about the risks of attaching the boats bow to bow.

This Fatal facts summary has been produced by the National Coronal Information System and 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.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>QLD.2010.1709</th>
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<td>Primary category</td>
<td>Water related</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Sports related, Leisure activity</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>42 – cases closed between July and September 2014</td>
</tr>
</tbody>
</table>

Case summary

An adult male drowned while free diving during an organised boating trip.

They were noted to be missing from the group, and were subsequently discovered on the ocean floor after being submerged in the water for a period of time.

They were brought back to the vessel where resuscitation was commenced. Crew members were unable to utilise the oxygen resuscitation equipment on board, as it was not functional due to a missing part. The adult was conveyed to hospital where they were pronounced deceased.

Coronial findings

The coroner found that the death was unintentional.

The coronial investigation revealed that the adult was known to free dive by themselves and was not conscious of the need to stay with a group or buddy.

The coroner found that there was insufficient information to be able to determine whether there were any breaches of safety legislation or regulations on board the vessel on the day of the incident. The coroner found that this was a direct result of the lack of cooperation from the company director and their crew.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That Office of Fair and Safe Work Queensland (OFSWQ) request [company], [company] and [company director] permit OFSWQ inspectors to conduct a comprehensive audit of all vessels used and/or owned by those entities for recreational diving and snorkelling activities on the [location] and that such audit include inspectors travelling on the vessels during usual trips to the reef in order to conduct such an audit and should such a request be refused or inspectors obstructed in their audits in any way that such information be provided to AMSA [Australian Maritime Safety Authority] and [marine park authority].
- That AMSA consider reviewing whether [company], [company], [company director], [crew member] and [crew member] are appropriate persons to hold the certificates of operation and competency which they currently hold.
- That [marine park authority] consider reviewing whether [company] and [company] are appropriate entities to hold permits allowing those entities to conduct tourist activities on the [location].
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>QLD.2014.585</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Water related</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Leisure activity</td>
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<tr>
<td>Fatal facts edition</td>
<td>42 – cases closed between July and September 2014</td>
</tr>
</tbody>
</table>

Case summary
An adult male drowned while swimming in a waterway. He became caught in the strong current and was swept downstream. He struck his head and subsequently drowned.

Coronial findings
The coroner found that the death was unintentional.

It was noted that the majority of visitors to the waterway are tourists with no local knowledge, and may not have English as their first language, or understand the dangers of the waterway. The coroner commended the parties involved in the inquest for their willingness to address the safety issues identified during the investigation.

Coronial recommendations
The coroner made the following recommendations related to this case:

- All of the stakeholders who operate in, or respond to incidents at, [the national park] form a committee and consider the issues raised at this inquest, including but not limited to:
  - The safety of pedestrians and cyclists on the [road] and whether a separate walking and bicycle path should be established;
  - The information provided to visitors at the Centre including the content of that information and how it is delivered;
  - The signage in the national park;
  - Information sharing between rangers and Centre staff in regard to water levels in the gorge and associated risks to visitors;
  - Whether at any time it would become appropriate to prohibit swimming in the national park due to high water levels in the gorge;
  - Review of procedures relating to responses to emergencies occurring in the national park;
  - Changes to the Centre’s website and brochures;
- Access to the landline in the rangers’ hut for all stakeholders;
- Improved mobile phone coverage in the national park.

- [The tourism company] engage a safety consultant to review the safety management in respect of its operation concerning:
  - The advice to be given to visitors concerning their safety in the [the national park]; and
  - The management of emergency incidents that occur in the [the national park].
TASMANIA
The following cases summaries and recommendations relate to deaths reported to a coroner in Tasmania.
Coronial recommendations: Fatal facts

<table>
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<tr>
<th>Case number</th>
<th>TAS.2011.472</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Child and infant death</td>
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<tr>
<td>Fatal facts edition</td>
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</tr>
</tbody>
</table>

Case summary

The female child died during birth after ingesting a large amount of amniotic fluid and meconium.

The infant was born in poor condition and required assistance after birth. The infant was to be transported to another hospital; however there was a significant delay in their transfer.

Coronial findings

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

The coroner found that the events surrounding the death of the child were unusual, involving discrepancies from communications and system deficiencies.

The coroner found that issues surrounding the child’s death had been appropriately addressed and improvements made by the hospitals and the emergency transport services responsible.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend regular reviews of the systems and processes into the future.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>TAS.2012.258</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Adverse medical effects</td>
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<tr>
<td>Fatal facts edition</td>
<td>42 – cases closed between July and September 2014</td>
</tr>
</tbody>
</table>

Case summary

An older adult female died when she ingested methotrexate. They were prescribed the medication for treatment of a condition but had not been taking it in the years prior to death. According to their general practitioner, the adult was aware of the potential side effects and complications of the medication.

Coronial findings

The coroner found that the death was unintentional.

The coroner was unable to determine why the deceased had resumed consuming methotrexate after a period of lapse. The coroner concluded that the deceased began taking the medication again after a flare up in their medical condition. Given the time lapse between prescription and consumption, they may have forgotten the dosage or assumed that increased amounts of the medication would alleviate symptoms of the condition sooner.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That each patient prescribed methotrexate be given clear directions for its safe use, such directions being both oral and in writing and be regularly reinforced throughout the course of treatment, most particularly after any interruption to their use.
- That any prescription for methotrexate be limited to one month’s supply.
- That medical practices maintain a register of all its patients prescribed methotrexate and that the register be utilized to ensure those patients receive regular blood monitoring.
- That a drug administration aid such as a Webster pack be utilized for the dispensation of methotrexate to those patients who are elderly or who may otherwise have a reduced capacity to comply with dosage instructions.
Coronial recommendations: Fatal facts

Case number
TAS.2012.474

Primary category
Falls

Addition categories
Older persons

Fatal facts edition
42 – cases closed between July and September 2014

Case summary
An older adult male died when they fell from a ladder. At the time of the incident, they were performing maintenance repairs on their workshop.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the ladder was not secured at its base by another person, nor tied off at the top or bottom (or both). The adult did not maintain three points of contact with the ladder at all times.

Coronial recommendations
The coroner made the following recommendations related to this case:

• I recommend that the following basic safety precautions are taken when using a ladder at home:
  o Take care to comply as far as possible with either the Australian Standard applicable to the task at hand or the Code of Practice approved under section 274 for the Work Health Safety Act 2012;
  o Ensure the ladder is in good condition and set up on firm and stable ground;
  o Ensure that the ladder is positioned so that it is neither too far from, nor too close to, the support structure;
  o Always ensure when using a ladder that it is secured either by being properly ‘fooled’ by another person or tied off at the top (or both); and
  o Only ever undertake light work while on the ladder - and then ensure that three (3) points of contact with the ladder are maintained at all times.

In addition, it is quite clear as [another coroner] observed in [another case] that while rates of deaths from ladders in the work environment remain relatively stable, they are increasing appreciably in a home maintenance context.

• Accordingly, I recommend further that the appropriate authority within government devise and deliver an advertising campaign warning of the risks of ladder use in the
home maintenance environment, directed towards men aged 65 years and over, and providing basic strategies to minimise the risk of falls and consequent death from ladder use. Such a campaign should include, but not be limited to, making the community aware of the existence of both the applicable Australian Standard and the Code of Practice.
Coronial recommendations: Fatal facts

<table>
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<tr>
<th>Case number</th>
<th>TAS.2013.419</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Falls</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Older persons, Domestic incident</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>42 – cases closed between July and September 2014</td>
</tr>
</tbody>
</table>

Case summary

An older male died following a fall from a ladder while carrying out domestic maintenance.

The adult sustained head injuries and were conveyed to hospital where they subsequently passed away.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the ladder was not secured in any way at the time of the incident.

Coronial recommendations

The coroner made the following recommendations related to this case:

- In my view the Code of Practice, and the guidance and recommendations it contains, is directly applicable to the use of ladders around the home for maintenance and the like. The Code should be followed.
- I recommend that the following basic safety precautions are taken when using a ladder at home:
  - Take care to comply as far as possible with either the Australian Standard applicable to the task at hand or the Code of Practice approved under section 274 for the Work Health Safety Act 2012;
  - Ensure the ladder is in good condition and set up on firm and stable ground;
  - Ensure that the ladder is positioned so that it is neither too far from, nor too close to, the support structure;
  - Always ensure when using a ladder that it is secured either by being properly “footed” by another person or tied off at the top (or both); and
  - Only ever undertake light work while on the ladder – and then ensure that three (3) points of contact with the ladder are maintained at all times.
- I recommend further that the appropriate authority within government devise and deliver an advertising campaign warning of the risks of ladder use in the home maintenance.
environment, directed towards men aged 65 years and over, and providing basic strategies to minimise the risk of falls and consequent death from ladder use. Such a campaign should include, but not be limited to, making the community aware of the existence of both the applicable Australian Standard and the Code of Practice.
Coronial recommendations: Fatal facts

<table>
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<tr>
<th>Case number</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Water related</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Leisure activity, Transport and traffic related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>42 – cases closed between July and September 2014</td>
</tr>
</tbody>
</table>

Case summary

An older adult male was presumed drowned at sea when their fishing boat was discovered without them aboard. Their body was not found.

Coronial findings

The coroner found that the death was unintentional.

Based on the evidence, the coroner was satisfied that the adult died at sea.

Coronial recommendations

The coroner made the following recommendations related to this case:

- When last seen [the deceased] was operating his boat and heading for open waters wearing a heavy yellow raincoat. There is significant doubt as to whether he was wearing a life jacket whilst the boat was underway. Two life jackets (being the reported normal number carried) were found on the boat after it was found, which indicate he was not wearing one at the time that he apparently fell overboard. Given that the boat was at that time travelling of its own accord and then beached itself after [he] fell overboard it is likely it was underway at the time. His apparent failure to wear a life jacket when his boat was underway could well have contributed to his death and once again this illustrates the need for all boat users to comply with applicable legislation in this regard.

- The engine cut out switch at the helm of the boat was operational and shut the motor down when disengaged. I am mindful of the general practice of small boat owners not to use this device as it can be restrictive. However this incident could well be an example of how its use may have assisted [the deceased] if he had fallen overboard and his boat continued travelling away from him. I recommend that persons operating a small boat single handed ensure that this device is able to be operated in circumstances where they are unable to have control of the boat.

- The water temperature on the following day was measured at 11.5 degrees Celsius. Immersion in water at this temperature would very soon lead to the effects of
hypothermia and [the deceased] would have been unable to survive in the water at that
temperature for any sustained period of time.

- The delay in activating a search for [him] is of concern. The on-duty police officer had
sufficient concern as to [the deceased’s] well-being that he checked his house at
10.00pm finding that is was in darkness and locked up with no one there. He was aware
at that time that [the deceased’s] boat and empty trailer were at the boat ramp. He was
also aware at 2.45 the next morning that [the deceased] had not returned to the boat
ramp yet no action was taken as to the possibility of there being a missing person
incident and a boating mishap. I request that the Police Department consider this issue
and take such action as may be required to ensure operational police officers act in a
consistent manner, perhaps as detailed in Standard Operating Procedures, when faced
with a similar circumstance. I am unable to say whether a search instituted on the night
of his disappearance would have led to a different outcome for [the deceased], but it
would have at least increased the possibility of a more positive outcome.

- The second aspect relating to the delayed search is [the deceased’s] failure to leave
details as to his intentions when going out on this day, particularly his planned return
time. If he had left this detail with a friend or neighbour or even left a note with his motor
vehicle at the boat ramp the likelihood is that a search would have been commenced
much sooner and his chances of being found and of survival would have been increased.
I strongly recommend that all boat users ensure such detail is left with someone who will
monitor their return or at the very least the detail is left with their vehicle and trailer at a
boat ramp if this is applicable.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>TAS.2013.45</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Transport and traffic related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>42 – cases closed between July and September 2014</td>
</tr>
</tbody>
</table>

Case summary

An older adult female was the passenger of a vehicle involved in a collision with a truck. The driver of the vehicle was attempting to execute a U-turn through an opening in the highway median strip and turned in front of the truck.

Coronial findings

The coroner found that the death was unintentional.

The coroner noted that the collision would not have occurred if the median strip opening did not exist, and acknowledged that there were plans underway to close the median strip.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the median opening be closed as soon as practicable in accordance with the plans by the Department of State Growth.
- I recommend that, pending the closure of the median opening, the Department considers erecting signage to prohibit U-turns, or alternatively signage to warn motorists of the possibility of encountering vehicles using the opening to perform U-turns.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>TAS.2013.107</th>
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<tr>
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<td>Falls</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Adverse medical effects</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>42 – cases closed between July and September 2014</td>
</tr>
</tbody>
</table>

Case summary
An older adult female passed away following a fall they suffered whilst in hospital.

At the time of the fall the adult was on blood thinning medication as prescribed by a doctor at the hospital. They had a significant medical history prior to their admission to hospital.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that there were significant short comings on the part of the hospital in the treatment and care of the patient. These were:

- failure to provide the echocardiogram requested by a doctor
- absence of a nursing care plan including a falls assessment
- incomplete and insufficient medical notes
- failure to promptly report a reportable death as required by the Coroners Act 1995.

Coronial recommendations
The coroner made the following recommendations related to this case:

- That the [hospital] review this case with a view to putting in place procedures to avoid their repetition.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>TAS.2013.139</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Adverse medical effects</td>
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<tr>
<td>Fatal facts edition</td>
<td>42 – cases closed between July and September 2014</td>
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</table>

Case summary

An older adult male died in hospital due to sepsis. The cause of the sepsis was unknown but though to be from pneumonia or spinal epidural abscess. The adult had been released from hospital on the morning of their death.

Coronial findings

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

The coroner found that the deceased should not have been released from hospital on the morning of their death, and in doing so they were denied the best chance of surviving their illness.

The doctors responsible for the care of the adult failed to diagnose and treat the sepsis.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I repeat my recommendation made in previous cases to the effect that a hospital should not discharge a patient without first undertaking a review of their medical status which review should include the taking and recording of their vital signs.

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.
VICTORIA

The following cases summaries and recommendations relate to deaths reported to a coroner in Victoria.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2006.4957</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Law enforcement</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Transport and traffic related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>42 – cases closed between July and September 2014</td>
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</table>

Case summary

A young female died due to a vehicle incident involving a police pursuit.

Coronial findings

The coroner found that the death was due to legal intervention. The coroner found that the police members involved were not at fault, and noted that they were only as effective as the training, tools and guidance they were provided with.

Coronial recommendations

The coroner made the following recommendations related to this case:

- Police should never pursue a vehicle simply because it is fleeing. A pursuit should only be undertaken where police hold a pre-existing belief on reasonable grounds that intercepting the vehicle is necessary:
  - to prevent a serious risk to public health and safety; or
  - in response to a serious criminal offence that has been committed, or is about to be committed, which involves serious harm to a person or persons.
- The current Victoria Police risk assessment model for police pursuits should be redeveloped and an alternative more appropriate model be adopted, such as the ‘traffic light model’, so as to guide police members as to what weight should be given to one particular risk factor over another. Any risk assessment model should be commensurate with appropriate industry practice in other safety critical environments.
- All police vehicles should be fitted with In Car Video.
- That Victoria Police introduce processes to ensure all police members record and report all incidents of vehicles fleeing police, to improve the evidence base for development, evaluation and review of Victorian police pursuit policies that strike the optimum balance between law enforcement and public safety imperatives.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2006.4364</th>
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<tbody>
<tr>
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<td>Adverse medical effects</td>
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<td>Fatal facts edition</td>
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</table>

Case summary

A middle aged female died when their aorta was lacerated during a lap band surgery.

The aortic injury was not detected, and was therefore not addressed for many hours during the surgery.

Coronial findings

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

The coroner found that the laceration of the aorta exhibited a degree of carelessness in the surgeon. The coroner also found that the anaesthetist did not properly communicate the decreasing blood pressure levels of the adult and failed to communicate their concerns about those readings.

Coronial recommendations

The coroner made the following recommendations related to this case:

- There should be a greater awareness raised of the risks of perforating the aorta whilst inserting the Visiport in a Lap Band procedure and for resultant bleeding not necessarily showing in the operative field. I recommend that the Royal Australasian College of Surgeons state or re-state, and build into its information and education programs, dissemination of the fact that significant retroperitoneal bleeding can occur without any intra-abdominal signs.
- In relation to obesity training, I note [expert witness]’s comment that the Royal Australasian College of Surgeons presently has "no guidelines for recognition of obesity training". I adopt [their] proposed recommendations:
  - Currently the Royal Australasian College of Surgeons has no guidelines for recognition of obesity training. The Royal Australasian College of Surgeons be encouraged to produce the guidelines based on advanced laparoscopic experience and familiarity in operating around the gastro oesophageal junction. The colleges should also ensure familiarity with cross clamping major vessels is taught during training as major bleeding is the fear of most surgeons whatever their discipline.
Dissemination of lessons learned from this case should be made known to the wider surgical and anaesthetic communities including other subspecialties involved in advanced laparoscopic procedures. In particular, it should be emphasised that significant retroperitoneal bleeding can occur without any intra-abdominal signs.

- Noting [expert witness]'s recommendation about refresher courses highlighting emergency situations in hospitals, I recommend: the respective professional colleges in Victoria for anaesthesia and surgery should incorporate mandatory training for those in the private sector dealing with elective procedures to undergo specific training in dealing with emergency situations. Such training should be on an annual basis.
Case summary

An adult male died of cardiac illness secondary to prescribed drug toxicity, including verapamil.

The adult had a complex medical history and a complex and fluid medication regime. They presented to hospital with cardiac concerns, but left before being admitted. They returned soon after when their condition declined, and were admitted. Their condition deteriorated, and despite resuscitation efforts they died in hospital.

Coronial findings

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

The coroner found that it was highly likely that they had accidentally exceeded their prescribed dose of verapamil. It was noted that the interactions between verapamil and other prescribed medications contributed to the cardiac illness.

The coroner found that the adult’s medical records indicated that there was a degree of confusion and uncertainty between their doctors surrounding the type and doses of medications prescribed.

The coroner noted that doctors are heavily reliant on patient self-disclosure, and found this practice inherently unsatisfactory. The coroner noted that patients with complex and frequently changing medication regimes are at risk of making unintended errors and omissions in their disclosures.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the Victoria Faculty of the Royal Australian College of General Practitioners, the Australian Medical Association Victoria, the Victorian Branch of the Pharmaceutical Society of Australia and the Victorian Branch of the Pharmacy Guild of Australia meet to discuss the feasibility of collaborating to develop and implement a real-
time prescription monitoring system to enhance their Victorian members’ ability to provide appropriate care to patients and reduce the harms and deaths associated with poor coordination of care.
Coronial recommendations: Fatal facts

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<thead>
<tr>
<th>Case number</th>
<th>VIC.2007.3935</th>
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<tr>
<td>Primary category</td>
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</tr>
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<td>Fatal facts edition</td>
<td>42 – cases closed between July and September 2014</td>
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</tbody>
</table>

Case summary

An older adult male took their own life by hanging. They had a history of self-harm.

The adult was a voluntary inpatient at a hospital psychiatric unit for aged persons. They were under regular observation and were found hanging in a bathroom shortly after an observation check.

Coronial findings

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

The coroner found that the adult had recently been downgraded from one-to-one supervision to regular observations by staff. The downgrading took place following an external consultation with a doctor.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend to [health service] that in all cases of observation down grade from special nursing level, that a consultant medical officer review the patient concerned in person and record details of the clinical reasons for so deciding.
- I further recommend that in all cases described in recommendation one above, where a consultant medical officer is unavailable to see a patient receiving special nursing and recommended for downgrade, that any approval for an observation downgrade by such consultant should only be given through an IT [information technology] approval system, which includes a time stamped document review, and a further clinical review setting out the consultant medical officers reasons for so deciding.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>The coroner held a joint investigation into the following deaths which resulted from the same incident: VIC.2008.39, VIC.2008.40, VIC.2008.41</th>
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<td>Fatal facts edition</td>
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</tbody>
</table>

Case summary

Two young males and an adult male died when a fire broke out in their home during the night due to a faulty computer monitor overheating. The inadequate electrical circuitry in the house, together with the multiple appliances connected to a power board, contributed to the computer monitor overheating.

Coronial findings

The coroner found that the deaths were unintentional.

The coroner determined that the number of people in the house did not contribute to the fire. The coroner found that scheduled property inspections by the real estate agent had not taken place leading up to the incident. As a result, it was unknown if smoke alarms were present at the time of the fire, and if so, whether they were activated.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the *Residential Tenancies Act* be amended to ensure all properties regardless of whether they are new residential buildings, constructed on or after 1 August 1997, subject to a Residential Tenancy Agreement be fitted with a hard-wired smoke alarm with ten year long-life tamper proof battery chamber back-up, on every floor level of every residence.

- That the *Residential Tenancies Act* be amended to clarify who bears responsibility for the testing and maintenance of smoke detectors. This could be done by ensuring the *Residential Tenancies Act* detail that:
  - at the beginning of a tenancy agreement and every year thereafter, a landlord or agent must certify that each and every smoke alarm at the rented premises:
    - has been properly installed in the correct location (as required by the Building Code of Australia or Building Regulations Victoria);
    - has been tested and cleaned in accordance with the manufacturer’s instructions; and
- is working effectively.

- During a tenancy, a landlord or agent must replace any smoke alarm before the end of its service life, or if it reaches the end of its service life, replace it immediately.

- A tenant must advise the landlord or agent if the tenant becomes aware that the smoke alarm is not working.

- Amend S86 of the Residential Tenancies Act, which provides grounds for entry by the landlord of rented premises, to include that for the purposes of an inspection under subsection 86(1)(f), the landlord or estate agent must check that the smoke alarms are working.

- Amend the definition of urgent repairs in 3(1) of the Residential Tenancies Act to include a "smoke alarm that is not working".

- That Consumer Affairs Victoria review and update the information on fire safety and smoke alarms in its guides and online content, including the red book, to include following information about smoke alarms and fire response such as:
  - the rights and obligations of landlords or agents and tenants in relation to the installation, maintenance, repair and replacement of smoke alarms;
  - a diagram of a smoke alarm and easy to understand instructions about where they should be located in the premises;
  - how to test and clean smoke detectors and how to change the batteries, and in particular, inform a tenant that the tenant must:
    - to gently dust around the outside cover annually;
    - test the smoke alarm every month to make sure it is working;
    - contact the agent/landlord if the smoke alarm is not working;
    - contact the agent/landlord if the smoke alarm emits an occasional chirping noise as the battery or smoke alarm is faulty.

- What to do in the event that the smoke alarm goes off, including what procedures might be adopted in the event of a fire such as to:
  - get down low and stay out of the smoke;
  - alert others on your way out if it’s safe to do so;
  - get out and call triple zero and ask for FIRE and be ready to give the address.

- the fire and safety risk of having multiple appliances connected to individual power points on multi outlet power boards without any safety switches;

- basic fire and safety information if a fire occurs at the premises; and

- it is also crucial that the guidebooks are translated into as many different languages as possible, including the first language of the residents at the premises.

- That Consumer Affairs Victoria promote fire safety messages as part of its ongoing education activities, including but not limited to utilizing the International Education Unit within the Department of Business and Innovation to provide information about smoke alarms on their website, Facebook and Twitter channels to promote education of smoke alarms and link back to the safety information on our website.
• That Consumer Affairs Victoria produce additional information for property managers and continue to provide education on fire safety by working with the Real Estate Institute of Victoria and other key industry groups about ways of alerting agents that offer property management services of the importance of the fire safety message being reinforced when letting a property. This must include adding information on fire safety to the "Landlord’s Kit".

• That the Real Estate Institute of Victoria and Registered Accommodation Association of Victoria develop best practice guidelines and provide education to real estate agents and landlords about their obligations under the Residential Tenancies Act which includes:
  o an education campaign (including training sessions) for real estate agents/landlords about their obligations in relation to fire safety;
  o identify ways that their membership can better communicate to people at the beginning of their tenancy or residency;
  o what a smoke alarm is, how to clean, test that it is working and replace batteries;
  o who is responsible for installing, maintaining and repairing smoke alarms;
  o the fire risk of overloading power boards;
  o their basic rights and obligations; and
  o the tenancy agreement.

• That the Real Estate Institute of Victoria to ensure every landlord provides a copy of the following information, in addition to the red book, is placed inside every residence subject to a residential tenancy agreement:
  o annex a diagram of the residence to the condition report indicating the location of smoke alarms together with advice about when the alarms were last inspected and when the next inspection is due;
  o a picture of at least 3 different smoke alarm models;
  o a smoke alarm will alert you to smoke or fire and provide time for you to get out and get help. If the smoke alarm goes "beep beep beep": get down low and stay out of the smoke; alert others on your way out if it’s safe to do so; get out and stay out; call Triple 000 and ask for FIRE and be ready to give the address;
  o a tenant needs to test their smoke alarm monthly (picture of broom handle test);
  o gently dust around the outside cover annually (picture of dusting);
  o a tenant must contact your agent or landlord if smoke alarm test makes no sound or the smoke alarm makes an occasional chirping noise like a bird as the battery or smoke alarm is faulty;
  o a tenant must not remove the battery from the smoke alarm or remove the unit from the ceiling and if they believe the unit to be faulty or not working please contact your agent.

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

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<th>Case number</th>
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</table>

Case summary

An adult male died of a gunshot wound during an interaction with police.

The adult was a passenger of a vehicle stopped by police for a traffic infringement. Police located a firearm in their bag, and the adult fled the scene. Police officers pursued them, and the adult fired shots. They were subsequently shot by police. Police officers contacted the Critical Incident Response Team (CIRT) to attend before approaching the adult, but there was a delay in the CIRT’s arrival and the adult had died by the time paramedics were permitted to approach them.

Coronial findings

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

The coroner accepted that the matter warranted the attendance of the Critical Incident Response Team, but that the delay in their arrival was unacceptable.

The coroner found that the decision made by the Critical Incident Response Team to handcuff the adult was unnecessary, as they were clearly deceased and posed no threat to themselves or the attending paramedics.

The coroner determined that additional police training regarding foot pursuits would be useful.

Coronial recommendations

The coroner made the following recommendations related to this case:

- The handcuffing of [the deceased] by Critical Incident Response Team members was unnecessary in the circumstances. With the aim of managing seriously injured and deceased persons more humanely, I adopt the suggestion for a recommendation made by Counsel on behalf of [the deceased’s family member] and supported by Counsel Assisting.
• I recommend that the training in respect of containment, restraint and arresting of seriously injured or deceased persons be reviewed and modified if appropriate, but at a minimum to take into account the necessity to proceed to handcuff a seriously injured or deceased person in circumstances where:
  o it is not necessary to give effect to containment, restraint and an arrest; and
  o it would be inhumane to handcuff that person; and/or
  o handcuffing the seriously injured person may cause further injury.

• With the aim of improving the integrity of an investigation into police contact matters and improving disclosure and distribution of relevant material in a timely manner I recommend:
  o investigating officers conduct a video recorded walkthrough of the scene of the incident;
  o where possible and appropriate, interviews with police officers involved in police-related fatalities should be video recorded; and
  o all relevant notes and materials be disclosed and provided to the Coroner and the investigating officer, Counsel Assisting and Interested Parties prior to the commencement of the inquest.

• With the aim of reducing perceptions of bias and collusion by families involved in the inquests of police contact deaths, I reiterate and repeat Recommendation 8 of [another coroner] made in [a similar death]:

  To allay perceptions regarding collusion and bias, without compromising the coherence of the account given by Victoria Police members following a police contact related death, I recommend that the Secretary to the Victorian Department of Justice provide an institutionally independent, legally trained person to observe the interview process with Victoria Police members involved in the incident.

• With the aim of reducing perceptions of bias and collusion by families involved in the inquests of police contact deaths I adopt in part the proposed recommendations made on behalf of [the deceased’s mother] in relation to the involvement of Civil Litigation and I recommend that:
  o in preparation for giving evidence at an inquest in police contact matters that a policy be developed that embraces the concept of transparency and ensures that when the Civil Litigation team instigate meetings between police witnesses and the Civil Litigation team, a member of Professional Standards is present at such meetings or if [the third recommendation] is adopted, an institutionally independent, legally trained person is present at these meetings; and
  o protocols are established to ensure that evidentiary materials and aids produced to officers during these meetings and/or provided to the Civil Litigation team by police witnesses should be disclosed to the Court, the investigating officer, Counsel Assisting and Interested Parties in a timely manner.
• With the aim of minimising risks and harm to police officers, offenders and members of the public, I recommend that a training module on foot pursuits of armed and suspected armed offenders be developed and incorporated into the Victoria Police Manual and introduced by way of an Operational Skills Tactics and Training component. Such a module should provide guidance to officers on the use of alternative tactical options to maintaining a foot pursuit against an armed or suspected armed offender such as but not limited to:
  o ensuring one member of a team takes responsibility for making radio communication about the direction and/or context of the foot pursuit;
  o considering whether disengagement is in the interests of public safety; and
  o considering whether the circumstances warrant the use of specialist resources.
• With the aim of improving scene management decision making and providing support to [involved police officer], I recommend that there be a review of the sub-officers’ training in this regard.
Coronial recommendations: Fatal facts

**Case number**  
VIC.2009.710

**Primary category**  
Homicide and assault

**Fatal facts edition**  
42 – cases closed between July and September 2014

**Case summary**

A young adult male was fatally stabbed in an organised altercation involving a number of assailants.

**Coronial findings**

The coroner found that the death was due to assault.

The coroner found that the young adult had been in a gang-like situation where weapons were involved and had become involved in the name of mistaken loyalty. The coroner found this was an example of how education initiatives could have been beneficial to some or all involved in the altercation.

**Coronial recommendations**

The coroner made the following recommendations related to this case:

- That the Victorian Government Department of Justice use the circumstances of this matter as an example to use in the ‘Choices for Boys’ program, to assist teenagers aged between 15 and 17 years in appreciating the importance of considering the consequences of their actions, walking away from violent situations and never carrying a weapon.
Coronial recommendations: Fatal facts

Case number: VIC.2010.4294
Primary category: Homicide and assault
Additional categories: Mental illness and health
Fatal facts edition: 42 – cases closed between July and September 2014

Case summary
An adult male died following an assault by a friend at a boarding house the two were residing. The two had been friends but had also been involved in previous altercations.

Coronial findings
The coroner found that the death was due to assault.

The coroner found that the friend was suffering from an episode of mental illness at the time of the incident. The friend had been released from a Community Treatment Order into the care of their general practitioner. Then coroner found that there was inadequate documentation and communication in the transition of the friend from their mental health team into the care of their general practitioner.

Coronial recommendations
The coroner made the following recommendations related to this case:

- That the Royal Australian College of Psychiatrists, or other relevant professional body, either mandate, or at least strongly recommend, that those responsible for the provision of psychiatric treatment and care of a patient who is being transferred to a general practitioner, prepare a discharge summary, taking into account input from the psychiatrist, or psychiatrists who have been providing care to the patient.

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

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<td>Primary category</td>
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<td>Fatal facts edition</td>
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Case summary

A middle aged adult male died by hanging after being discharged from hospital. They had been taken to hospital by police, but were discharged prior to a mental health assessment.

Coronial findings

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

The coroner accepted that if the adult had been detained at hospital overnight, they would likely have been released following assessment by a psychiatrist the next morning. The coroner concluded there was no failure by the hospital in the adult's care and release.

Coronial recommendations

The coroner made the following recommendations related to this case:

- [The hospital] introduce a clear written procedure whereby patients brought into an Emergency Department by police pursuant to Section 351 Mental Health Act 2014 cannot be discharged prior to a mental health assessment and completion of a Mental Health Assessment Form.
- [The hospital] introduce a clear written procedure in the event a patient brought into an Emergency Department by police pursuant to Section 351 Mental Health Act 2014 absconds or is discharged without a mental health assessment. Particular consideration should be given to requiring immediate notification of Emergency Services Telecommunications Authority (ESTA) and the on-call consultant psychiatrist.
- The Chief Commissioner of Police, [the hospital] and the Department of Health investigate the feasibility of requiring the Mental Disorder Transfer Form to record the signature of the person to whom custody has been transferred, as well as the date and time of transfer.

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

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<td>Fatal facts edition</td>
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Case summary

A young male drowned in a river. They were discovered in the river some days after they were last seen alive. A family member had made multiple enquiries with police about their whereabouts in the days prior to them being discovered.

Coronial findings

The coroner was unable to determine the circumstances of the death.

The coroner addressed concerns regarding the police response to the culturally and linguistically diverse (CALD) persons involved in the incident. The coroner found that the language and practices of police could be amended to improve relationships with CALD communities.

At inquest, a family member submitted the following proposal regarding missing persons reports:

“The first is to have available at Police stations information for the public - in multiple languages - which outlines the criteria for making a missing persons report; the kind of information required to make such a report; and the steps that will be taken once such a report has been made.

Secondly, it is submitted that a receipting and recording process should be introduced. This process would involve a police member providing a document to a reporting person at the time of their attendance to the police station identifying the following factors:

i. the date and time of the contact/inquiry;
ii. the name of the person making the enquiry;
iii. the name of the person being reported missing or for whom concerns are held;
iv. a clear identification of whether a missing persons report has been filed;
v. if a missing persons report has been filed - the steps being undertaken by police; and those that can or should be undertaken by the reporting person;
vi. If a missing persons report has not been filed - the reasons why it has not been filed; and the steps that the reporting person needs to take;

vii. the name, rank and police ID of the member/s interacting with the reporting person;

viii. confirmation that a missing persons information pack has been provided to the reporting person (ie. this may include a pamphlet as to missing persons procedures in an appropriate language; and

ix. confirmation that the response record has been explained and understood by the reporting person - including an indication as to whether an interpreter has been used where there are language difficulties.

Thirdly, it is submitted that a system should be introduced to log all Inquiry Response Records where a missing persons report has not been taken, together with the reporting member’s notes as to the contact person, in order to enable police members to more readily understand the concerns for a person’s welfare - especially in circumstances where multiple reports are made by the same or different reporting persons.

That concern for the welfare or fears for the safety of a person be assessed by reference to concerns of the reporting person, rather than those of police members, provided the concerns are reasonable.”

Coronial recommendations

The coroner made the following recommendations related to this case:

• I recommend to Victoria Police that it consider implementation of the proposal set out above (which is in three parts). Appendix A of [the family member’s] submission set outs: “Example of Proposed Missing Persons Inquiry Response Record”. I attach that to these findings and recommend that Victoria Police consider implementation of a system/process designed to achieve the same purpose.

• That Victoria Police provide training and information to members on cultural factors which might impact upon the method of delivering a death message and the importance of seeking accurate cultural guidance wherever possible prior to the delivery of the death message.

• That Victoria Police review the language used to categorise and describe deaths to ensure that the terms used are clear and are likely to be understood by members of the family and/or community of the deceased person.
Coronial recommendations: Fatal facts

**Case number**  VIC.2012.483

**Primary category**  Drugs and alcohol

**Fatal facts edition**  42 – cases closed between July and September 2014

**Case summary**

A young adult male died after consuming a number of drugs that were not prescribed to them, including methadone.

**Coronial findings**

The coroner found that the death was unintentional.

The coroner noted the risk of takeaway methadone doses being supplied to a third party. The coroner highlighted the systemic failure in the regulation of access to takeaway methadone.

**Coronial recommendations**

The coroner made the following recommendations related to this case:

- That the Victorian Department of Health request the Advisory Group for Drugs of Dependence review the circumstances of [the deceased’s] death, the discussion and comments included in this finding, and the data on Victorian methadone deaths included in Appendix A to this finding, when considering whether the current takeaway dosing advice in the Victorian Policy for Maintenance Pharmacotherapy for Opioid Dependence adequately balances client benefits with risks to public health and safety.

- That the Victorian Department of Health request the Advisory Group for Drugs of Dependence consider the probable impact on pharmacotherapy clients and the broader public, of revising the Policy for Maintenance Pharmacotherapy for Opioid Dependence so that an opioid replacement therapy client is eligible to receive at most two takeaway methadone doses per week and no consecutive takeaway doses. Given the current significant harms associated with methadone takeaway dose diversion, the Advisory Group for Drugs of Dependence should ideally report publicly on its conclusions, so the Victorian public is informed as to the rationale for the Advisory Group and Department of Health’s stance on access to takeaway methadone.

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Coronial recommendations: Fatal facts

Case summary

An adult male drowned while swimming in the ocean.

The adult had been socialising with friends and drinking alcohol. The group of friends attended a pier, and the adult jumped into the water to swim. They were swept under water by waves and pushed into a pylon. The friends' rescue attempts were unsuccessful. The deceased's body was found washed ashore later that morning.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that they were affected by acute alcohol toxicity at the time of the incident.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That Life Saving Victoria continues to develop targeted programs and campaigns for the promotion of public safety messages, such as Don't Drink and Drown, to raise awareness in the community of the dangers of alcohol related drowning across Victoria.

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

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Case summary

An adult male took their own life by hanging while on leave from a mental health clinic.

They had been voluntarily admitted to a clinic due to ongoing depression.

Coronial findings

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

The coroner found that the adult was allowed escorted leave whilst at the clinic. At the time of their death, the adult and the clinic were non-compliant with escorted leave policies.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That [the clinic operator] implement procedures in relation to patient leave that require staff to:
  - review the patient leave register at the commencement of hourly rounds; and
  - introduce an audible alert system that can be set for the expected return time to prompt staff to check if patients have not returned on time.

- That [the clinic operator] conduct regular compliance audits to check whether staff are complying with their policies and if instances of non compliance are identified ensure that the staff involved participate in retraining.

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Coronial recommendations: Fatal facts

Case number | VIC.2012.3594
Primary category | Transport and traffic related
Fatal facts edition | 42 – cases closed between July and September 2014

Case summary

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

They were crossing the tracks at a designated pedestrian crossing at the time of the incident. The crossing did not have pedestrian gates or audible tones that operated for the passage of trains. The train driver did not have time to sound a warning before the collision.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the young person was distracted by their mobile phone at the time of crossing the tracks, and did not see or hear the oncoming train.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that consideration be given to making the [location] pedestrian crossing active through the provision of pedestrian gates and audible tones that operate to warn pedestrians of the passage of trains.
- I commend rail authorities for their current education programs, and recommend they continue to remind pedestrians of the dangers of the rail track environment and in particular the danger to pedestrians of distraction from electronic 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

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Case summary

A female infant died in hospital shortly after birth.

Their mother’s membrane ruptured but labour did not commence until two days later. Against hospital policy, the mother declined tests for infections and antibiotics, and refused medical intervention during the early stages of labour.

The mother was an employee of the hospital at the time.

Coronial findings

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

An expert witness at inquest discovered that the placenta had a well-established bacterial infection. It was noted that the results of this infection would have significantly compromised the infant’s ability to cope with the subsequent delivery complications and resuscitation attempts.

The coroner found that the incident highlighted the dangers of blurring professional boundaries. The familiarity between the midwives and the mother, due to the mother’s employment at the hospital, meant that there was a degree of apprehension in challenging the mother over treatment decisions.

The coroner found that the familiarity with the hospital may have contributed to mother’s decisions to disobey various hospital policies.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Victorian Department of Health Chief Nurse and Midwifery Officer, the Midwifery Board of Australia and AHPRA each consider using the death of [the infant] as a case example to highlight the importance of health professionals maintaining professional boundaries.
• That the Victorian Department of Health Chief Nurse and Midwifery Officer, the Midwifery Board and AHPRA each consider ways to raise awareness amongst midwives of the possibility of serious subclinical infections in the case of PROM [Term Pre Labour Rupture of Membranes].
• That [the hospital] consider using the death of [the infant] as a case example to its staff to highlight the importance of safe practice and maintaining professional boundaries.
• That [the hospital] consider whether there is a need to establish protocols for the obstetric management of colleagues or friends.
• That relevant policies [at the hospital] should be amended to explain the importance of prophylactic antibiotics, both in preventing infection and in treating subclinical infections.
• That [the hospital’s] [relevant antenatal] policy should be amended to explain what is required by way of ‘assessment’.
• That relevant policies [at the hospital] should be amended to explain the reason why continual CTG [cardiotocography] monitoring is preferred over intermittent auscultation, in particular its greater capacity to detect reduced foetal heart rate variability.
• That the PROM policy should be amended to align with the already amended Water Immersion Policy to explain that bathing in the case of PROM possibly involves an increased risk of infection.
Coronial recommendations: Fatal facts

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Case summary

A middle aged adult female died when their vehicle was struck by a truck.

At the time of the incident, the road was wet and in less than adequate condition. The driver of the truck lost control around a corner, causing the trailers to slide into the path of oncoming traffic.

Coronial findings

The coroner found that the death was unintentional.

The coroner made a comment that the collision occurred on a series of bends with a 100 kilometre per hour speed limit, and the speed limit was lowered to 80 kilometres per hour shortly after the incident.

Coronial recommendations

The coroner made the following recommendations related to this case:

- The Victoria Police Major Collision Investigation Unit commented that the road surface at this location is poor and has low friction value. I recommend that VicRoads review the road and consider resurfacing it, in an attempt to prevent incidents of a similar nature in the future.

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Coronial recommendations: Fatal facts

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<thead>
<tr>
<th>Case number</th>
<th>VIC.2013.5206</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Misadventure</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Drugs and alcohol</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>42 – cases closed between July and September 2014</td>
</tr>
</tbody>
</table>

Case summary

A young adult male fell unconscious during the recreational use of nitrous oxide.

Coronial findings

The coroner found that the death was unintentional.

The coroner noted that the adult was aware of the risks involved with nitrous oxide, and had been refining their methods of ingestion. The coroner also noted that no other person was in a position to influence the adult’s behaviour to reduce their intake or monitor their methods.

Coronial recommendations

The coroner made the following recommendations related to this case:

- The Victorian Department of Health should consider developing educational resources for recreational users of nitrous oxide, outlining the dangers of the substance in general, as well as the specific increased risks associated with practices such as using tubes and masks for ingesting the substance. Further, the Department could also distribute this information to, or develop specific educational resources for, online retailers and suppliers of equipment and apparatus that can be used for the ingestion of nitrous oxide, as well as store-based retailers to the catering industry and medical and dental professions. Additionally, sharing this information with their counterparts in other Australian jurisdictions should also be considered, including the benefits of a national approach to prevention and harm minimisation.

- The Coroner is aware that, unlike Australian websites selling nitrous oxide cream whipper bulbs similar to those used by [the deceased], at least one overseas website (details can be provided if required) contains the following specific warning:
  - "When nitrous oxide is prepared and used by professionals in a medical environment then it is done so in a safe and controlled fashion. Any attempt at self-medication with laughing gas could lead to immediate death by asphyxiation (lack of oxygen) or at the very least there are serious long-term mental and physical side-effects. What is actually referred to as "Laughing Gas" is in fact not actually pure nitrous oxide which
is what is contained within cream chargers, but is a mix of approximately 70% oxygen and 30% nitrous oxide."

- The Department could consider using, and encouraging in appropriate quarters, the use of similar warnings on relevant websites and in relevant retail stores.

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

Case number | VIC.2013.5209
Primary category | Transport and traffic related
Fatal facts edition | 42 – cases closed between July and September 2014

Case summary

A middle aged male sustained fatal injuries in a motorcycle crash. They approached an intersection at high speed, causing the motorcycle to leave the roadway. They were found deceased at the base of an embankment by their fellow motorcyclists.

Coronial findings

The coroner found that the death was unintentional. The incident occurred in an area prone to traffic collisions. A joint review by the transport authority and two local councils identified interventions to improve the road’s safety for users. These interventions included:

- remarking the centre line
- providing a fog line (i.e edge line) to improve the definition of the traffic lanes
- providing additional chevron signage at bends
- providing additional guardrails
- providing potentially ‘Black Ice’ signs at critical locations
- providing additional signs ‘High Risk Area for Motorcycles’
- eliminating any existing reverse camber
- reviewing and providing advisory speed limit signs on slow corners
- providing two helipad locations with 40 metre radius for air ambulance for general emergency use.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the proposed joint funding application by [two local councils] to the Federal Government’s Black Spot Program, be prepared and submitted without delay.
- In the event of the application not being successful, the identified safety interventions referred to above, be funded and implemented by the responsible councils.

This Fatal facts summary has been produced by the National Coronial Information System and 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

<table>
<thead>
<tr>
<th>Case number</th>
<th>The coroner held a joint investigation into the following deaths which results from the same incident: WA.2012.1930, WA.2014.100</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Water related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>42 – cases closed between July and September 2014</td>
</tr>
</tbody>
</table>

Case summary

A young adult male and adult male died after being caught in an ocean rip.

An adult male became caught in the rip while body boarding, and a young adult male attempted a rescue with other companions. The young adult male was swept out to sea and their body was not recovered. The adult male was unable to be revived.

Coronial findings

The coroner found that the deaths were unintentional.

The coroner was satisfied that the young adult male died by drowning.

The coroner found that the ocean conditions on the day were dangerous, and warning signs about rip currents at the beach had been vandalised and destroyed. The coroner noted that both persons could swim and did not deliberately engage in risky activities, but were unaware of the risks of the particular beach due to the lack of signage.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the Department of Parks and Wildlife take steps to create and maintain a roadway to facilitate direct beach access for emergency vehicles and other lifesaving assets and equipment to [the beach] and to ensure that the relevant organisations are informed of how the roadway can be accessed.

This Fatal facts summary has been produced by the National Coronial Information System and released with the approval of the relevant State or Chief Coroner.
## APPENDIX A: FATAL FACTS WEB TOOL CATEGORY TAGS

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adverse medical effects</td>
<td>Adverse after effects from a recent medical or surgical treatment, failure to comply with medical advice.</td>
</tr>
<tr>
<td>Aged care</td>
<td>Incidents that occurred in an aged care or assisted living facility or residence including a retirement village.</td>
</tr>
<tr>
<td>Animal</td>
<td>Incidents where an animal was involved in the cause of death.</td>
</tr>
<tr>
<td>Child and infant death</td>
<td>Any case involving a child or infant - 12 years old and under.</td>
</tr>
<tr>
<td>Domestic incident</td>
<td>Fatal incident that occurred as a result of domestic injury or event.</td>
</tr>
<tr>
<td>Drugs and alcohol</td>
<td>Death where drugs or alcohol or both were a primary or secondary cause of death.</td>
</tr>
<tr>
<td>Electrocution</td>
<td>Cases where electrocution is the primary cause of death.</td>
</tr>
<tr>
<td>Falls</td>
<td>Incidents where a fall was involved in the circumstances or cause of death.</td>
</tr>
<tr>
<td>Fire related</td>
<td>Incidents where a fire was involved in the circumstances or cause of death.</td>
</tr>
<tr>
<td>Geographic</td>
<td>Cases where the geographic region is significant to the cause of death, for example remote location.</td>
</tr>
<tr>
<td>Homicide and assault</td>
<td>Includes interpersonal violence and family domestic violence.</td>
</tr>
<tr>
<td>Indigenous</td>
<td>Cases related to a specific demographic group.</td>
</tr>
<tr>
<td>Intentional self-harm</td>
<td>Cases determined intentional self-harm (ISH) by coronial investigation</td>
</tr>
<tr>
<td>Law enforcement</td>
<td>Includes police pursuit, death in custody, parole issues, pending or previous court cases including family court, restraining order and coronial investigation procedures.</td>
</tr>
<tr>
<td>Leisure activity</td>
<td>Any leisure actively that directly influence the circumstances including holiday.</td>
</tr>
<tr>
<td>Category</td>
<td>Description</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Location</td>
<td>Cases where the location of either the incident or the discovery of the body is of significance, does not refer to geographic location.</td>
</tr>
<tr>
<td>Mental illness and health</td>
<td>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.</td>
</tr>
<tr>
<td>Misadventure</td>
<td>Risk taking behaviour such as train-surfing, unintentional drug overdose.</td>
</tr>
<tr>
<td>Natural cause death</td>
<td>Cases where the death is due to natural causes.</td>
</tr>
<tr>
<td>Older persons</td>
<td>Cases related to a specific demographic group or where the age of a person was a factor in the death.</td>
</tr>
<tr>
<td>Physical health</td>
<td>Cases where the existing physical health of the person contributed but were not necessarily cause the death.</td>
</tr>
<tr>
<td>Sports related</td>
<td>Cases where a sports incident significantly impacted the cause of death.</td>
</tr>
<tr>
<td>Transport and traffic related</td>
<td>Cases involving road, water and air vehicle incidents, motorised or naturally powered. Also includes cases where pedestrians are impacted by transport vehicles.</td>
</tr>
<tr>
<td>Water related</td>
<td>Includes swimming, scuba, snorkelling, boating, fishing and all water related activity in both a recreational or commercial context.</td>
</tr>
<tr>
<td>Weather related</td>
<td>Cases where the environmental conditions such as heatwave or storm conditions were significant to the cause of death.</td>
</tr>
<tr>
<td>Work related</td>
<td>Includes cases where work is related to the death and also where unemployment is significant.</td>
</tr>
<tr>
<td>Weapon</td>
<td>Cases where the involvement of a weapon is significant.</td>
</tr>
<tr>
<td>Youth</td>
<td>Cases related to a specific demographic group.</td>
</tr>
</tbody>
</table>