Coronial recommendations: Fatal facts

A summary of cases and recommendations made between October and December 2014

Edition 43
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CORONERS’ RECOMMENDATIONS

A coroner may make recommendations as part of their inquiry into a death. Recommendations are made to help prevent similar deaths from occurring in the future.

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

Coronial recommendations: Fatal facts includes case summaries and recommendations for cases closed between October and December 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.
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<th>Case number</th>
<th>NSW.2009.2504</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Intentional self-harm</td>
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<tr>
<td>Additional categories</td>
<td>Mental illness and health, Drugs and alcohol, Youth</td>
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<td>Fatal facts edition</td>
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Case summary

A young female took their own life by hanging. They were under government care at the time of their death and had recently been discharged from hospital. They were found in their home and later passed away in hospital.

Coronial findings

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

The coroner found that the local health district failed to ensure the young person was discharged from hospital with a proper care plan. In addition, the local health district failed to confirm who the ongoing treating consultant psychiatrist was and confirm an appointment with that psychiatrist.

The coroner found that the local health district’s level of service provision afforded to the young person had been reduced without an adequate care plan. This resulted in the disengagement of the young person, who was a high risk patient with complex needs.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the [local health district] ensures that discharged and transfer plans are reviewed and approved by signature of the treating consultant psychiatrist.
- Where patient care is shared between the Children and Adolescent Mental Health Service and the Adult Mental Health Service that clear policies and procedures are in place so that responsibility for that care is communicated and maintained.
- Where a patient’s care and treatment by a consultant psychiatrist is transferred across the various [local health district] service demarcations, that such transfer is endorsed in writing by the appropriate [local health district] administrator, by the previous psychiatrist and by the replacement psychiatrist, in order to ensure that continuity of care and treatment is maintained.
• Where the services of a locum tenens is used by a consultant psychiatrist in the employ of the [local health district], that the handover of care include a personal communication between the locum tenens and the consultant psychiatrist, rather than relying solely on the treating registrar so that accurate and correct information is communicated between the locum tenens and the consultant psychiatrist to ensure that continuity of care and treatment is maintained.

• Where persons under the age of 18 years are prescribed psychotropic medication, that the [local health district] give consideration to the introduction and implementation of a requirement that a separate written document be kept of the patient’s answers to specific questions about any side-effects of that medication as well as the medication’s reported benefits, so that an historical record exists to ensure continuity of care and treatment. Such written document to be in addition to the treating doctor’s written records of their own clinical observations of any extrapyramidal effects.
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<th>Case number</th>
<th>NSW.2010.3945</th>
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Case summary

A middle aged male died of electrocution in a workplace incident.

They and their supervisor were contracted to replace high voltage equipment at a substation. Neither they nor their supervisor were qualified to work as an electrician at the time of the incident.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the death arose from the combination of poor supervision, poorly understood or clarified rules, minimal training, and the acceptance of the middle aged person to assist in a procedure about which they knew little.

The coroner found that the electrical company had sought to improve regulations and supervision on substations since the incident.

Coronial recommendations

The coroner made the following recommendations related to this case:

To [electrical company] and to the NSW [New South Wales] Electricity Industry Safety Steering Committee:

- Consideration to be given to the development of a mechanism to lock the clamps on the ends of earth grid bridging leads to prevent the unauthorised removal of the bridging lead.

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<td>Fatal facts edition</td>
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</table>

Case summary

An adult female died of multiple drug toxicity.

They had a history of mental health problems and were prescribed a number of medications. They attended a psychotherapist and a general practitioner who regulated their insomnia medication. The psychotherapist was responsible for the holding, regulation and distribution of the medication.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the regulation of the insomnia medication by their general practitioner and psychotherapist was well-intentioned, but unorthodox.

The coroner found that the psychotherapist did not routinely record sessions with the adult. The psychotherapist did not record the steps they took to ascertain, when the many and frequent requests for medication were made, why the adult needed the medication and if it could be avoided.

The coroner found that the psychotherapist was aware they adult was doctor shopping, but did not report this to the general practitioner.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the Health Care Complaints Commission:


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<th>NSW.2011.3755</th>
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</table>

Case summary

An adult male died in hospital days after receiving a kidney transplant.

Their body began rejecting the kidney and a bleed occurred. Emergency surgery was performed, but the source of the bleed was unable to be discovered. Resuscitative efforts were discontinued and the adult passed away.

Coronial findings

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

The coroner found that there was a delay in the hospital providing medical records to the Coroners Court for the purposes of the inquest.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the Director-General of the Ministry of Health:

- That consideration be given to the development of a policy or protocol for the timely provision of all medical records to the coroner when a death is notified pursuant to s.6(1) (b) and (e) of the Coroners Act 2009.

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Coronial recommendations: Fatal facts

Case summary

An adult female died in a motor vehicle incident in which they were a pedestrian.

They were crossing a road at a pedestrian crossing when they were struck by a bus that was turning a corner. They suffered fatal injuries and died in hospital.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult was crossing with a green light and that the bus driver did not see the adult before the collision. The walking pace of the adult matched that of the bus, and they were at all times moving in the blind spot of the bus.

Coronial recommendations

The coroner made the following recommendations related to this case:

The Department of Roads and Maritime Services (RMS):

- That the RMS consider carrying out a review and assessment of all 2-phase intersections on State roads to prioritise and implement the installation of traffic signal delay phasing so that vehicle traffic be held on a red light while a green walk sign permits pedestrians to leave the footpath unimpeded for a period of time.
Coronial recommendations: Fatal facts

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Case summary

An adult male died when the tractor they were operating rolled. The adult reversed the tractor over a retaining wall, causing them to be ejected onto a road. They suffered fatal head injuries and died at the scene.

The adult was not wearing a seatbelt, and the tractor did not have its rollover protection engaged. They were employed to use the tractor to undertake property maintenance, and were on a trial period at the time of the incident.

Coronial findings

The coroner found that the death was unintentional.

The coroner made the following comments:

The coroner found that Workcover recommended tractor operators ensure that the tractor is fitting with a rollover protection structure and that the structure should be used in combination with a fully maintained and function seatbelt whilst in operation.

The coroner also found that a certificate for the operation of a skid steer loader was no longer required, and that tractors by their nature are inherently dangerous machines.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I would recommend that any operator of a tractor in a commercial scenario, be required to obtain a certificate of competency before being able to utilise such machinery.
Coronial recommendations: Fatal facts

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<th>Case number</th>
<th>NSW.2013.311</th>
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Case summary
An adult male was fatally injured in the water when overrun by a powered vessel. They were spear fishing at the time of the incident.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that at the time of the incident the adult was compliant with all the requirements relating to carrying the International Code Flag A (Alpha Flag) and that the driver of the motorised vessel failed to notice the flag. The flag is internationally recognised; however the colour of the flag is blue and white and could be poorly viewed on the water.

The coroner found that at the time of the incident there was no signage at the boat ramp to alert boaters about the potential for divers to be in the area.

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

To the Minister for Transport, NSW [New South Wales]

- That all persons who operate a powered registered vessel on NSW waters be required to hold a current and valid boating licence, in accordance with the recommendation of Transport NSW 2014/15 review of licensing.
- Consideration be given to introducing a mandatory requirement that divers display, in addition to the International Code Flag A, a fluorescent yellow/green coloured flag (as recommended by the Maritime Management Centre) to assist in increasing the visibility of the International Code flag A.
- Any future review or update of the NSW Boating Handbook or an associated education campaign provide additional and specific information to inform boat operators about 'diver safety' or 'diver awareness'. Such material includes advisory warnings to boat users of the distances that divers/spear fishers could be from the positioning of the International Code Flag A (Alpha Flag) as displayed or seen in the water.
• That the Maritime Management Centre conduct a review of the ‘minimum distance’ requirements between a vessel and person when an International Code Flag A (Alpha Flag) is displayed. Consideration should be given to including a requirement that all boat operators keep a minimum, distances of 60 metres or more (or if not possible a safe distance) from all persons in or on the water at all times unless such vessels are engaged in the activity of dropping off or picking up persons.

To General Manager, [council] & General Manager Maritime Management Centre (MMC)

• The Court recommends [council] conduct a review of the current council signage at all boat ramps for which Council has oversight for the purpose of obtaining and displaying the most current and updated signage that is available from the MMC. This recommendation is made to ensure that any such signage provides information/advice to all water users of the presence of divers or spear fishers.

To the Minister for Police & Emergency Services

• The Court recommend that consideration be given by your office for an award to be provided commending the actions of [deceased’s friend] for [their] conduct and efforts in recovering the body of the [deceased] who had been fatally injured on [date] at [location] including all resuscitation attempts undertaken by him until the arrival of Emergency Services.
Coronial recommendations: Fatal facts

Case number: NSW.2013.1645
Primary category: Leisure activity
Additional categories: Transport and traffic related
Fatal facts edition: 43 – cases closed between October and December 2014

Case summary
A middle aged male died when the glider he was launching collided with a second glider that was coming in to land. The gliding club was only using one air strip for take-off and landing on the day of the incident.

The gliding club members and glider pilots did not consider the radios in the gliders as vital. Key radio transmissions regarding the second glider’s location were not received or heard in the lead-up to the collision.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the launch site was too close to large trees that obscured the second glider as it was coming in to land. The coroner also noted that the club members on the ground assisting the launch were aware the second glider was in the air.

The coroner found that the procedures for gliding depended on amateur rules and traditions which were subject to human error at any time.

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

To the Gliding Federation of Australia (GFA)

1. That the GFA give consideration to all gliders being required to be equipped with appropriate dual band very high frequency (VHF) radio.
2. That the GFA, during audits of other similar winch-launch specific glider airfields, identify where launch sites are not visible on final approach and introduce appropriate measures to ensure that separation is maintained of landing and launching gliders.
3. That the GFA review the [gliding club]’s standard operating procedures and audit and satisfy itself of the appropriateness of operational safety arrangements at the [gliding club]’s airfield, including but not limited to:
- The clear visibility of gliders on [runways] launch sites to gliders on final circuit, at all times including final approach, on an appropriately marked displaced threshold;
- The use of headsets or similar in the winch (to ensure there is no interference between VHF and citizen's band (CB) radio broadcasts and that both are audible);
- The responsibilities of those involved in operations, including wing tip runner and pilot in command ready for launch.

- That the GFA review its auditing procedures for operational audits of clubs, to ensure that all operational aspects of a club's flying operations are known and understood as part of the audit.
- That the GFA by way of appropriate bulletin issue clarification of, and guidance about the responsibilities of key operational personnel (including Pilot in Command and Duty Instructor).
- That the GFA and the [gliding club] consider the use of a common VHF frequency at [location] (using the [location] common traffic advisory frequency (CTAF) frequency in lieu of the gliding frequency), in consultation with the Civil Aviation Safety Authority (CASA).
- That the GFA consider entering into a dialogue with its members re the suitability and economics of FLARM [potential flight collision alarm system] being installed in gliders.
- An independent auditor which could include CASA be engaged to re-examine with the GFA gliding operations at [gliding club].

To the [gliding club]

- That the [gliding club] adopt and continue with its policies of:
  - Separate VHF and CTAF [Common Traffic Advisory Frequency] radios for the Duty Pilot unless and until proposed recommendation [regarding common VHF frequency] above is implemented;
  - Portable VHF radio for the duty pilot;
  - And mandate those policies in its club Operations Manual.
- That the Club have a preference for landings to be on runway 23L whenever launches are being conducted from runway 23, and on runway 05R when launching from runway 05, unless emergency and/or immediate pilot safety considerations apply.
- That the club's operations manual, unless and until recommendation [regarding common VHF frequency] above is introduced, clearly identify that the primary frequency for glider to glider and glider to ground communication is 122.7.
Coronial recommendations: Fatal facts

Case number: NSW.2013.4339
Primary category: Youth
Fatal facts edition: 43 – cases closed between October and December 2014

Case summary
A young female died in hospital following an incident at a public pool in which they sustained a head injury.

Coronial findings
The coroner found that the death was unintentional.

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

- The wire fence abutting the pool fence be removed as a matter of extreme urgency.
- If necessary and if possible, council do all things necessary to cause that fence to be removed.
- Any replacement fence if any to be erected in material and in a manner to deter the use thereof to gain access to the pool.

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Coronial recommendations: Fatal facts

Case number: NSW.2014.65  
Primary category: Transport and traffic related  
Additional categories: Child and infant death  
Fatal facts edition: 43 – cases closed between October and December 2014

Case summary
A male child died as a result of head injuries when they were struck by a vehicle. The child was holidaying with family at a beach property. The child was fatally injured when they ran onto the roadway in front of the property and were struck by a passing vehicle.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the speed limits in the area could be reduced to improve public safety.

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

To: The Minister of Roads and Ports

• That Roads and Maritime Services carry out a speed zone review in consultation with the Centre of Road Safety to assess whether a 40km per hour speed zone is appropriate in [area].
Coronial recommendations: Fatal facts

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Case summary

An adult male died following an intentional fall. They had a history of mental illness for which they had received sporadic treatment over a number of years.

While at work, the adult realised they were suffering a relapse of their mental illness. They attended a psychologist with their employer, followed by the emergency department of a hospital. However, the adult left the hospital before being seen by a doctor. Their body was later found in the ocean.

Coronial findings

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

The coroner found that there were deficiencies in the services provided by the Mental Health Acute Team contacted by the adult’s employer and that there was a delay in the adult being seen by a doctor in hospital. The adult’s parents were not made aware of the incident unfolding until after the death had occurred.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I am satisfied the existing policies for telephone triaging of mental health calls for service to the [location] Mental Health Acute Team are sound and appropriate – the deficiency apparent in this case relates to their implementation. That the intake officer who dealt with [the deceased’s] case did not appreciate even by the time of the inquest that she had failed to comply with significant aspects of relevant guidelines suggests that [intake officer] is probably not the only intake officer who had an inadequate understanding of what is required in cases such as this. Accordingly, I recommend the Chief Executive of the [local health district] cause to be undertaken a training needs analysis of the intake staff members of the [location] Mental Health Acute Team and address any identified gaps in knowledge of the relevant policies and procedures.
• As the mental health patient in this case was not seen within the target time-limit of his triage category, was not reassessed as that time limit approached and was exceeded and as staff in the [emergency department] did not notice for a further significant period that he had left without being seen by a medical practitioner, there is cause for concern about the efficacy of patient monitoring in the [emergency department]. Accordingly, I recommend the Chief Executive of the [local health district] cause to be undertaken a review of the implementation of policies in place at the [emergency department] for monitoring mental health patients awaiting psychiatric review.

• In numerous circumstances, ready access to contact details for a person’s next of kin could enable police to more effectively preserve the person’s safety and provide to the person’s next of kin timely information they would want to know. Individuals would need to consent to information being disseminated in stipulated circumstances to nominated people and there would be technological challenges in storing and retrieving the data. However the potential benefits warrant the matter being further investigated in my view. Accordingly, I recommend that the Minister for Police consider establishing a project team to investigate the benefits, costs and practicalities of such a facility.
NORTHERN TERRITORY

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

A young male died due to cardiac issues.

The young male had played a sporting game and reported pain and dizziness at half time. They were taken to the medical clinic where their symptoms were diagnosed as dehydration. They were connected to an intravenous cannula (IV) drip and collapsed soon after. Resuscitation attempts were unsuccessful and they were declared deceased.

Coronial findings

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

The coroner found that the adult received regular medical attention from the medical clinic, and the clinic should have recognised the risk factors for cardiac problems.

The coroner acknowledged that the treating medical professionals may have considered cardiac issues unlikely due to the age of the young person, and lack of typical cardiac symptoms. The coroner noted:

“This inquest should permanently drive home to all medical personnel treating Aboriginal people in the NT that the risk of coronary disease is a live consideration, in the circumstances as they presented here, notwithstanding the youth and absence of persistent complaints of chest pains of the patient.”

The coroner found that the adult had multiple risk factors for cardiac problems, including sedentary lifestyle, obesity, Aboriginality and smoking. The coroner stressed the need to address the problem of early detection of cardiac issues in young Aboriginal men.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That consideration be given by those charged with editing the Central Australian Remote Practitioners Association (CARPA) manual to it being amended so that there is a specific sub-chapter, preferably in the Emergency section, that deals with the problem of the
diagnosis of heart attack victims who are not displaying chest pains. This is for the specific purpose of assisting medical personnel placed in this position of making the correct provisional differential diagnosis. This should also address how a provisional diagnosis of cardiac disease may be confused with a diagnosis of dehydration.

- That consideration be given by those charged with editing the CARPA manual to it being amended so that there is a specific chapter that deals with dehydration that is both in a separate chapter and which deals specifically with adults.

- That consideration be given by those charged with editing the CARPA manual to it being amended so that there is a specific chapter in the Emergency section specifying that, in an emergency presentation, an electrocardiograph (ECG) test should be conducted in all cases in which blood pressure is unable to be obtained or hypotension (low blood pressure) exists. In addition, that consideration ought to be given for the manual to be amended so as to require, that in the circumstance of a nurse being placed in the position of having to make a provisional diagnosis in circumstances such as [the deceased]'s case, that the nurse be required to phone the District Medical Officer (DMO) for medical assistance.

- I acknowledge fully the efforts of the Department of Health to promote its chronic disease strategy comprising Adult Health Checks and Cardiovascular Risk Assessments. I recommend that by way of supplementing these efforts, that substantial further education be encouraged, both of medical personnel and of Aboriginal people especially in remote areas, of the reality of young Aboriginal people developing cardiac disease at a very early age. This point must be driven home to all medical personnel in the NT to assist them in making the correct diagnosis of cardiac disease, particular in the circumstances as they presented in the case of [the deceased]. It must also be emphasised to all medical personnel and Aboriginal people in the NT that heart attacks can occur in the absence of chest pains.

- Having previously acknowledged the efforts of the Department of Health, I recommend that a coordinated strategy be embarked upon by the Department of Health for the purpose of screening of heart disease in young Aboriginal people, especially in remote areas of the NT. I recommend that a proactive approach be taken in this regard and that it extend to the non-government organisation (NGO) sector and, in particular, organisations such as [health centre].

- I recommend that the Department of Health engage in a coordinated strategy to educate medical practitioners and nurses in this field to engage in proactive testing and screening for cardiac disease.

- I recommend that [health centre] conduct a review of its own practices and staff with particular efforts being made to encourage training of staff to be proactive in screening for cardiac disease, and conducting the appropriate tests and treatment plans pursuant to the protocol specified in the CARPA manual. I encourage [health centre] to liaise with the Department of Health in this regard and also in regard to the education of [health centre]'s clientele especially in regard to cardiac risk identification and avoidance. I
emphasise that [health centre] advertise the point in its clinics that unless dealt with, heart disease will kill, and will strike down many young people unless steps are taken to deal with it. I would further emphasise that [health centre] promote the point that I have emphasised in these findings that Coronary Heart disease can strike without warning and without chest pains. Specifically, the importance of regular wellness checks must be emphasised by [health centre] and impressed upon its clientele.

- The risk of smoking cigarettes and the very high rate of smoking amongst Aboriginal communities in the NT must be part of a public health campaign targeted at Aboriginal people that emphasises the grave danger to the health of all smokers and the significant risk of early death. Such a public education campaign could include a reference to the fact that the smoking of a small quantity of cigarettes prior to a football match, as occurred in this case, possibly can produce a spam in an artery and contribute directly to causing a heart attack, leading directly to death.

- Regarding the installation of ISTAT (handheld blood analyser) devices, I understand that they have been distributed to major health clinics as well as centres with populations in excess of 1,000 or so throughout the NT. I recommend, given their effectiveness, that they be installed in all medical clinics in the NT. The ability to have a quick and reliable analysis of blood cannot be underestimated. Together with an up to date ECG devices, it means that much more expensive technology is not necessary in order to promptly ascertain a diagnosis of a cardiac issue of a patient living in a remote area.

- If an ISTAT device is not available at a clinic that clinic must ensure that it has a Troponin test kit that is available and functioning for the purpose of testing for this important enzyme.

- I endorse the installation of the most up to date ECG devices (that are able to transmit results digitally to an on call cardiologist for immediate review) to all medical facilities in the NT. I understand from [Aboriginal rural health expert] that these devices are being delivered throughout the entire NT at this point and that it is expected that this will be completed in the next month or so. This is to be commended.

- I recommend that the education of nurses emphasise that a nurse not make a provisional diagnosis of a medical problem unless there is clear support for it in the CARPA manual. Further, in terms of making a provisional diagnosis, if in any doubt, a medical practitioner must be consulted immediately. Finally, in terms of making a provisional diagnosis it ought to be emphasised that a nurse (or doctor) must consult the patient history and furthermore, make a note of what was discovered in that regard in the clinical or patient notes.

- I recommend that the Central Australian Rural Practitioners Association consider the findings of this Inquest when preparing the next edition of the CARPA manual.

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Case summary
An adult male died due to cardiac issues. They appeared fit and healthy and had no previous documented cardiac history.

The adult had played sport and smoked cigarettes afterwards. They attended a medical clinic with shortness of breath, but reported an improvement and returned home after some observations. They collapsed at home soon after, and were brought back to the medical clinic. Resuscitation attempts were unsuccessful and they were declared deceased.

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

The coroner found that the treatment by the medical centre staff was appropriate in both consultations. The coroner found that there was a family history of cardiac issues that was not known to the medical clinic. The adult had not undergone an Adult Health Check prior to their death. The coroner found that the adult had multiple risk factors for cardiac problems, including familial cardiac history, Aboriginality and smoking. The coroner stressed the need to address the problem of early detection of cardiac issues in young Aboriginal men.

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

- Again, in relation to the early detection of coronary artery disease in young Aboriginal people, I have dealt with this in detail in my Findings and Recommendations in respect to the associated inquest that concerned [the similar death]. I adopt those recommendations for the purpose of this inquest.

The coroner made the following recommendations related to a similar case:

- That consideration be given by those charged with editing the Central Australian Remote Practitioners Association (CARPA) manual to it being amended so that there is a specific sub-chapter, preferably in the Emergency section, that deals with the problem of the
diagnosis of heart attack victims who are not displaying chest pains. This is for the specific purpose of assisting medical personnel placed in this position of making the correct provisional differential diagnosis. This should also address how a provisional diagnosis of cardiac disease may be confused with a diagnosis of dehydration.

- That consideration be given by those charged with editing the CARPA manual to it being amended so that there is a specific chapter that deals with dehydration that is both in a separate chapter and which deals specifically with adults.

- That consideration be given by those charged with editing the CARPA manual to it being amended so that there is a specific chapter in the Emergency section specifying that, in an emergency presentation, an electrocardiograph (ECG) test should be conducted in all cases in which blood pressure is unable to be obtained or hypotension (low blood pressure) exists. In addition, that consideration ought to be given for the manual to be amended so as to require, that in the circumstance of a nurse being placed in the position of having to make a provisional diagnosis in circumstances such as [the deceased]'s case, that the nurse be required to phone the District Medical Officer (DMO) for medical assistance.

- I acknowledge fully the efforts of the Department of Health to promote its chronic disease strategy comprising Adult Health Checks and Cardiovascular Risk Assessments. I recommend that by way of supplementing these efforts, that substantial further education be encouraged, both of medical personnel and of Aboriginal people especially in remote areas, of the reality of young Aboriginal people developing cardiac disease at a very early age. This point must be driven home to all medical personnel in the NT to assist them in making the correct diagnosis of cardiac disease, particular in the circumstances as they presented in the case of [the deceased]. It must also be emphasised to all medical personnel and Aboriginal people in the NT that heart attacks can occur in the absence of chest pains.

- Having previously acknowledged the efforts of the Department of Health, I recommend that a coordinated strategy be embarked upon by the Department of Health for the purpose of screening of heart disease in young Aboriginal people, especially in remote areas of the NT. I recommend that a proactive approach be taken in this regard and that it extend to the non-government organisation (NGO) sector and, in particular, organisations such as [health centre].

- I recommend that the Department of Health engage in a coordinated strategy to educate medical practitioners and nurses in this field to engage in proactive testing and screening for cardiac disease.

- I recommend that [health centre] conduct a review of its own practices and staff with particular efforts being made to encourage training of staff to be proactive in screening for cardiac disease, and conducting the appropriate tests and treatment plans pursuant to the protocol specified in the CARPA manual. I encourage [health centre] to liaise with the Department of Health in this regard and also in regard to the education of [health centre]'s clientele especially in regard to cardiac risk identification and avoidance.
emphasise that [health centre] advertise the point in its clinics that unless dealt with, heart disease will kill, and will strike down many young people unless steps are taken to deal with it. I would further emphasise that [health centre] promote the point that I have emphasised in these findings that Coronary Heart disease can strike without warning and without chest pains. Specifically, the importance of regular wellness checks must be emphasised by [health centre] and impressed upon its clientele.

- The risk of smoking cigarettes and the very high rate of smoking amongst Aboriginal communities in the NT must be part of a public health campaign targeted at Aboriginal people that emphasises the grave danger to the health of all smokers and the significant risk of early death. Such a public education campaign could include a reference to the fact that the smoking of a small quantity of cigarettes prior to a football match, as occurred in this case, possibly can produce a spam in an artery and contribute directly to causing a heart attack, leading directly to death.

- Regarding the installation of ISTAT (handheld blood analyser) devices, I understand that they have been distributed to major health clinics as well as centres with populations in excess of 1,000 or so throughout the NT. I recommend, given their effectiveness, that they be installed in all medical clinics in the NT. The ability to have a quick and reliable analysis of blood cannot be underestimated. Together with an up to date ECG devices, it means that much more expensive technology is not necessary in order to promptly ascertain a diagnosis of a cardiac issue of a patient living in a remote area.

- If an ISTAT device is not available at a clinic that clinic must ensure that it has a Troponin test kit that is available and functioning for the purpose of testing for this important enzyme.

- I endorse the installation of the most up to date ECG devices (that are able to transmit results digitally to an on call cardiologist for immediate review) to all medical facilities in the NT. I understand from [Aboriginal rural health expert] that these devices are being delivered throughout the entire NT at this point and that it is expected that this will be completed in the next month or so. This is to be commended.

- I recommend that the education of nurses emphasise that a nurse not make a provisional diagnosis of a medical problem unless there is clear support for it in the CARPA manual. Further, in terms of making a provisional diagnosis, if in any doubt, a medical practitioner must be consulted immediately. Finally, in terms of making a provisional diagnosis it ought to be emphasised that a nurse (or doctor) must consult the patient history and furthermore, make a note of what was discovered in that regard in the clinical or patient notes.

- I recommend that the Central Australian Rural Practitioners Association consider the findings of this Inquest when preparing the next edition of the CARPA manual.

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

**Case number**
NT.2013.123

**Primary category**
Law enforcement

**Additional categories**
Intentional self-harm, Mental illness and health

**Fatal facts edition**
43 – cases closed between October and December 2014

**Case summary**
A middle aged male took their own life by hanging while they were detained in a detention centre.

The adult had arrived in Australia by boat as an asylum seeker and were detained. Their recorded mental health history included anxiety, depression and post-traumatic stress disorder. During their period of detention, they were regularly reviewed by a psychologist.

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

The coroner found that the ligature had been taken from an object inside the detention centre, and it had been concealed until the incident.

The coroner found that the medical and psychiatric care they received was appropriate. The coroner found that no steps could have been taken by medical or detention centre staff to prevent the death.

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

- I recommend that the three stakeholders administering detention centres and other like facilities in the Northern Territory and elsewhere being the Department of Immigration and Citizenship, [detention centre operators] and International Health and Medical Service examine the evidence of [the deceased’s psychologist] and [Client Service Officer] to ensure that information relevant to the treatment of a patient including the reasons for the transfer of a patient between facilities is available to all medical staff but in particular to treating clinicians.

*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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<td>Fatal facts edition</td>
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Case summary
An adult female died from injuries sustained when they fell from a horse.
At the time of the incident the rider was participating in a designated horse race.

Coronial findings
The coroner found that the death was unintentional.
The coroner found that the rider was thrown from the horse when the horse baulked at a pedestrian crossing. The severity of the reaction from the horse to the crossing was found to be very unexpected. Horses are known to baulk at crossings but not to the extent that this horse did.
At the time of the incident, the horse was travelling at great speed and in the last stage of the race. The coroner found that the position of the pedestrian crossing so close to the finish line contributed to the severity of the injuries sustained, given how fast the horse was travelling at the time of the incident.

Coronial recommendations
The coroner made the following recommendations related to this case:
- That the Australian Racing Board articulates and implements a written Protocol for the assistance of Principal Racing Authorities (PRA’s) in each State and Territory, advising against crossings being positioned in the final stages of a race.
Coronial recommendations: Fatal facts

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

A male child drowned after being swept down a storm drain in which they had been playing. The water in the drain rose rapidly as a result of heavy rainfall. The child jumped into the drain and was swept under the water. They were located some distance from the entry point. Bystanders were unable to remove them from the drain for some time due to a steel bar preventing access. The child was conveyed to hospital and passed away the following day.

Coronial findings

The coroner found that the death was unintentional. The coroner found that there was no schedule in place for inspection and maintenance of the drains by the council. It was noted that the council relied on reports of drains in need of repair. The coroner noted that the council were installing signage warning of the dangers of children playing in pipes and drains, and commended their proactive approach.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the [location] Council:

- [Location] Council compile and maintain a register of all secured drains (“the register”).
- With respect to those drains listed on the register, [location] Council inspect those drains and the integrity of the drain, any fixed metal, 24 bolts and other fixings securing the said drain on a regular basis at least:
  - Once prior to the commencement of the wet season each and every year;
  - Once during the course of wet season each and every year; and
  - Once at the conclusion of the wet season each and every year.
- [Location] Council ensure that all danger signs installed by the Council in relation to any pipes and drains have a 24 hour contact number placed upon the sign.

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

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

Case number: QLD.2010.3619
Primary category: Transport and traffic related
Fatal facts edition: 43 – cases closed between October and December 2014

Case summary
An older adult male died following a light aircraft crash in which they were a pilot.

The aircraft had been subjected to several months’ worth of maintenance and the incident occurred during a test flight.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that significant changes had been made to the aircraft’s weight and balance and the manufacturer had falsified the aircraft weight documentation. In addition, there was a lack of formal documentation and knowledge to support the guidance provided by the manufacturer to the aircraft engineer undertaking maintenance. There were also inadequacies in the aircraft’s dual battery system.

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

- It is vital that if RA-Aus [Recreational Aviation Australia] is to continue in their current role with limited resources, they must rely on the integrity and honesty of those seeking to have registration under its auspices. There must therefore be a clear deterrent to anybody who intends to circumvent the systems of safety by wrongly registering an aircraft. As such, I recommend that RA-Aus take the strongest possible action they can against [manufacturer’s Chief Executive Officer] and they should consider terminating his membership and cancelling all certificates and endorsements currently in his possession.
- I also recommend that within their limited resources, RA-Aus implement a more effective screening and auditing system to randomly check information such as weight calculations and other information provided for registration.
- RA-Aus provides a valuable service to police and coroners by investigating recreational aircraft accidents involving their members and aircraft registered with them, when the ATSB [Australian Transport Safety Bureau] chooses not to investigate. Unfortunately, this coronial investigation was affected by RA-Aus’ failure to finalise their investigation into this matter. I therefore recommend that better procedural processes be established by
management to ensure that all investigations are finalised within a timely manner in the future.

- Also, an allegation arose in this inquest of RA-Aus altering an investigator’s report into a different matter. RA-Aus submitted, and it is accepted, that their investigators are contracted by them to provide them the information to furnish an organisational report. Management consults with investigators to amend their findings where they do not align with RA-Aus’ view. In order to uphold the public’s confidence into the future, it is recommended that such consultation between RA-Aus as an organisation and their investigators be recorded and transparent. Where agreement is not reached, consideration should be given by RA-Aus to finalising a report and annexing the investigator’s report, including areas where there are distinguishing aspects.

- It is clear that CASA [Civil Aviation Safety Authority] had investigated [manufacturer’s Chief Executive Officer] prior to the inquest in relation to his provision of false information for other aircraft, but there appears to have been little communication with RA-Aus. It is recommended that CASA review its policies and procedures to ensure that any adverse findings, or indeed any issues arising from CASA investigations relating to pilots who are also members of recreational aviation associations, are communicated with those associations. This will highlight for those associations any potential issues and enable them to assess any safety implications for their association. It will then place them in a position of having constructive knowledge of events and circumstances to enable them to take appropriate action if required.

- Also, whilst it is accepted that there are limited resources, it is recommended that CASA review its delegation to RA-Aus in terms of what is expected of them in screening and auditing aircraft documentation, which is submitted by its members. Random audits by RA-Aus would be appropriate to assist in the deterrence aspect, but further funding needs to be provided for this purpose, or CASA should consider undertaking such audits itself.

- The process for investigation of aircraft incidents and the ad hoc manner that other organisations provide reports to QPS [Queensland Police Service] make the system burdensome and time consuming. It is recognised that a lack of training and lack of knowledge of aircraft will tend to lead the QPS to rely heavily on external investigations such as investigations carried out by RA-Aus.

- In this case, RA-Aus was assisting police with their investigation, but custody of the wreckage and primacy over the coronial investigation belonged with QPS. However, QPS had no oversight or control over the testing of the GPS [global positioning system] and engine control unit being carried out by RA-Aus (through the ATSB). Nor did QPS seem to realise that RA-Aus was not going to finalise their investigation (based on an understanding that QPS required nothing further from them). To avoid these miscommunications into the future and to ensure that QPS has overall control of coronial investigations into aviation incidents, it is recommended that QPS revise its procedures to ensure that any testing or expert reports by such external organisations are arranged...
by the QPS. It is also recommended that QPS ensure that if an external organisation is assisting them with their investigation, that they are requested to finalise their report for the Coroner within a reasonable time frame. A police investigation report should aim to consolidate all of the external investigation reports and the outcome of their own enquiries for the Coroner.

- Also, it is vitally important that all evidence from aircraft wreckage is adequately secured by the QPS for the purposes of the coronial investigation. It is recommended that procedures at the [location] Police Station be reviewed so that all relevant components of an aircraft wreckage are collected, catalogued, registered and safely secured from the site of the incident, through the transport process, to the holding yard until finalisation of the matter.

- Clearly there are significant issues in regards to [manufacturer] and the registration of their aircraft with RA-Aus. [Manufacturer’s Chief Executive Officer] eventually admitted that he falsified key aircraft documentation. It is therefore recommended that [manufacturer’s Chief Executive Officer]:
  - reviews and corrects any inaccurate aircraft documentation provided to Aviation Associations and all individuals in respect of its aircraft.

- Due to [RA-Aus investigator’s] observations in his investigation report, it is also recommended that [manufacturer’s Chief Executive Officer]:
  - reviews the undercarriage system for his company's replica [aircraft] to ascertain whether a more simplified system could be implemented; and
  - reviews the design of the electrical system to ensure that there is a true double redundancy system and a true battery isolation control system with better in-cock pit indications for both battery status and battery supply.
Coronial recommendations: Fatal facts

Case number


Primary category
Fire related

Fatal facts edition
43 – cases closed between October and December 2014

Case summary

Eleven people died when a fire broke out in their home during the night.

The fire was well established by the time it was discovered, and the occupants were unable to escape. Fire investigators determined that the fire originated in the downstairs office area of the house. They were unable to identify if the fire was caused by a cigarette, a lamp or an electrical fault.

Coronial findings

The coroner found that the deaths were unintentional.

The coroner was unable to determine the exact cause of the fire, but found that it was not deliberately lit.

Coronial recommendations

The coroner made the following recommendations related to these cases:

- Legislation should be put in place as soon as possible the effect of which is such that all places where people sleep should be provided with early warning of a fire occurring at a sound level capable of waking them. That is a minimum of 75 Decibels at the bed head. To enable this to be achieved the legislation should provide:
  - That as a minimum in all areas of a building where people sleep, approved smoke alarms are installed in any storey containing bedrooms:
    - between each part of the dwelling containing bedrooms and the remainder of the dwelling and in every bedroom; and
    - where bedrooms are served by a hallway, in that hallway; and
  - in any other storey not containing bedrooms, and
  - in the case where there is more than one alarm required they shall be interconnected by hard wiring where possible and by wireless signal where hard wiring is impractical.
• The above implementation should take a staged approach to allow homeowners to prepare for the changes. After the commencement of the legislation, homeowners are required to ensure the new legislative requirements are met in the following circumstances:
  o If a dwelling does not have smoke alarms, or does not have smoke alarms that comply with the current legislation, the new legislative requirements must be met immediately [or alternatively, within a stipulated period of grace of, say, 6 or 12 months];
  o When smoke alarms cease to operate when tested or are at the end of their useful life (10 years from manufactured date);
  o If the owner enters into a contract to sell the dwelling, the day before the date of settlement;
  o With respect to rental properties, before any new tenancy commences, and within 12 months of the commencement of the legislation in the case of existing tenancies.
  o The current legislative requirements continue to apply until the new requirements are met in accordance with this staged approach.
• An approved smoke alarm for these purposes means a photoelectric type smoke alarm that complies with Australian Standard AS 3786(Smoke Alarms) and:
  o If installed in a newly constructed domestic dwelling, is a 240 volt hard wired smoke alarm, or
  o If installed in an existing domestic dwelling in addition to, or replacing existing smoke alarms, a 240 volt hard wired smoke alarm where access is available to the ceiling space or, otherwise, a 10 year lithium battery smoke alarm which is interconnected wirelessly, to all other required smoke alarms in the dwelling. It is important that all smoke alarms are interconnected so that if one alarm is triggered all the remaining alarms also operate. This will only be possible if all alarms are the same type and are compatible with each other.
• It is also important to say that smoke alarms are only part of the process to ensure people escape to a point of safety from their burning home. A practiced Escape Plan is the other critical component of safe evacuation. It is also recommended that the importance of smoke alarms and other safety requirements such as an Escape Plan be well publicised by QFES and Government. It is hoped that by the full implementation of these recommendations a tragedy such as this will never again occur.
Coronial recommendations: Fatal facts

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Case summary
A young female drowned in a river when the strong current pulled them into an underwater cave system. The river was flooding due to recent heavy rains. The young person and their group were unfamiliar with the area and the effects of the weather on the landscape. There was no signage stating the area the group chose was unsafe for swimming.

Coronial findings
The coroner found that the death was unintentional. The coroner found that the information provided to guests by the nature park was grossly inadequate as a safety measure and the owners of the nature park had repeatedly refused to address safety issues within the park.

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

- Office of Fair and Safe Work Queensland (OF SWQ) re-open its investigation into the death of [the deceased] to consider the further factual information that has been obtained during this inquest and the current safety measures in place at the park;
- OFSWQ consider whether the information now available requires that a prohibition notice be issued to [the nature park] prohibiting visitors from undertaking any activities in the park until OFSWQ inspectors are satisfied that:
  - [Nature park] has engaged an independent expert to conduct a risk assessment on all activities offered at the park; and,
  - All recommendations made by that expert have been fully implemented at the park.
- The Organisational Response Group of the OFSWQ, in consultation with other agencies, consider the introduction of guidance material relating to undertakings concerned with the interaction of the public with nature activities, such as those offered by the park.

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Coronial recommendations: Fatal facts

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Case summary
A middle aged male died from injuries sustained in a bicycle accident.
The bicycle came into contact with a semi-trailer travelling at speed on a highway.

Coronial findings
The coroner found that the death was unintentional.
The coroner found that the driver of the semi-trailer failed to provide sufficient space between the two vehicles when they overtook the cyclist.
The highway had recently undergone a redesignation due to the volume of traffic the road saw. The Department of Transport and Main Roads found that there was no need to restrict the use of the highway from cyclists on the basis of the policy that was mandated. The coroner found that at the very least a risk assessment should have been carried out before the decision to ban or accept cyclist to the motorway.

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

• That the Department of Transport and Main Roads should immediately prohibit cyclists from using the [highway] between [town] and the [motorway].

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Coronial recommendations: Fatal facts

Case number | QLD.2011.2311
---|---
Primary category | Homicide and assault
Additional categories | Law enforcement
Fatal facts edition | 43 – cases closed between October and December 2014

Case summary
An adult female died when they were assaulted by their partner. The adult’s partner disposed of their body in a remote location.

The adult was a known victim of domestic violence and had engaged with a range of agencies and persons regarding their experience of domestic violence.

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

The coroner found that despite all the engagement with relevant agencies and persons, they were still subject to fatal domestic violence.

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

- The key recommendation for this inquest is that relevant government Departments should establish an appropriate interdepartmental process, with engagement from appropriate community organisations, with a view to establishing a pilot ‘Domestic violence centre’ in an appropriate part of Queensland.
- This recommendation should align with the implementation of a model similar to a Suspected Child Abuse and Neglect (SCAN) team for victims of domestic violence; and the implementation of a common assessment tool for agencies dealing with domestic violence victims.
- I recommend that General Practitioners treating victims of domestic violence should be able to report concerns about their patients confidentially to police, even in circumstances where there is no immediate and severe threat to the patient’s life.
- Further, I recommend that the medical profession itself, along with appropriate government agencies should establish simple guidelines to assist General Practitioners who are treating victims of domestic violence.
- In relation to the policing of domestic violence, I recommend the following:
the Queensland Police Service should consider implementing, and promulgating to station officers in-charge, examples of the types of training and consequences which might properly accompany managerial guidance, and guidelines on the considerations which the station Officer In Charge should have in mind when determining the appropriate form of managerial guidance;

that additional Domestic and Family Violence Coordinator positions should be established in parts of Queensland where domestic violence is prevalent, and that a state-wide coordination role should be re-implemented within police headquarters; and

the Queensland Police Service should identify an appropriate and realistic way to ensure, so far as possible, that domestic violence assaults are not misclassified as non-domestic violence assaults.
Coronial recommendations: Fatal facts

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Case summary

A young male died as a result of injuries sustained in an assault.

The young male was a prisoner at the time of their death. They were attacked by a fellow prisoner and suffered fatal injuries as a result.

Coronial findings

The coroner found that the death was due to assault.

The coroner found that the deceased and assailant were both known to exhibit violent behaviour. A risk assessment regarding association between the two was not carried out. The coroner identified a number of failures on behalf of the prison regarding incident recording and reporting, prisoner associations, prisoner handling instructions and staff training.

Coronial recommendations

The coroner made the following recommendations related to this case:

I adopt the following recommendations related to the death of [the deceased] that were initially made as part of the OCI [Office of the Chief Inspector] Report (numbered as per that report). These recommendations are comprehensive and are likely to prevent a death from happening in similar circumstances at [prison].

**Recommendation 1:**

- That [prison] ensure that Supervisors and Area Managers cross check IOMS [Information and Offender Management System] Case Notes with handover notes to ensure consistency and accuracy during any auditing.
- [Prison] reminds all staff about the importance and reasons for completing intelligence information notices/reports.
- QCS [Queensland Corrective Services] consider removing the copy and paste functionality in IOMS concerning case noting.
• [Prison] ought to remind staff of the requirement for timely and accurate IOMS reporting and the relevance and significance thereof to the risk assessment.
• [Prison] reminds staff of the importance of case noting corrective behaviour directions to accurately record prisoner behaviour and compliance.
• [Prison] ought to develop and use a formal and consistent handover note that requires specific details to be entered to ensure timely and accurate exchange of information for incoming personnel for the unit. The documents ought to be retained and archived in compliance with accurate record keeping practices.

Recommendation 2:
• That [prison] implement a robust and documented procedure for the DU [Detention Unit] concerning the association process between prisoners.
• The procedures ought to give clear and unambiguous instructions to document fully: all requests for associations from prisoners (written request form); the authorisation process including a robust risk assessment process; the outcome concerning authorisation (such as declined or authorised and the reasoning why); the authorised duration of any association or any other restriction/s; specific handling or supervision requirements; whether the authorisation stands until completed or whether it requires daily renewal (complemented by a robust risk assessment that documents the process); and the outcome of any association in fact completed.

Recommendation 3:
• That [prison] implement procedures for the DU that requires all ‘specific handling instructions’ for prisoners within the DU that may be issued by Supervisors or Managers to be immediately (or as soon as is reasonably practicable operational requirements permitting) entered onto IOMS.
• IOMS ought to record: the specific details; the officer who gave the instructions, duration of the instructions who is authorised to alter or rescind the specific instructions.

Recommendation 4:
• That [prison] develop and implement specific unit induction training or an information training package for all staff that perform duties in the DU on either a permanent, part-time or casual basis to ensure officer awareness of the specific requirements relevant to the DU environment.

Recommendation 5:
• That [prison] implement a robust ‘situational awareness training program’ or similar to minimise officer complacency for staff attached to special units such as the DU, and take such other reasonable measures to minimise officer complacency.
Recommendation 6:
• That [prison] implement a robust and documented procedure for all property within common areas of the DU that specifically identifies the approval process for any property and the officer authorising it. The procedure ought to assist all [prison] personnel attending the DU to identify unauthorised property and to provide guidance for immediate rectification.

Recommendation 7:
• That [prison] ensures all Supervisors, Area Managers and other Senior Management Personnel are reminded of, and receive further training on, proactively identifying risks involving items of property when conducting unit checks and to implement immediate rectification once risks are identified.

Recommendation 8:
• That [prison] implement a process/procedure to ensure that any verbal handling instructions or directions concerning a prisoner that is given by a supervisor or manager is immediately relayed to the relevant unit officer and to direct for those instructions and or directions to be immediately entered onto IOMS. The relevant supervisor or manager ought to be responsible for ensure that those instructions are carried out and that IOMS accurately records their verbal instructions as given.

Recommendation 9:
• That [prison] review and consider the use of diaries by supervisors and managers and implement a formal diary system that includes the annual allocation of a numbered diary to senior personnel. The diary ought to be checked and audited throughout the year for compliance and accuracy and collected at the conclusion of each calendar year for record retention and stored in compliance with the relevant Standards.

Recommendation 10:
• That [prison] earlier ensure adequate procedures are implemented to ensure DU Officers attend relevant shift briefings unless operational requirements excuse their attendance.

Recommendation 11:
• That [prison] ensure adequate procedures are implemented in the DU to ensure that outside personnel attending the unit are briefed on specific risks or handling instructions for particular prisoners (where relevant) prior to those persons interacting with the particular prisoners. This procedure ought to ensure that outside personnel are fully informed of any risks or concerns to ensure appropriate levels of prisoner awareness.
 Recommendation 12:
- That [prison] ensure adequate procedures are implemented in the DU concerning the process for the medication rounds to ensure that nursing staff and escort officers are not exposed to the risk of insecure prisoners within the unit or multiple prisoners within one location (such as the main exercise yard). The procedure ought to minimise the opportunity for prisoners to share prescription medications.

 Recommendation 13:
- That [Queensland Corrective Services] take immediate steps to correct the CCTV defect within the DU main exercise yard.

 Recommendation 14:
- That [prison] ensure that personnel relieving in the roles of Supervisor and Area Manager receive appropriate training on incident command and control.
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 similar incidents: QLD.2012.343, QLD.2012.964, QLD.2012.2592</th>
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<tr>
<td>Primary category</td>
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<td>Fatal facts edition</td>
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</table>

Case summary – QLD.2012.343

An adult female died in hospital.

The adult presented to their general practitioner (GP) with fever symptoms and had blood tests done. After receiving concerning results, the GP told them to immediately attend hospital, and also rang the hospital (Hospital A) to provide the results to the admitting doctor. Hospital A was closed and the GP was unable to leave a voicemail.

The adult presented at Hospital A and a nurse took observations. The nurse recorded meningitis symptoms. They were not seen by the doctor until the following day. The doctor did not read the nurse’s observations, and was unaware of the meningitis symptoms. Later that day, the doctor observed meningitis symptoms and arranged for the adult to be transferred to a major hospital.

The adult collapsed in transit. Resuscitation was attempted at the major hospital, but they passed away shortly after arrival.

Coronial findings

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

The coroner found that the adult did not receive appropriate treatment and care at Hospital A. There was a failure to diagnose and treat the adult in a timely manner, largely as a result of the lack of adequate staffing at Hospital A.

The coroner found that the adult’s triage category was not met, and they were therefore not seen by a doctor overnight after their admission. The coroner found that as the doctor had not been present overnight, and had not read the nurse’s notes, they did not recognise the seriousness of the condition and failed to commence appropriate treatment.

The coroner found that despite the severity of the adult’s illness, it was a possibility that Hospital A’s failure to deliver appropriate treatment may have contributed to the death.
It was noted that nurses were reluctant to contact the on-call doctor overnight unless the matter was extremely urgent. At inquest, an emergency medicine specialist noted that there were only two doctors sharing on-call for Hospital A at the time of the incident. The specialist found this was completely unacceptable and resulted in fatigue that affected treatment of patients.

Case summary – QLD.2012.964

A young male died in hospital.

The young person presented to their general practitioner (GP) with fever symptoms and had blood tests done. After receiving concerning results, the GP told them to immediately attend hospital, and also rang Hospital A to provide the results to the admitting doctor. Hospital A had no record of this phone call.

They presented at Hospital A coughing up blood, and were discharged pending further tests. They continued to cough up blood and returned to Hospital A via ambulance the following night. They underwent observations, but they were not seen by the doctor until the following day.

The following day, the doctor considered their presentation required a medical emergency to be called. The young person continued to deteriorate. Resuscitation attempts were unsuccessful and they passed away.

Coronial findings

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

The coroner found that the GP should have been able to diagnose the young person at the time of their presentation, and treat them accordingly.

The coroner found that the severity of the young person’s illness was underestimated by the nursing staff, and their actions during the night were inappropriate to the severity of their illness.

The coroner found that Hospital A’s workplace culture valued historical processes over best practice, which led to poor communication and failure to provide appropriate or timely care.

It was noted that at the time of the inquest, there was still no doctor present at Hospital A overnight. The coroner found this to be unacceptable as it resulted in the people of Hospital A’s district receiving a lesser standard of healthcare than those in surrounding districts.

The coroner found that despite the severity of the young person’s illness, it was a possibility that Hospital A’s failure to deliver appropriate treatment may have contributed to the death.
Case summary – QLD.2012.2592

An older female died in hospital.

The adult was brought to hospital (Hospital B) via ambulance with a possible infection. They underwent observations, and an Adult Deterioration Detection Tool (ADDS) was completed, but the ADDS score was not calculated.

Tests revealed the possibility of an infection. They were not reviewed by a doctor after these tests, and were discharged without receiving antibiotics.

Their health declined over the next few days and they returned to Hospital B via ambulance. They deteriorated despite medical treatment, and passed away.

Coronial findings

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

The coroner found that the adult did not receive appropriate treatment at Hospital B.

The coroner found that their triage score was too low, and a necessary emergency call was not actioned due to the ADDS score not being calculated. The medical staff consistently failed to correctly utilise the ADDS tool which resulted in a failure to recognise the severity of their illness.

The coroner found that the adult was discharged inappropriately, and the discharge summary was inconsistent with prior observations. The coroner found that staff failed to identify septicaemia, despite positive cultures of which they were advised.

The coroner found that it was possible that the timely administration of antibiotics may have changed the outcome for the adult.

Coronial recommendations

The coroner made the following recommendations related to these cases:

- [District health service] implement the proposed workforce model at [Hospital A] as soon as possible and report as to the implementation of the workforce and its continuation to the Office of the State Coroner, annually for 5 years, with the first such report to be delivered by 28 February 2015.
- [District health service] ensure that pathology testing laboratories and local General Practitioners and Medical Centres are provided with a telephone number for the Emergency Department for [Hospital A] and [Hospital B] which is answered at all times and through which the caller is able to be put through to the on duty medical officer.
- [District health service] and/or Queensland Health consider funding a full time radiographer at [Hospital A].
• [District health service] and/or Queensland Health consider funding for a full-time nurse educator for the [health centre].

• Queensland Health appraise itself of the report and evidence of [inquest expert] and educate its clinicians (doctors and nurses) as to the importance of acting upon haemoptysis, and the importance of not discounting haemoptysis as being likely due to a burst blood vessel from coughing.

• The Australian College of Rural and Remote Medicine, the Australian College of General Practitioners, the Australian College of Nursing, the Medical Board of Australia (Queensland Office) and the Nursing Board appraise themselves of the report and evidence of [inquest expert] and consider disseminating information to their members as to the importance of acting upon haemoptysis, and the importance of not discounting haemoptysis as being likely due to a burst blood vessel from coughing.
Coronial recommendations: Fatal facts

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<tr>
<th>Case number</th>
<th>QLD.2012.2555</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Drugs and alcohol</td>
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<tr>
<td>Fatal facts edition</td>
<td>43 – cases closed between October and December 2014</td>
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</tbody>
</table>

Case summary
An adult female died due to mixed drug toxicity.

The adult suffered from several chronic conditions for which they were on strong prescription-only painkillers. At the time of their death, they were seeing up to four practitioners to obtain the painkillers.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the prescription of the medication to the adult was appropriate under the circumstances, but that the practitioners failed to identify that the adult was using many more tablets than she disclosed and that they failed to restrict the quantity of medications the adult was taking.

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

I propose to refer these findings and the medical records to the Office of the Health Ombudsman [OHO] for review; and include the following suggestions for OHO’s consideration and appropriate action:

- That the Prescription Shopping Program [PSP] be alerted to the fact that their “alert service” failed [the deceased]
- There should be instituted a national computerised pharmacy system which automatically registers a patients prescription as soon as it is dispensed which would alleviate the six week time gap from dispensing until the PSP send out notifications.

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.
TASMANIA

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

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<th>Case number</th>
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<tr>
<td>Primary category</td>
<td>Drugs and alcohol</td>
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<tr>
<td>Fatal facts edition</td>
<td>43 – cases closed between October and December 2014</td>
</tr>
</tbody>
</table>

Case summary

A young male died due to drug toxicity after self-administering a large quantity of methylphenidate. They were not prescribed methylphenidate at the time of their death.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that they had been purchasing the methylphenidate from a family whose child was prescribed the medication. The young person had burgled the family’s house to access the drugs prior to their death.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That relevant agencies consider whether there is a need for a public education campaign with a view to reducing the harm caused by illicit diversion of psychostimulants, and in particular, to highlight the dangerous practice of intravenous injection of such substances.
- That in developing updated guidelines for the issuing of authorities to prescribers, the PSB [Pharmaceutical Services Branch] consider current evidence of the prevalence of and harm caused by diversion and misuse of psychostimulants in the community.
- That relevant agencies consider reviewing the availability and adequacy of treatments for ADHD [Attention Deficit Hyperactivity Disorder] and Autistic Disorder in this State, including the need for a single pathway for assessment and therapeutic intervention for children with developmental disorders.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>TAS.2012.486</th>
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<td>Weather related</td>
</tr>
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<td>Fatal facts edition</td>
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</tr>
</tbody>
</table>

Case summary
An adult female died from injuries sustained in a motorcycle accident when they lost control of their motorcycle and collided with a barrier.

The adult had limited experience riding a motorcycle. At the time of the accident, there were reported strong crosswinds.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the rider was inexperienced and would have been unlikely to have previously encountered weather conditions similar to those on the day of the incident. The rider had successfully completed the mandatory safety course required to obtain a motorcycle licence. However, the course did not have a unit on safe riding in adverse weather conditions.

The coroner found that the injuries sustained where significantly contributed by the rider impacting with the barrier. The barrier did not include underrun protection and as such allowed the passage of the rider under the barrier rather than along it.

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

- That motor cycle training safety courses (both learner and provisional) be extended to include training in relation to the control of motor cycles in adverse weather conditions.
- Where possible steel Armco rail posts be fitted with underrun protection, particularly in areas identified as high risk in terms of motorcycle accidents.

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

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<td>Fatal facts edition</td>
<td>43 – cases closed between October and December 2014</td>
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</tbody>
</table>

Case summary
A middle aged male died of positional asphyxia while acutely intoxicated. They consumed alcohol while they were alone and were known to have a history of problems with alcohol.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that death was due directly to the ingestion of a very large quantity of alcohol on a single occasion.

The coroner noted that alcohol is the most widely used recreational drug in Australia. Due to its wide use and social acceptance of its use, it is often not considered to be a ‘drug’, nor is it considered to be particularly harmful. The coroner noted the guidelines of the National Health and Medical Research Council (NHMRC) regarding alcohol intake, but that knowledge of these guidelines was low within the population. In addition, it was identified that there had been no major Commonwealth government initiatives to raise awareness within the Australian community of these guidelines since their publication.

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

- I recommend that relevant State and Federal agencies develop and implement a strategy to significantly increase the awareness in the community of the National Health and Medical Research Council (NHMRC) guidelines for low risk drinking, when people choose to drink.
- I recommend that relevant State and Federal agencies consider the development of a comprehensive strategy to reduce unsafe alcohol consumption and its related harm, based on evidence.
Coronial recommendations: Fatal facts

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<tr>
<th>Case number</th>
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</tr>
<tr>
<td>Fatal facts edition</td>
<td>43 – cases closed between October and December 2014</td>
</tr>
</tbody>
</table>

Case summary

An older female died in hospital due to a bleeding stomach ulcer.

The adult presented at hospital with abdominal pain, but their symptoms were not diagnosed for many days. A diagnostic surgery identified the perforated ulcer but failed to diagnose active bleeding.

They were attended by the hospital’s medical emergency team (MET team) when they had clearly suffered a sudden and significant bleed. The MET team ordered a computed topography (CT) scan and left the older person on the ward to wait for the scan. Their condition rapidly deteriorated and they were transferred to theatre for emergency surgery. They died before surgery commenced.

Coronial findings

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

The coroner found that the condition is not ordinarily fatal, and could have been readily and successfully treated if it had been diagnosed in a timely manner.

The coroner found that the MET team’s response was grossly inadequate, and that the MET team should have recognised the need for emergency surgery when they attended the older person.

Coronial recommendations

The coroner made the following recommendations related to this case:

- In 2010 I handed down findings into [a similar death]. That case also involved [hospital]’s MET team. I was advised that following its own investigation of that death the [hospital] introduced a protocol whereby the MET team was to be controlled by an ICU [intensive care unit] consultant and the team could only be stood down by that consultant. It is apparent from my investigation of [the deceased]’s death that this protocol has been abandoned. I venture the view that had it been in place for [the deceased] the
shortcomings surrounding her first MET call may have been avoided. This leads me to recommend that [hospital] conduct a review of its MET team with a view to adopting changes which address those deficiencies that have presented in this case.
Coronial recommendations: Fatal facts

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<tr>
<th>Case number</th>
<th>TAS.2013.411</th>
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<td>Fatal facts edition</td>
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</tbody>
</table>

Case summary

A middle aged male died from acute ethanol intoxication. They had consumed alcohol in a social setting and were known to have a history of alcohol abuse.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that death was due directly to the ingestion of a very large quantity of alcohol on a single occasion.

The coroner noted that alcohol is the most widely used recreational drug in Australia. Due to its wide use and social acceptance of its use, it is often not considered to be a ‘drug’, nor is it considered to be particularly harmful. The coroner noted the guidelines of the National Health and Medical Research Council (NHMRC) regarding alcohol intake, but that knowledge of these guidelines was low within the population. In addition, it was identified that there had been no major Commonwealth government initiatives to raise awareness within the Australian community of these guidelines since their publication.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That relevant State and Federal agencies develop and implement a strategy to significantly increase the awareness in the community of the National Health and Medical Research Council guidelines for low risk drinking, when people choose to drink.
- That relevant state and Federal agencies consider the development of a comprehensive strategy to reduce unsafe alcohol consumption and its related harm, based on evidence.

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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<td>Fatal facts edition</td>
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</tbody>
</table>

Case summary

A middle aged male died of positional asphyxia while acutely intoxicated. They had consumed alcohol whilst alone. They were known to be dependent upon alcohol and were a frequent heavy drinker.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that death was due directly to the ingestion of a very large quantity of alcohol on a single occasion.

The coroner noted that alcohol is the most widely used recreational drug in Australia. Due to its wide use and social acceptance of its use, it is often not considered to be a ‘drug’, nor is it considered to be particularly harmful. The coroner noted the guidelines of the National Health and Medical Research Council (NHMRC) regarding alcohol intake, but that knowledge of these guidelines was low within the population. In addition, it was identified that there had been no major Commonwealth government initiatives to raise awareness within the Australian community of these guidelines since their publication.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that relevant State and Federal agencies develop and implement a strategy to significantly increase the awareness in the community of the National Health and Medical Research Council (NHMRC) guidelines for low risk drinking, when people choose to drink.
- I recommend that relevant State and Federal agencies consider the development of a comprehensive strategy to reduce unsafe alcohol consumption and its related harm, based on evidence.

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Coronial recommendations: Fatal facts

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<td>Fatal facts edition</td>
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</tbody>
</table>

Case summary

A middle aged male drowned after being caught in a rip on an unpatrolled, isolated beach.
They were a poor swimmer and ocean conditions were dangerous on the day of the incident.

Coronial findings

The coroner found that the death was unintentional.

The coroner noted that there was no signage in the car park or anywhere on the beach warning of the danger of strong rips, currents or undertows.

Coronial recommendations

The coroner made the following recommendations related to this case:

- As has been already noted, [beach] is an isolated surf beach with dangerous rips, currents and undertows. It is in an isolated part of Tasmania and is not patrolled by surf lifesavers. There are no warning signs at the car park or on the beach to alert members of the public of the potential dangers of swimming at [beach]. There should be. Had there been, it is possible that [the deceased] would have not made the ultimately fatal decision to enter the water. Certainly there was nothing to alert him as to the dangers of swimming at [beach]. I recommend that signs warning of the presence of strong rips, undertows and currents be erected in the car park and on the beach as soon as possible.
Coronial recommendations: Fatal facts

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<th>Case number</th>
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<td>Fatal facts edition</td>
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</table>

Case summary

A middle aged male died as a result of acute alcohol toxicity. They consumed an excessive amount of alcohol over a period of time at a family party.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that death was due directly to the ingestion of a very large quantity of alcohol on a single occasion.

The coroner noted that alcohol is the most widely used recreational drug in Australia. Due to its wide use and social acceptance of its use, it is often not considered to be a ‘drug’, nor is it considered to be particularly harmful. The coroner noted the guidelines of the National Health and Medical Research Council (NHMRC) regarding alcohol intake, but that knowledge of these guidelines was low within the population. In addition, it was identified that there had been no major Commonwealth government initiatives to raise awareness within the Australian community of these guidelines since their publication.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That relevant State and Federal agencies develop and implement a strategy to significantly increase the awareness in the community of the National Health and Medical Research Council guidelines for low risk drinking, when people choose to drink.
- That relevant state and Federal agencies consider the development of a comprehensive strategy to reduce unsafe alcohol consumption and its related harm, based on evidence.

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VICTORIA

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

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<th>Case number</th>
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<td>Fatal facts edition</td>
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</table>

Case summary

A middle aged male died in a vehicle incident in which they were a passenger.

A second vehicle was attempting to overtake a truck at speed. The driver of this vehicle lost control, causing it to spin into the path of the vehicle in which the adult was travelling. It was raining at the time of the incident.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the drivers of the two vehicles did not cause or contribute to the collision. The coroner found that the road surface was in poor condition, and that VicRoads did not adequately inform drivers of the dangers presented by the road condition.

The coroner found that the danger was exacerbated by speed and rain. This combination of circumstances was predictable, and required remedy as a matter of urgency.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that VicRoads adopt a working protocol, which would authorise Vic Roads Regional Directors to impose temporary speed limits, in the vicinity of known road friction black spots, such as that which had been identified in this instance.
- I also recommend that emergency funding be made available for expenditure at the exclusive discretion of Vic Roads Regional Directors, in respect of road surface friction repair issues, to be applicable in such circumstances to be determined and published as part of an operational procedure, by the VicRoads Chief Executive in consultation with the Director of Operations.

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Coronial recommendations: Fatal facts

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<th>Case number</th>
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<td>Additional categories</td>
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<td>Fatal facts edition</td>
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</table>

Case summary

A male child died when the ski boat they and their family were in collided with a second vessel. The bow of the second vessel penetrated into the ski boat and struck the child, causing fatal injuries.

None of the vessel’s occupants were aware of the presence of the other boat until the moment of the collision.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the ski boat had right of way, and the second vessel failed to give way. The coroner found that both vessels were exceeding the speed limit required within proximity to other vessels, and both operators were failing to keep a proper lookout.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that there be a re-consideration by relevant authorities of whether the estimated benefits of a practical component of the Victorian recreational boat license regime continues to outweigh the costs. I recommend that such a re-consideration take into account the need to strike an appropriate balance between public safety and public cost, which may require a recalibration of the equation and a greater weighting of the public safety component of that equation.
Coronial recommendations: Fatal facts

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<th>Case number</th>
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Case summary

A female child drowned in a pool at their home. Their family were tenants at the property.

The child was unsupervised and playing outside, and after a short time they were discovered in the pool. They were conveyed to hospital where they were pronounced deceased.

Coronial findings

The coroner found that the death was unintentional.

The coroner was unable to determine how the child entered the pool enclosure, but noted that there were two possible entry points.

The pool gates and fencing were found to be non-compliant with Australian Standards. The coroner found that the owners of the property were aware of the non-compliance issues.

There was a breakdown in communication between the homeowners, the builder of the pool and the council building inspector, which meant that problems with the pool fencing were not identified by the regulatory parties or rectified by the owners.

The coroner found that the real estate agency responsible for the tenancy was not expected to have an understanding of industry requirements for Australian Standards in respect to swimming pools and fences. The coroner noted that the real estate agency has since introduced a system to ensure pools on properties managed by the agency provide a certificate of compliance.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the relevant legislation be amended to make clear that if the pool builder contracts with the property owner to only construct a swimming pool (and not also the pool safety barriers) then the responsibility to construct the mandatory safety barriers will be imposed on the owner.
• That the relevant legislation be amended to impose a clear obligation on the Building Permit holder to inform the relevant Building Surveyor when they have commenced building work as most other time based obligations under the [Building Act 1993] flow from that commencement date.

• That the relevant legislation be amended to impose a mandatory obligation on the relevant Building Surveyor to inspect any swimming pool Building Permit site within two months of the relevant Building Permit lapsing.

• That the Building Commission review the existing information it makes available for property owners building a swimming pool and prepares a summary brochure specifically targeting the responsibilities of Building Permit holders and property owners for swimming pools. This targeted information should highlight mandatory reporting and inspection obligations, focusing in particular on commencement of building work and final inspection and the provision of a compliant safety barrier for the swimming pool before it is filled with water.

• That the relevant legislation be amended to impose a mandatory obligation on the relevant Building Surveyor that the information prepared under [the recommendation above] be sent to the Building Permit holder (and the property owner if they are not the Building Permit holder) with the Building Permit each time one is issued for a swimming pool.

• That the legislation be amended to extend the powers of a Municipal Building Surveyor to issue infringement notices for breaches of the legislation in relation to swimming pools, such as failures to have a mandatory inspection conducted, failure to cease work when a mandatory inspection has not been conducted and failure to have a compliant swimming pool barrier.

• That the legislation be amended to enable authorised officers to enter private properties upon reasonable written notice for the specific purpose of investigating or monitoring compliance with the legislation and any Building Permit relating to a swimming pool.

• That swimming pool owners be required to obtain a mandatory inspection of their swimming pool safety barriers every three years by licensed pool safety inspectors, with the results to be recorded on the Statewide swimming pool register. A new offence should be established for failing to have a mandatory inspection of the swimming pool conducted with a suggested penalty of at least 20 penalty units to reinforce the gravity of the obligation given the importance of public safety.

• That the relevant legislation be amended to make it a mandatory pre-condition to the sale or rental or house sitting of any property that has a swimming pool, that pool safety barriers be inspected and where necessary brought into compliance and a certificate of compliance be received from a registered pool inspector, before occupation by the purchaser, tenant or house sitter can occur.

• That the Real Estate Institute of Victoria and Law Institute of Victoria alter the standing contract of sale or rental agreement to reflect the amended legislation in [the recommendation] above.
• That pool owners be required to self register free of charge on a Statewide, online register and provide certification that their pool barrier complies with the legislation. Pool owners should have twelve months to register and provide the necessary certifications. A new offence should be established for failing to register a swimming pool with a suggested penalty of at least 20 penalty units to reinforce the gravity of the obligation given the importance of public safety.

• That the Victorian Parliament consider providing a single piece of legislation containing a uniformed set of rules and requirements relating to the construction and fencing of pools, irrespective of their date of construction. The post May 2010 requirements relating to the use of boundary fences should be applied regardless of the construction date, so that the requirements are consistent and pool owners can ensure that the barrier remains compliant. Pool owners should be given a reasonable period of time within which to obtain compliance with these requirements or risk penalty/fines.

• That the Real Estate Institute of Victoria educates its members about the importance of swimming pool surrounds forming part of property inspection from a duty of care prospective to ensure the health and wellbeing of tenants.

• That Consumer Affairs Victoria amends its residential tenancy forms and publications created for tenants and landlords to include regulatory information about swimming pools safety barrier fencing.

• That the Building Commission improves the dissemination and availability of information about the construction and maintenance of swimming pools and their safety barriers and the relevant Building Permit process including by ensuring that all relevant Community Information Sheets, Practice Notes and other Building Commission publications are linked to the Commission's webpage for the public on swimming pools and spas.

• That the Building Commission publish a laminated cardiopulmonary resuscitation guide, which also includes the simple reminder as to maintaining pool barriers, to be distributed through the Council network and also be made available to Building Surveyors who issue swimming pool permits, so that they could be provided to pool owners at final inspection or final certificate stage.
Coronial recommendations: Fatal facts

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<th>Case number</th>
<th>VIC.2009.1402</th>
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<td>Primary category</td>
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<td>Fatal facts edition</td>
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</table>

Case summary

A young male took their own life by hanging. There had been a recent relationship breakdown which seemed to be the precursor to the incident.

Coronial findings

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

The coroner found that there were no other factors other than the relationship breakdown that could have influenced the decision of the young person.

The coroner sought assistance from the Coroners Prevention Unit (CPU) to investigate the increased number of suicidal deaths in persons under the age of 18 within the region.

The CPU review identified four factors that warranted further examination and / or input from external organisations:

- The presence and association between exposure to suicidal behaviour in the social network and an individual's risk of suicide.
- Media treatment of youth suicide, including:
  - The potential for media coverage of youth suicides to trigger further suicides among vulnerable and impulsive young people; and
  - The potentially intrusive and distressing nature of reporters' behaviour towards a grieving family whose child has suicided.
- The presence and role of bullying and cyber-bullying on youth suicide.
- The local post-vention response by:
  - The Department of Education and Early Childhood Development (DEECD), including [secondary school], and
  - [Local health unit].

Coronial recommendations

The coroner made the following recommendations related to this case:
That the Department of Health together with Victoria Police, the Municipal Association of Victoria, the Royal Australian College of General Practitioners and the Chief Psychiatrist undertake a review of these reports and develop a policy framework that aligns, where appropriate, with the National Suicide Prevention Strategy.

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

A young female took their own life by hanging. They had experienced a recent relationship breakdown and their former partner had recently taken their own life.

Following the former partner’s death, the young person had become withdrawn.

Coronial findings

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

The coroner found that the death of the young person was primarily due to relationship breakdown and subsequent suicide of the former partner.

The coroner sought assistance from the Coroners Prevention Unit (CPU) to investigated the increased number of suicidal deaths in persons under the age of 18 within the region.

The CPU review identified four factors that warranted further examination and / or input from external organisations:

- The presence and association between exposure to suicidal behaviour in the social network and an individual's risk of suicide.
- Media treatment of youth suicide, including:
  - The potential for media coverage of youth suicides to trigger further suicides among vulnerable and impulsive young people; and
  - The potentially intrusive and distressing nature of reporters' behaviour towards a grieving family whose child has suicided.
- The presence and role of bullying and cyber-bullying on youth suicide.
- The local post-vention response by:
  - The Department of Education and Early Childhood Development (DEECD), including [secondary school], and
  - [Local health unit]

Coronial recommendations

The coroner made the following recommendations related to this case:
• That the Department of Health together with Victoria Police, the Municipal Association of Victoria, the Royal Australian College of General Practitioners and the Chief Psychiatrist undertake a review of these reports and develop a policy framework that aligns, where appropriate, with the National Suicide Prevention Strategy.
Coronial recommendations: Fatal facts

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

An adult female died when they were assaulted by their ex-partner.

The ex-partner was on parole at the time of the assault. They had been admitted to hospital as an involuntary patient in the week prior to the incident.

Coronial findings

The coroner found that the death was due to assault.

The coroner found that Corrections Victoria did not possess any information to lead to the conclusion that the ex-partner posed a risk to the deceased.

The coroner found that significant steps had been taken to address the deficiencies identified in the parole system since the death.

Coronial recommendations

The coroner made the following recommendations related to this case:

- To ensure that the Adult Parole Board is provided with current and complete information regarding a parolee’s mental health status, I recommend that Corrections Victoria amend its prescribed circumstances (if not already amended), for Special Reports to the Adult Parole Board to include any psychiatric admissions or contact with an emergency department under the Mental Health Act 2014, and where known, any voluntary psychiatric admissions or contact with an emergency department for psychiatric issues.
Coronial recommendations: Fatal facts

**Case number**: VIC.2009.3458

**Primary category**: Intentional self-harm

**Additional categories**: Youth, Child and infant death

**Fatal facts edition**: 43 – cases closed between October and December 2014

**Case summary**

A female child took their life by hanging. Prior to the incident, the child was conversing online with a friend. The two had an argument and the child spoke to their parents about their desire to self-harm over the argument.

**Coronial findings**

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

The coroner found that the death of the child was primarily due to the recent argument.

The coroner sought assistance from the Coroners Prevention Unit (CPU) to investigate the increased number of suicidal deaths in persons under the age of 18 within the region.

The CPU review identified four factors that warranted further examination and / or input from external organisations:

- The presence and association between exposure to suicidal behaviour in the social network and an individual's risk of suicide.
- Media treatment of youth suicide, including:
  - The potential for media coverage of youth suicides to trigger further suicides among vulnerable and impulsive young people; and
  - The potentially intrusive and distressing nature of reporters' behaviour towards a grieving family whose child has suicided.
- The presence and role of bullying and cyber-bullying on youth suicide.
- The local post-vention response by:
  - The Department of Education and Early Childhood Development (DEECD), including [secondary school], and
  - [Local health unit]
Coronial recommendations

The coroner made the following recommendations related to this case:

• That the Department of Health together with Victoria Police, the Municipal Association of Victoria, the Royal Australian College of General Practitioners and the Chief Psychiatrist undertake a review of these reports and develop a policy framework that aligns, where appropriate, with the National Suicide Prevention Strategy.
Coronial Recommendations: Fatal Facts

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<td>Additional categories</td>
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<tr>
<td>Fatal facts edition</td>
<td>43 – cases closed between October and December 2014</td>
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Case summary

A female child took their own life by hanging. The child suffered from severe acne for which they received treatment by ingestion of oral isotretinoin.

Coronial findings

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

The coroner found that the child took their own life after they became depressed regarding their medical condition. The coroner concluded that the medication the child was taking for their medical condition could have exacerbated their depressive state.

The coroner sought assistance from the Coroners Prevention Unit (CPU) to investigate the increased number of suicidal deaths in persons under the age of 18 within the region.

The CPU review identified four factors that warranted further examination and / or input from external organisations:

- The presence and association between exposure to suicidal behaviour in the social network and an individual's risk of suicide.
- Media treatment of youth suicide, including:
  - The potential for media coverage of youth suicides to trigger further suicides among vulnerable and impulsive young people; and
  - The potentially intrusive and distressing nature of reporters' behaviour towards a grieving family whose child has suicided.
- The presence and role of bullying and cyber-bullying on youth suicide.
- The local post-vention response by:
  - The Department of Education and Early Childhood Development (DEECD), including [secondary school], and
  - [Local health unit].
Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Department of Health together with Victoria Police, the Municipal Association of Victoria, the Royal Australian College of General Practitioners and the Chief Psychiatrist undertake a review of these reports and develop a policy framework that aligns, where appropriate, with the National Suicide Prevention Strategy.
Coronial recommendations: Fatal facts

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<td>Youth</td>
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<td>Fatal facts edition</td>
<td>43 – cases closed between October and December 2014</td>
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Case summary

A young female took their own life by hanging. The young person was under the care of a psychologist at the time of their death.

They had a complicated medical history as a child and had an eating disorder with body image issues. The young person also had a history of major depressive disorder and suffered post-traumatic stress disorder. As a result, they suffered from recurrent nightmares, flashbacks and lowered mood. They were also subjected to bullying at school.

Coronial findings

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

The coroner sought assistance from the Coroners Prevention Unit (CPU) to investigate the increased number of suicidal deaths in persons under the age of 18 within the region.

The CPU review identified four factors that warranted further examination and / or input from external organisations:

- The presence and association between exposure to suicidal behaviour in the social network and an individual's risk of suicide.
- Media treatment of youth suicide, including:
  - The potential for media coverage of youth suicides to trigger further suicides among vulnerable and impulsive young people; and
  - The potentially intrusive and distressing nature of reporters' behaviour towards a grieving family whose child has suicided.
- The presence and role of bullying and cyber-bullying on youth suicide.
- The local post-vention response by:
  - The Department of Education and Early Childhood Development (DEECD), including [name] Secondary College, and
  - [Local health unit].
Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Department of Health together with Victoria Police, the Municipal Association of Victoria, the Royal Australian College of General Practitioners and the Chief Psychiatrist undertake a review of these reports and develop a policy framework that aligns, where appropriate, with the National Suicide Prevention Strategy.
Coronial recommendations: Fatal facts

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

A young male took their own life by hanging. They had an intellectual disability and received a disability support pension.

The young person had recently been transferred into a voluntary care facility. They were granted a period of leave, which was shortened to less than they had anticipated. They were later found to have passed away at their family home.

Coronial findings

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

The coroner found there were a number of administrative defects on behalf of the voluntary care facility and an inpatient psychiatric facility at which they had been treated. In addition, there were communication failures between these facilities, their staff, the adult and their carers.

Coronial recommendations

The coroner made the following recommendations related to this case:

- There needs to be mandated minimum requirements of documentation that must transfer with the patient to PARC [Prevention and Recovery Care] from an inpatient facility. There needs to be a policy formulated as to what this documentation needs to be. At a minimum it would be an expectation that the patient’s records from the previous 7 days (assuming they had been an inpatient for that long) would be made available. There should be minimal reliance on verbal handover of information.

- The [health care group] should prepare its own policy surrounding the decision making process of granting permission for a leave of absence from PARC. This policy should reflect, to the extent relevant, the considerations as outlined in the Chief Psychiatrists guidelines on Inpatient leave for voluntary and involuntary patients. The policy should emphasise the importance of decisions as to periods of absence being made with a full understanding of the patient's background and personal circumstances. The policy
should also ensure the patient and (where appropriate) the carer are consulted and involved in the discussion of any absences. In addition the patient and carer need to be provided with a fully informed explanation as to the reasoning behind the decision making process.

• The [health care group] needs to ensure that all policies that do exist are properly and fully explained to the staff. There needs to be regular and mandatory training of staff to ensure they are apprised of the Policies and how to implement them. The [health care group] should consider facilitating a fixed program regarding ongoing education of staff. Inclusive of this training, is not only a familiarisation with the internal policies of [health care group] by which they are governed, but also all of the Chief Psychiatrists guidelines that may have useful application to their care of patients.

• If not already in place there needs to be a clear chain of responsibility as to who is responsible for overseeing an internal review of a patient’s death.

• A Clinical team meeting should not discuss a patient unless the consultant psychiatrist has actually met with the patient and reviewed his or her file. This should be more readily achievable given the additional days of attendance of a consultant psychiatrist. This is particularly important as ultimately the decisions on leave and other management of a patient are the responsibility of the psychiatrist.
Coronial recommendations: Fatal facts

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<th>Case number</th>
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<tr>
<td>Fatal facts edition</td>
<td>43 – cases closed between October and December 2014</td>
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Case summary
A middle aged male took their own life by hanging. They had a long history of psychiatric illness. At the time of the incident, they were an involuntary patient and were granted escorted day release visits.

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

The coroner found that the clinic’s leave procedure was inadequate as were the communications of the clinic’s staff and leave escorts. The coroner found that the adult was effectively left without any escort for part of the leave, due to the clinic’s suboptimal practice and inadequate communications about escorted leave.

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

- That the [clinic] review its Client Leave Procedure to ensure that it complies with the Chief Psychiatrist's September 2009 Guideline on Inpatient Leave of Absence, with particular emphasis on the inclusion of requirements for communicating responsibilities to leave escorts and recording crisis information. I note that as at the time of inquest [...] the [clinic] had almost completed a significant revision of its leave policy and anticipated that the new policy would be finalised by the end of 2013.

- That the [clinic] review its Absconded Psychiatric Clients Protocol to ensure it contains a clear process and mandates a timely response to a patient’s failure to return from an approved leave of absence.

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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<th>Case number</th>
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<td>Child and infant death, Work related</td>
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<tr>
<td>Fatal facts edition</td>
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Case summary
A male child drowned after being submerged in a dam. They were on a school camp at the time of the incident.

The child was swimming in the dam with friends when they began to struggle in the water. The friends were unable to bring them ashore and they sank below the surface. The friends alerted supervising adults to the incident.

The adults entered the water and were unable to immediately locate the child. Their body was recovered some hours later.

Coronial findings
The coroner found that the death was unintentional.

It was noted that the students who were swimming were supervised, but not numerically counted or ticked off a list for identification before entering the water. There were no flotation devices or emergency equipment available.

The coroner found that the supervising adults were distracted and talking. They did not immediately understand the friends’ distress and did not comprehend the lethality of the incident as it occurred.

The coroner found that the response of the supervising adults was disorganised and sub-optimal. The coroner found that the school failed to undertake an appropriate assessment of the risk involved with swimming in the dam, and did not provide appropriate instruction for supervising the students or managing an emergency.

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

- I recommend to the National Catholic Education Commission, that if such has not already occurred, that all Victorian Catholic Schools voluntarily adopt the Department of Education and Early Childhood Development (DEECD) Guidelines protocol, concerning
the management of safety issues relating to all school student swimming and related water based sporting activity.

- I further recommend that the responsible Minister and the Victorian Regulation and Qualifications Authority (VRQA), give consideration to promoting the notion of a voluntary adoption of the DEECD protocols, by all Victorian Schools, this by the inclusion of same within the VRQA Guide, and in all other related VRQA materials.

- I recommend that at or near this time, (that is when full compliance is in reach for all non-government schools) that the VRQA consider making compliance a condition of registration, in respect of all schools in the State.

- I further recommend that [school] (and other similarly interested parties), purchase a defibrillator or defibrillators, and obtain instruction in their use, for deployment at all student camps, and at such other sporting activities as the School’s medical officer may advise.

- Having regard to the to the availability of first rate and cost effective safety equipment, in support of swimming, I further recommend that all Catholic Schools purchase and maintain appropriate levels of safety equipment as advised by Lifesaving Victoria, this through periodic requests for risk management advice emanating from the Catholic School Principals Association, to Lifesaving Victoria.

- I similarly recommend that all active "organisation" members of the Australian Camps Association, also purchase a defibrillator, and obtain instruction in its use.
Coronial recommendations: Fatal facts

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

A middle aged male died from natural causes.

The adult had recently been arrested and were being held at a police station. They were released from the police station only to be taken to hospital, where they subsequently passed away.

The adult spoke only broken English and suffered from a liver condition.

Coronial findings

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

The coroner found that the adult was not properly checked or monitored during their period of incarceration. No physical checks were conducted on the person while in custody, only closed caption television checks had been recorded. However, it was a requirement that severely intoxicated persons be viewed and found verbally responsive every half hour.

At no time during the adult’s arrest did they communicate that they were of ill health. They were interviewed though a slot in the door of their cell. During the interview with a police officer, an interpreter was present, the detainee requested to be taken to hospital both in English and their native language. They were witnessed to be writhing in pain on the floor.

The coroner found that the adult was not fit for interview at this stage and the manner with which the interview was conducted was not appropriate. The coroner found it should have been clear the adult required medical assistance.

Upon the adult’s release, the officer in charge offered no assistance when it was clear that they were in a considerable amount of pain and distress.

The coroner found that the death was not considered to have been a death in police custody. However, the conduct of some officers involved required review.
Coronial recommendations

The coroner made the following recommendations related to this case:

- In the absence of any suspicion as to possible criminal conduct and where practicable investigators should:
  - audio and visually record a ‘free narrative’ account of what happened by police involved in any incident involving a death associated with police contact as soon as possible after the incident has occurred.

- 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.
Coronial recommendations: Fatal facts

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

An adult male took their own life in a deliberate fall from height. They had a long history of mental illness and were undergoing treatment.

In the week prior to their death, they were a respondent in a family violence matter and were undergoing a separation from their partner. Family members had contacted police to arrange a mental health welfare check, however this was not communicated to the relevant mental health service and was not conducted.

At the time, the incident location did not have preventative barriers.

Coronial findings

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

The coroner found that access to the location, the adult’s psychiatric illness and their recent relationship separation were contributing factors in their decision to end their life.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I reiterate the recommendation made by [other coroner] made following [a death in similar circumstances]:
  - "That in the interests of prevention, VicRoads takes into account the risk of suicide when designing, modifying or upgrading any infrastructure, particularly bridges, that could be a possible site for jump from height suicide."
  - VicRoads responded positively to the recommendation, though it is not clear whether any action has been taken. An updated response is required in light of this finding.
- To improve the safety of patients referred to the [location mental health service], a process should be developed to formally re-contact Victoria Police after requesting a welfare check in response to a third party crisis referral. This should also include a formal communication of the referral and the outcome to the patient's general practitioner.
• In view of the recent contact [the deceased] and [the deceased’s partner] had with [location] Magistrates’ Court, I recommend that the Secretary to the Department of Justice extend the current respondent support worker program to the [location] Magistrates’ Court.

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Coronial recommendations: Fatal facts

Case number: VIC.2010.4243
Primary category: Adverse medical effects
Fatal facts edition: 43 – cases closed between October and December 2014

Case summary
An older adult female died after surgery due to complications arising from the surgery that were undiagnosed.

Coronial findings
The coroner found that the death was due to complications of medical or surgical care.
The coroner found there was a breakdown in communication between doctors over the care and treatment of the patient.

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

- To improve the safety of patients of healthcare organisations, I recommend that the Victorian Department of Health and the Australian Commission on Quality and Safety in Healthcare undertake action to raise the awareness of healthcare organisations of their responsibility to ensure quality documentation of patient care.
- To improve the safety of patients, I recommend that [health care provider] undertake action to raise the awareness of their practitioners and clinicians to their obligations to provide quality documentation of patient care, including documentation of clinical handover between shifts.
- That [health care provider], as part of their process for a patient whose death may be regarded as a coronial case, in that it appears to fulfil the criteria for a "reportable death" in Section 4 Coroners Act 2008, encourage staff at the first opportunity, to commit to writing a record of their involvement in the management of that patient that they can refer to throughout any internal and/or external investigation.

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Coronial recommendations: Fatal facts

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

A young female died following a fall down an apartment garbage chute. Their medical history included multiple mental health diagnoses alongside drug and alcohol misuse.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the young person climbed into the garbage chute while under the influence of alcohol and zolpidem (Stilnox), which had caused them to fall into a sleep-like state or become deeply confused and disorientated.

Coronial recommendations

The coroner made the following recommendations related to this case:

- Specifically, I recommend to the ATGA [Australian Therapeutic Goods Administration], that in accord with current United States FDA [Food and Drug Administration] requirements, that the dosage of Stilnox, recommended for administration to female patients be reduced by 50%.
- I further recommend that henceforward only 5 mg tablets, rather than the scored 10mg tablets currently in use, become the tablet size permitted to be supplied to all users in Australia. To elaborate, that one tablet size only, should be made available to both male and female patients, (and should not continue to be offered as a 10mg tablet, which can be divided into equal parts).

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

Case number: VIC.2011.4783
Primary category: Drugs and alcohol
Fatal facts edition: 43 – cases closed between October and December 2014

Case summary
A middle aged female died due to mixed drug toxicity. They had a complex mental health history and were medication-dependent. They had attended multiple medical practitioners and were repeatedly prescribed the same medications from each practitioner.

Coronial findings
The coroner found that the death was unintentional. The practitioners were aware of the "doctor shopping", but their communication was restricted by privacy regulations.

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

- I recommend that the Victorian Department of Health progress the implementation of a Victorian-based real-time prescription monitoring system as a matter of urgency to prevent ongoing harms and deaths associated with pharmaceutical drug misuse and inappropriate prescribing and dispensing of pharmaceutical drugs.
- I recommend that while the Victorian Department of Health continues with its efforts to implement a real-time prescription monitoring program for Schedule 8 drug dispensing, it also identifies the legislative and regulatory barriers that might prevent drugs listed in other schedules (particularly Schedule 4) from being monitored within the scope of the program. If any such barriers are identified, I recommend that the department then considers what reforms are necessary so that in due course its real-time prescription monitoring program can be expanded beyond Schedule 8 drugs. This will enhance clinicians' ability to make appropriate clinical decisions about patients.
- I recommend that the Victorian Department of Health consider meeting with private health information technology developers and vendors to discuss and, if appropriate, address the legislative and regulatory barriers that might prevent private companies providing real-time prescription monitoring capacity through their products and services.

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Coronial recommendations: Fatal facts

**Case number**: VIC.2011.1474  
**Primary category**: Adverse medical effects  
**Additional categories**: Child and infant death  
**Fatal facts edition**: 43 – cases closed between October and December 2014

**Case summary**
A male child died from a serious infection that was not detected in a timely manner. The child was otherwise well until a few days before their death.

**Coronial findings**
The coroner found that the death was due to complications of medical or surgical care. The coroner found that the death of the child was unexpected and avoidable. If the child had have received antibiotics sooner, they would not have passed away. The coroner also found the tardiness in communication between pathology and the hospital to be an issue. This was in part due to the nationwide public holiday that occurred whilst the child was in hospital awaiting test results.

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

- That there be clearer protocols between the hospital and [pathology service] so that information is readily available to inform hospital staff in relation to the following:
  - The hours of operation over public holidays and weekends.
  - The name and contact details of the on-call scientist for urgent blood results on evenings, weekends and public holidays.
- That [pathology service] should inform [hospital], via the on-call physician liaison officer with the laboratory, if a coagulase test is to be commenced less than two hours before staff leave in order that a decision might be made by clinical staff as to whether they require the attendance of the on-call scientist to read the results at the 2 hour, 4 hour intervals. Similarly, the same should apply if the 2 hour result is known but the laboratory will be closed when the four hourly interval result is to be known. It would be expected that that physician should then pass on that information to the treating team.

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Coronial recommendations: Fatal facts

Case number | VIC.2011.1553  
Primary category | Law enforcement  
Additional categories | Weapon  
Fatal facts edition | 43 – cases closed between October and December 2014

Case summary
An adult male died from firearm-related injuries sustained in an altercation with police. The adult had previously been in prison.

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

The coroner found that the gunshot wounds were inflicted as an act of self defence and/or defence of a colleague on behalf of the police officers. At the time of the incident, the adult was brandishing a knife an intending to do harm to a police officer.

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

- That the Chief Commissioner of Police consider utilising the circumstances surrounding [this death] as a basis for a Operational Safety Training Tactics training scenario to further reinforce and focus the importance of planning at the operational level.
- Bereaved family members and the community are entitled to expect that the investigation conducted in relation to 'police contact deaths' will be transparent, accountable and thorough. In this case, the account given by [police officer] in [their] written statement lacked critical details which were only revealed during the inquest. There is no doubt that assumptions were made regarding what occurred at the [location] engagement based on his written statement. The OPI [Office of Police Integrity] suggested in the Review of the investigative process following a death associated with police contact […]:

In the absence of any suspicion as to possible criminal conduct and where practicable investigators should audio and visually record a 'free narrative' account of what happened by police involved in any incident involving a death associated with police contact as soon as possible after the incident has occurred.
I am of the view that this approach would have strengthened the investigative process in this case and consequently I recommend its adoption.

- In addition, in the finding into the [another death], [another coroner] adopted a recommendation made by then [State Coroner] in [a separate 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".

I note that this recommendation has not been implemented at the date of this finding.

- I add my voice to [other coroner's] proposal and the suggestion of the OPI and adopt both these as recommendations.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2011.1986</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Child and infant death</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>43 – cases closed between October and December 2014</td>
</tr>
</tbody>
</table>

Case summary

An infant died from sudden infant death syndrome (SIDS) in a sleeping environment that could be considered unsafe and did not follow SIDS guidelines.

Coronial findings

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

The coroner found that the infant child was sleeping in a portable cot. Inside the portable cot was a couch cushion to make the bedding soft. The child was put to sleep on their stomach with their head tiled to one side.

SIDS guidelines do not recommend the use of soft bedding in a potable cot and do not recommend a child be placed to sleep on their stomach.

The coroner found that over the course of the child’s short life, the parent had been shown and instructed on the SIDS guidelines twice by a maternal and child health nurse, however this was very early on in the child’s life.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That maternal and child care nurses address the issue of safe sleeping, including the transition to different sleeping environments, at every ‘Key Ages and Stages’ appointment with infant's caregiver.
- That maternal and child care nurses continue to educate caregivers about the suffocation dangers of using extra mattresses or padding in portable cots.
- That the Australian Competition and Consumer Commission include a mandatory warning on all portable cots that they should only be used for temporary use only and are not suitable for long term or permanent sleeping arrangements.

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Coronial recommendations: Fatal facts

Case number: VIC.2012.365
Primary category: Drugs and alcohol
Fatal facts edition: 43 – cases closed between October and December 2014

Case summary
An adult male died as a result of complications of prescription drug use. They had a history of multiple co-morbidities, drug dependency and mental health issues. The adult regularly saw two doctors, who prescribed multiple medications.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the adult’s two treating doctors were unaware of each other’s role in treating the deceased, and that, unknown to them, the deceased was taking a combination of benzodiazepines and methadone. The coroner found the current prescribing system to be reliant on patients communicating changes in their medication to doctors.

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

- As a matter of urgency, the Victorian Department of Health must implement a real-time prescription monitoring system that records information on dispensing of all Schedule 8 drugs and all Schedule 4 drugs of dependence in Victoria and makes this information available to all Victorian pharmaceutical drug prescribers and dispensers, so they can use the information to inform their clinical practice and reduce the harms and deaths associated with pharmaceutical drugs.
- That the Victorian Department of Health seek advice from the Advisory Group for Drugs of Dependence, regarding whether guidance should be produced to assist doctors who treat ORT [opioid replacement therapy] clients for conditions other than opioid dependence. Particular areas of guidance might include how and when to communicate with the patient’s ORT provider, pharmaceutical drugs that can interact with the drugs prescribed in ORT, and warning signs that the patient might be becoming unstable in ORT (and what to do if these warning signs are identified).

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2012.2142</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Intentional self-harm</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Mental illness and health</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>43 – cases closed between October and December 2014</td>
</tr>
</tbody>
</table>

Case summary

An adult male took their own life in a deliberate fall from height.

The evening before the incident, they had been taken to hospital after contacting police advising of psychosis. On this occasion, they left the hospital before seeking treatment.

A few hours after leaving hospital, they were found delusional and suicidal by police. They were arrested under the Mental Health Act 1986 and taken to hospital. Again, the adult left hospital without treatment.

Coronial findings

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

After being triaged on the first occasion, the patient was left without a support person in the emergency department of the hospital. They were unable to be located by psychiatric triage staff. No follow up was conducted. The coroner found this was a missed opportunity to offer the patient much needed help.

On the second presentation to hospital, under police arrest, the patient was not triaged as a suicide risk despite being arrested by police under the Mental Health Act 1986. The coroner found that the patient was assessed by an experienced psychiatric nurse who believed the patient would be willing to comply with help and wanted to remain in hospital to receive help. The patient was taken outside for fresh air prior to being allocated a bed. It was at this time that the patient left the hospital untreated.

They were subsequently located in a car park. Police were called in for negotiations, however these negotiations were unsuccessful.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That [hospital] review, or continue to review, relevant procedures and protocols to ensure that it is clear to hospital staff that they need to ensure that persons presenting on their
own in relation to mental health issues are given every reasonable opportunity to ensure that someone they trust is contacted to be with them while they are waiting to be assessed, and if necessary, are assisted in making the contact.

• That the Department of Health commission a review, in conjunction with [relevant hospitals] of the systems of communication between service providers (Emergency Departments) for the purposes of providing early communication and notification between Emergency Departments about patients who have attended an Emergency Department seeking or requiring mental health treatment or advice, but who leave that Emergency Department without being seen by a relevant medical practitioner. In short, I recommend a consideration of what aspects of the Redevelopment of Acute and Psychiatric Information Directions (RAPID) (or other) communication system could be improved by creating a notification system between Emergency Departments.
Coronial recommendations: Fatal facts

Case number: VIC.2013.2359

Primary category: Location

Fatal facts edition: 43 – cases closed between October and December 2014

Case summary
A young male died when the vehicle they were driving was struck by a falling tree. They died at the scene.

Coronial findings
The coroner found that the death was unintentional.

An inspection of the tree revealed the stem had extensive termite damage and rot decay, which caused the failure of the stem on the day of the incident. The arborist who performed the inspection formed the opinion that the damage to the tree was not able to be identified without an extensive investigation.

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

- That the Council consider sending information about tree safety and reporting risky trees to rate payers with the annual rates notices.
- That the Council continue their engagement with the community on the issue of tree safety and further consider the possibility of more advertising on local radio stations.
- That the Council continue to consider options in relation to their website for reporting trees in order to make it more accessible and informative for the public.
- That, as part of the Council’s the review of the Tree Management plan, they consider simplifying parts of the plan to make them more accessible and readable.
- That the Council consider the possibility of placing advertising on their tree maintenance vehicles, this to inform the public about the work being undertaken and possible Council contact, if they have concerns about the health of a particular tree.

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Coronial recommendations: Fatal facts

Case number | VIC.2013.2556
Primary category | Drugs and alcohol
Additional categories | Adverse medical effects
Fatal facts edition | 43 – cases closed between October and December 2014

Case summary
An older male died due to complications of chronic lithium therapy.

The adult had an intellectual disability and resided in a care facility. They suffered from multiple mental illnesses and were prescribed lithium as a result. The adult was admitted to hospital with a high lithium level. Their condition deteriorated, and they were transferred to another hospital, where they were subsequently palliated until their death.

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

The coroner found there were deficiencies in recognising the association between the deceased’s worsening health and lithium toxicity.

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

- I recommend that the Therapeutic Goods Authority (TGA) issue an alert to prescribers to exercise caution when prescribing lithium over the long term for ageing patients and patients with medical comorbidities. In particular the alert should draw prescribers’ attention to the increased risk of toxicity in patients who take the drug long-term, and the possibility that even when target serum concentration of lithium is within recommended parameters, clinical presentation changes (including but not limited to the recognised signs and symptoms of lithium toxicity) may indicate lithium toxicity.

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Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2013.4466</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Water related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>43 – cases closed between October and December 2014</td>
</tr>
</tbody>
</table>

Case summary

A young male drowned in the ocean when they were knocked from rocks into the sea.

Coronial findings

The coroner found that the death was unintentional.

The beach was known to have a highly hazardous rating due to strong rips and undertows. The beach was acknowledged to have the capacity to change from seemingly calm to extremely hazardous in a short time, particularly with the rise of the tide.

The coroner found that the area where the accident occurred was inherently dangerous, with sudden changes in tide making the area treacherous. There were no warning signs at the entrance of the beach to warn of the extreme dangers which could arise at short notice, especially in the rocky areas beneath the cliffs.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend the immediate installation of clear signs, explaining in simplistic language, the dangers of the region and the possibility of quick changes in the sea from conditions of relative calm to those of extreme danger.

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Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2013.4527</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Transport and traffic related</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Older persons, Falls</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>43 – cases closed between October and December 2014</td>
</tr>
</tbody>
</table>

Case summary

An older female died in a vehicle incident in which they were a pedestrian.

They were attempting to cross a road using a walking frame. They became entangled in their walking frame and fell onto the roadway. They were struck by a vehicle that did not see them lying on the road.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the vehicle had a large forward blind spot. The older person was in the vehicle’s blind spot at the time of the incident.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Department of Infrastructure and Regional Development give consideration to amending the Australian Design Rules to require all new medium to large sized vehicles, including Sports Utility Vehicles and Four Wheel Drives, to have forward looking cameras to counteract the forward vision blind spot areas on these vehicles.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2013.4843</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Transport and traffic related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>43 – cases closed between October and December 2014</td>
</tr>
</tbody>
</table>

Case summary

A middle aged male died in a vehicle incident in which they were a motorcyclist.

The adult was riding their motorcycle downhill and lost control while negotiating a bend in the road. They braked heavily and were thrown off the motorcycle and into the path of an oncoming vehicle.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that they miscalculated the apex of the bend, and were riding too fast to successfully negotiate the bend.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That VicRoads erect a sign before the bend between the [distance] posts to warn vehicles travelling down [road] in a westerly direction of the severity of the bend. This should include a speed advisory sign to allow motorists to safely negotiate the bend. This sign should complement the ‘Slippery when wet’ sign and the two chevrons indicating a left bend which already exist at the site.
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.2013.5088, VIC.2013.5089</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Transport and traffic related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>43 – cases closed between October and December 2014</td>
</tr>
</tbody>
</table>

Case summary

An older male and older female died in a vehicle incident when they drove into the path of a second vehicle on a freeway.

They were attempting to enter a crossover point on the median strip to travel in the opposite direction.

Coronial findings

The coroner found that the deaths were unintentional.

The coroner found that the driver of the second vehicle did not have time to brake or take evasive action to avoid the collision.

Coronial recommendations

The coroner made the following recommendations related to these cases:

- I recommend that earnest consideration be given to the closing of the median "strip crossovers" on the [freeway] at [five locations].

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Western Australia

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

Case number
WA.2010.888

Primary category
Natural cause death

Additional categories
Indigenous, Child and infant death

Fatal facts edition
43 – cases closed between October and December 2014

Case summary
A male infant died as a result of meningitis following an infection.

The child had been admitted to hospital following a bout of illness and was prescribed antibiotics upon discharge. The underlying condition that caused their illness was not diagnosed. Several weeks later, the mother and child went to visit relatives in a remote area. They were attended by a government crisis care team and the child was found unresponsive. Despite being conveyed to hospital, the child did not recover.

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

The coroner raised a number of concerns at inquest regarding the care of the deceased, particularly the sharing of information regarding their medical history between the Department for Child Protection and Family Support (the Department) and health services.

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

- I recommend continued resourcing of AACC [Aboriginal Ambulatory Care Coordination] outreach program and its expansion to all regions in Western Australia. It is of critical importance to the provision of a future for Aboriginal children.
- I recommend the Department trial a practice requiring all mothers subject to the Department’s pre-birth planning processes to nominate a GP [general practitioner] (or appropriate alternative) for the child for follow up purposes after birth.
- I recommend WACHS [Western Australian Country Health Service] ensure the nominated GP both receives, understands and is supported for the implementation of follow up information and care.
- I recommend WACHS continue to progress the implementation of clinical information sharing systems to facilitate the sharing of patient information across the [region], such as the Communicare system.
I recommend the Department and WACHS work together to clarify the need to provide relevant health care information to the Department for children not “in care” but with families unlikely to understand the significance of complex medical information and needing assistance with complying with medical recommendations.
## 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>
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</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>