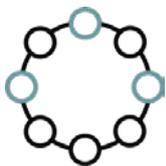




Coronial recommendations: Fatal facts

A summary of cases and recommendations made
between January and March 2015

Edition 44



NATIONAL CORONIAL INFORMATION SYSTEM

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Coroners Court
of Victoria



QUEENSLAND
COURTS



CORONIAL SERVICES
OF NEW ZEALAND
Parangō Ō te Āh Kōwhiri



Coroner's Court
of New South Wales



Coroners Court of
Western Australia



MAGISTRATES COURT
OF THE AUSTRALIAN CAPITAL TERRITORY



MAGISTRATES COURT of TASMANIA
CORONIAL DIVISION



NORTHERN TERRITORY OF AUSTRALIA
Office of the Coroner



Courts Administration Authority
of South Australia

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CORONERS' RECOMMENDATIONS

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

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

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

Coronial recommendations: Fatal facts includes case summaries and recommendations for cases closed between January and March 2015.

Previous summaries and recommendations are available

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

AUSTRALIAN CAPITAL TERRITORY CASES

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

Coronial recommendations: Fatal facts

Case number	ACT.2014.38
Primary category	Natural cause death
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

An adult female died from complications associated with diabetes mellitus.

The adult was unwell at home and an ambulance was called. They were conveyed to hospital where they subsequently passed away.

Coronial findings

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

The coroner found that the ambulance was called to the adult’s house, however the ambulance service communication clinician assigned the priority incorrectly. As a result, there was a delay in the adult being attended by paramedics, which consequently led to delays in their arrival to hospital.

The coroner found that the adult would have had a better chance of survival if they had reached the hospital sooner.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the recommendations in the Level B Case Review dated 18 September 2014 conducted by Australian Capital Territory Ambulance Service be implemented.

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.

NEW SOUTH WALES

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

Coronial recommendations: Fatal facts

Case number	NSW.2009.2642
Primary category	Homicide and assault
Additional categories	Child and infant death
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

An infant died from injuries sustained in an assault.

The infant was born prematurely and had been unwell for a few days prior to death. An ambulance was called for the infant due to an incident in which they became unresponsive. The infant was conveyed to hospital where they subsequently passed away.

Coronial findings

The coroner found that the death was due to assault.

The coroner found that previous injuries sustained by the infant were consistent with having been handled aggressively. The new injuries were likewise consistent with being treated with aggressive force. The coroner found that infant’s prematurity appeared to have masked their traumatic injuries.

Whilst in hospital, the infant underwent an x-ray, and the old and new skeletal injuries were identified. However, the police were not contacted, nor was a report made for DOCs (Department of Community Services) Helpline. Police were only alerted to the potential of non-accidental injuries several hours after the initial x-ray. The delay in contacting the police allowed time for the scene of the incident to be cleaned and thereby evidence destroyed.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Commissioner of Police and the Ministry of Health consider the feasibility of whether there should be an automatic requirement for police to attend premises where NSW [New South Wales] Ambulance Service officers are called to attend to a child in circumstances where that child requires resuscitation.
- That the Commissioner of Police and the Ministry for Family and Community Services (FaCS) consider whether the screening and response priority tool (SCRPT) utilised by the FaCS Child Protection Helpline should include questions whereby the mandatory reporter is asked whether Police have been called or should be called.

- That the Commissioner of Police and the Department of Family and Community Services and the Ministry of Health consider whether the Child Protection Mandatory Reporters Guide should include a decision tree whereby mandatory reporters are advised to report a matter to the police where they suspect a criminal offence against a child has been committed.
- That the attention of the Attorney General be drawn to the findings in this matter for consideration as to whether an offence and relevant criminal procedure provisions should be enacted further to the discussion in the NSW Parliamentary Research Service e-brief 12/2014 "Criminal liability of carers in cases of non-accidental death or serious injury of children"

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	The coroner held a joint investigation into the following deaths which resulted from the same incident: NSW.2011.4947, NSW.2011.4948, NSW.2011.4949, NSW.2011.4950, NSW.2011.4951, NSW.2011.4952, NSW.2011.4960, NSW.2011.4961, NSW.2011.4978, NSW.2011.5029, NSW.2011.5086, NSW.2011.5227, NSW.2011.5384 NSW.2012.907
Primary category	Fire related
Additional categories	Aged care, Older persons, Drugs and alcohol
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

Fourteen older adults died following a fire in an aged care facility.

All of the adults were elderly people who required high levels of care due to their advanced ages and ill-health. All of the adults passed away during or in a period soon after the fire.

Coronial findings

The coroner found that the fire had been deliberately lit by a staff member at the facility, however the deaths were unintended.

The staff member had been employed without adequate background checks. They had a history of drug addiction, and lit the fire in order to conceal evidence of theft from the facility.

A number of design features were identified within the facility that hindered the evacuation from and response to the fire. In addition, there were deficiencies in staff members' response to the incident.

Coronial recommendations

The coroner made the following recommendations related to these cases:

To the Minister for Emergency Services and the Commissioner for Fire and Rescue NSW:

- That the NSW government provide funding for the instalment of mobile data terminals in Fire and Rescue NSW vehicles;
- That Fire and Rescue NSW develop a digital database of pre-incident plans for use in major structural fires;
- That Fire and Rescue NSW develop and disseminate a 'lessons learned' e-learning package to all staff with particular emphasis on issues that arose in relation to the [nursing home] fire. Topics of high significance would include urgent escalation of the

alarm level for structure fires involving building occupied by large numbers of people; rescue techniques, especially the rescue of non-ambulant patients and patients attached to medical equipment; and management of hose lines jammed in fire doors.

- That Fire and Rescue NSW and the Department of Planning work together to address the issue of hose lines becoming jammed in fire doors;
- That, pending the results of any such consultation, Fire and Rescue NSW consider either issuing fire fighters with blocks or wedges to enable them to advance lines without undue hindrance or, alternatively, that, if resources and circumstances allow, whenever a hose line is being advanced, a fire fighter be tasked to keep advancing lines free until he or she is no longer required for that purpose;
- That Fire and Rescue NSW (FRNSW) consider issuing a bulletin to all aged care and other types of residential facilities in NSW identifying the difficulties encountered by fire fighters at the [nursing home] fire and the lessons learned. In particular, emphasis might be laid on:
 - The urgent necessity for at least one '000' (and preferably more than one) call to be made by staff following a fire alarm to give FRNSW time to 'scramble' appropriate resources to attend the fire;
 - That staff cross-check with one another to ensure that a '000' call has been made and to make one if unsure;
 - That staff members remove patients or residents then close ward doors and other fire doors as quickly as possible to confine fires within fire compartments;
 - That removal of non-ambulant patients and residents should, if reasonably practicable, be done by wheeling them out of danger in beds or wheelchairs but that alternative dragging methods may need to be employed;
 - That if patients are wheeled out of their wards or rooms efficiently, passage ways must be kept as clear as is reasonably practicable;
 - That the facility's fire evacuation plan takes into account potential impediments to rescuing non-ambulant patients, such as connection to medical equipment, and makes specific provision for addressing those challenges in an emergency;
 - That fire exits and other doors be kept clear of obstructions that could hinder urgent movement of non-ambulant patients in the case of sudden emergency;
 - That facilities include in their fire and emergency training regular scenario-based practical training including practice of the urgent removal of non-ambulant patients and residents.

To the Commonwealth and New South Wales Ministers for Health and the Chief Executive Officer of the Australian Health Practitioner Regulation Agency:

- That Australian Health Practitioner Regulation Agency (AHPRA) consider requiring employers to notify it when a health professional falling under the agency's jurisdiction commences work and when he or she leaves that employment. I recommend that any

regulatory changes necessary to implement such a practice be given urgent consideration;

- That AHPRA consider including employment details in its registration data base. Those details might include name and contact details of the employer; period of employment; and any notifications made to AHPRA concerning the employee. I recommend that any regulatory changes necessary to implement such a practice be given urgent consideration.

To the Commonwealth Minister Social Services and the NSW Minister for Ageing:

- That the Commonwealth Department of Social Services and the NSW Department of Aged Care, Disability and Home Care, in consultation with peak industry bodies such as Aged and Community Services Australia Inc, consider publishing in their media outlets directed towards services providing residential care a 'lessons learned' case study document dealing, in particular, with the issues of signs of drug-dependency among nursing staff and other health professionals; mandatory reporting requirements; scrutiny of employment records in which large gaps appear; security of Schedule 8 drugs; and emergency evacuation training.

To the NSW Ministers for Emergency Services and Planning and the Commissioner for NSW Fire and Rescue NSW:

- That Fire and Rescue NSW consult as to the best and most practical means for ensuring that in a structural fire, Fire and Rescue's hose lines can be advanced beyond fire doors without either jeopardising the integrity of fire compartments or jamming hose lines.

To the NSW Minister for Health:

- That the Minister refer this case to the Poisons Advisory Committee to consider whether regulations under the Poisons and Therapeutic Goods Regulation 2008 should be amended to improve security of Schedule 8 drugs in nursing homes and similar facilities;
- That the Minister consider requiring nursing homes by regulation to use identification armbands on all patients at all times unless there are overriding medical reasons not to do so.

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Coronial recommendations: Fatal facts

Case number	NSW.2011.2715
Primary category	Adverse medical effects
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

A middle aged male died from a brain injury due to the incorrect placement of a central venous line while in hospital.

The adult was in poor health due to long-term alcohol and nicotine use and had recently undergone a surgical procedure.

Coronial findings

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

The coroner found that the adult had a central venous line incorrectly inserted by hospital staff following surgery, which ultimately resulted in their death. The error was not detected until many hours after insertion.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the [Local Health District] introduce a policy mandating that practitioners confirm venous placement of Central Lines consistent with the Medical Quality Committee advice to [hospital] on 1 December 2011 and the NSW Health Policy Directive PD2011_060.

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Coronial recommendations: Fatal facts

Case number	NSW.2012.985
Primary category	Intentional self-harm
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

An adult male took their own life with a firearm.

The adult had significant debt due to gambling and lack of income from unemployment. At the time of the incident, they had taken a hostage in a residential location. The adult was found deceased by attending police.

Coronial findings

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

The residence where the incident occurred was known to the adult. They had approached this house in order to obtain money from its occupants.

A relative of the occupants had recently received threatening text messages in relation to business dealing that had failed. Police were unable to identify the person responsible as they had obtained the SIM card used to send those messages under a false name and address.

Coronial recommendations

The coroner made the following recommendations related to this case:

To: The Minister of the Commonwealth of Australia responsible for the administration of the Telecommunications Act 1997 (Commonwealth) or other relevant legislation:

- That the Government give consideration to requiring that, before a person is able to purchase a SIM card for use in a mobile telephone or other similar device, that person establish their identity by the provision to an appropriate authority of evidence in a similar manner to that required when opening an account with a bank or other financial institution.

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Coronial recommendations: Fatal facts

Case number	NSW.2012.5174
Primary category	Intentional self-harm
Additional categories	Youth
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

A young female took their own life in a train incident.

The young person had recently experienced a relationship breakdown with a fellow student, following which that student attempted to take their own life. The young person was also experiencing an episode of family disharmony.

The young person had previously tried to take their own life on a number of occasions. They sought fairly regular, and at times, intensive care and treatment for mental health issues.

Coronial findings

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

The coroner found that the young person died a short time after being released into parental care following an attempt on their own life. This was the third such attempt in a few months. Following the attempts, the young person had been voluntarily admitted into the mental health ward of a hospital.

After being released into the care of the parents, the parents called the hospital and requested the young person be returned to hospital. However, they were advised to remain at home and not return to hospital. The young person subsequently left the family home without their parents' knowledge.

The coroner found that the care and treatment of the young person at each hospital visit was appropriate and that the circumstances in which they took their own life could not have been foreseen.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the Chief Executive of the [Local Health District]:

- That consideration be given to clarifying the term of “adolescent” in the [mental health facility] Referral Package to reflect the existing discretion to admit patients at or under the age of 18 years who otherwise meet the admission criteria to that Unit.

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Coronial recommendations: Fatal facts

Case number	NSW.2013.709
Primary category	Natural cause death
Additional categories	Youth, Sports related
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

A young male passed away suddenly from natural causes.

At the time of death, they were participating in a martial arts training session. The young person was severely over weight and suffered from a genetic heart condition known to cause sudden and unexpected cardiac arrest in young persons, especially under the stress of intense physical exercise.

Coronial findings

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

The coroner found that people who suffer from this type of genetic heart condition are advised to lead a sedentary life style or participate only in light physical activity.

At the time of the incident, the young person had been advised by their practitioner to abstain from physical activity until consultation with an expert cardiologist. The practitioner did not supply a medical clearance certificate for the young person to participate in physical activity.

A couple of days before death, the young person attended and joined a mixed martial arts gym. They disclosed the heart condition on their application forms, and a medical certificate was not requested by the gym.

The coroner found it likely that the young person did not appreciate the delicate nature of their condition and unknowingly and inadvertently place themselves at risk.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend to the Minister for Fair Trading that, if this has not already been done, [they] consider liaising with Fitness Australia to develop, implement and reinforce a code of conduct for the fitness industry in NSW [New South Wales] that would include the following recommendation.

- I recommend that Fitness Australia consider including in the National Fitness Industry Code of Practice it is currently developing or, if more appropriate, its guidelines for pre-exercise risk assessment and management, a guideline to the following effect:

If a prospective client is assessed under its pre-exercise screening tool as being at significant risk, the client should be referred to his or her medical practitioner(s) for clearance to undertake the proposed fitness program. The client should not be accepted into the program unless written clearance is received from the client's doctor to do so.

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Coronial recommendations: Fatal facts

Case number	NSW.2013.4060
Primary category	Transport and traffic related
Additional categories	Child and infant death
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

A male child was fatally injured in a motor vehicle collision. The child was riding a motorised bicycle at the time of the incident, and was attempting to evade police.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the police were not responsible for the incident. Rather, the child had acknowledged the police officers' presence and continued to ride away at speed.

The child had purchased the bicycle from a friend. The friend had purchased a kit used to convert the pedal powered bicycle to a motorised bicycle. The bicycle did not have the required safety features.

Coronial recommendations

The coroner made the following recommendations related to this case:

To: The Minister of the Commonwealth of Australian responsible for the administration of Part 3-3 of Schedule 2 to the *Competition and Consumer Act 2010*.

- That having regard to the inherent dangers associated with the use of motorised bicycles consideration be given to the banning, under Australian Consumer Protection Law, such equipment and products designed to enable the conversion of pedal powered bicycles into motorised bicycles.

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Coronial recommendations: Fatal facts

Case number	NSW.2013.4653
Primary category	Transport and traffic related
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

A young male died due to injuries sustained in a motor vehicle incident.

The vehicle they were driving collided with an oncoming vehicle.

Coronial findings

The coroner found that the death was unintentional.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the Roads and Maritime Service review the speed limit for the 80 kilometre per hour speed limit section of [road], and consideration be given in any such review to a wet weather variable speed limit. I further recommend that the Roads and Maritime Service undertake a Safety Audit for that part of [road] north of [location] to the beginning of the 80 kilometre per hour speed zone.

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Coronial recommendations: Fatal facts

Case number	NSW.2013.4871
Primary category	Misadventure
Additional categories	Transport and traffic related, Drugs and alcohol
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

An adult male suffered the fatal injuries when they were struck by a train.

The adult had boarded a train home while severely intoxicated. For unknown reasons, the adult disembarked at a train station several stops before their intended stop. They walked onto the rail corridor and were struck by a passing train.

Coronial findings

The coroner found that the death was unintentional.

Police had been notified that an urgent response was required due to a trespasser on the tracks. The Security Control Centre Operator, Train Controller and Security Monitoring Facility were also notified.

The police radio officer who received the 000 call also notified the Security Control Centre Operator.

The coroner found that there was miscommunication between [train operator] staff and 000 call operators which resulted in alternate action taken to the trespasser on the tracks.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that [train operator] develops a comprehensive policy instructing its staff on what issues they should consider and what criteria they should apply when determining how to respond to these incidents.

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	NSW.2013.5212
Primary category	Homicide and assault
Additional categories	Law enforcement
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

A middle aged male went missing and was subsequently presumed deceased.

Coronial findings

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

Coronial recommendations

The coroner made the following recommendations related to this case:

To the Commissioner of Police:

- That the circumstances of the death of [the deceased] be referred to the Unsolved Homicide Division of the NSW [New South Wales] Police Force for further investigation in accordance with the procedures of that Division.

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Coronial recommendations: Fatal facts

Case number	NSW.2014.3205
Primary category	Water related
Additional categories	Weather related, Leisure activity
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

A young male was presumed to have drowned at a beach. They were a tourist from outside Australia.

The young person and two friends proceeded to the beach to surf. Not long after entering the water, the group got into difficulty due to the large swells. The young person was seen to go under the water. They did not resurface.

Emergency services were called and surf life savers responded but had to withdraw due to the terrible sea conditions. The search was recommenced the following day, however it was again discontinued due to the hazardous conditions.

Coronial findings

The coroner found that the death was unintentional.

At the time of the incident, the beach was not monitored by Surf Life Saving Australia (SLSA). There were warning signs at the entrance of the beach indicating as such.

The signage was static and did not reflect the sea conditions at the time, rather a general guide to beach goers of the potential dangers.

Gale force winds and increasing sea heights were predicted for the day of the incident. A hazardous and dangerous surf conditions warning was broadcast on local television and radio that morning.

The friends of the young person confirmed that they had not heard the broadcast warnings on the radio that morning as they were not accustomed to Australian broadcasting. In addition, they ignored the signs at the beach entrance, as one of the friends had previously been to the beach and known it to be calm.

Coronial recommendations

The coroner made the following recommendations related to this case:

- Accommodation providers to communicate warnings
 - Accommodation providers are better placed than news media to communicate relevant weather warnings to their guests. [Police] meet bi-annually with many of the budget accommodation providers who cater to the backpacker market. I recommend that the NSWPF [New South Wales Police Force] Local Area Command instruct the officer attending that meeting to regularly encourage all accommodation providers to institute a system for bringing weather alerts and warnings to the attention of their guests.
- Real time signs
 - [The deceased's] friends acknowledged there were signs warning of the absence of life saving services and the presence of hazardous conditions at [beach] but they ignored them because the signs did not reflect contemporary conditions and were incongruent with the conditions experienced at the beach a few days before. In my view, to be credible, such signs need to reflect current conditions. Accordingly, I recommend [council] consider installing signs that are updated daily with current information about the surf conditions.

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NORTHERN TERRITORY

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

Coronial recommendations: Fatal facts

Case number	NT.2011.100
Primary category	Transport and traffic related
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

An adult male died when they were struck by a motor vehicle whilst walking alongside a roadway.

The driver of the vehicle that struck the adult was intoxicated at the time of the accident.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the incident took place on a stretch of road with no street lighting. The young person was dressed in dark clothing. Given the time of the incident, the young person would have been difficult to see.

Due to their intoxication, the driver of the vehicle was travelling in the auxiliary lane in which the adult was walking.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the [local council]

- That the [local council] conduct an urgent review of the section of [road] from 100 metres west of [road] to 80 metres east of [place] (1.6 kilometres) with a view to making the purpose of the auxiliary traffic lane identifiable and to considering street lighting.

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Coronial recommendations: Fatal facts

Case number	NT.2014.7
Primary category	Natural cause death
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

An older adult female passed away from natural causes associated with heavy, long-term smoking.

Coronial findings

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

The coroner found that the adult had held a conversation with their medical practitioner years before their death about not wishing to receive invasive interventions should their condition become life-threatening. At the peak of the adult’s deterioration, their wishes were not discussed or followed up.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Department of Health give consideration to implementing an advance care program similar to ‘Respecting Patient Choices®’.

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QUEENSLAND

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

Coronial recommendations: Fatal facts

Case number	QLD.2012.730
Primary category	Work related
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

A middle aged male died as a result of a workplace incident. They were standing underneath the load of a crane when the load fell.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that a major safety component of the crane was installed incorrectly. The incident occurred when the crane’s free fall function was inadvertently activated by the operator. The crane had been inspected on several occasions and the installation error was not noticed. The coroner found that this could in part have been due to the original manual for the crane being printed in a language other than English.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend to Australian Standards that its committee dealing with the mobile crane standards review the standards to consider if any amendments should be made to include, but not limited to:
 - how free fall mechanisms can most effectively be made inoperative and should this be included in the Standard;
 - if free fall capability is to remain on a particular crane, as to how the functions can be unambiguously signed and locked out when not in use; and
 - the provision of appropriate certification by relevant experts that such functions are now safe and adequate
- I recommend that CraneSafe review its inspection program to include an inspection of and testing of the free fall function and appropriate safety features as against the operations manual if such functions are capable of continued operation.

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Coronial recommendations: Fatal facts

Case number	QLD.2012.3176
Primary category	Law enforcement
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

An adult male died due to asphyxia while being physically restrained.

The adult was restrained as part of a citizen's arrest after they had assaulted other people.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the position that the adult was in whilst being restrained along with the pressure applied by those performing the citizen's arrest contributed to their death.

The coroner found that the initial decision to restrain the adult was reasonable under state legislative powers of citizen's arrest. However, the persons restraining the adult failed to recognise the danger that the adult would be unable to breathe.

Coronial recommendations

The coroner made the following recommendations related to this case:

- First aid training providers consider including a component in their training to raise awareness about the dangers of positional and restraint asphyxia.

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Coronial recommendations: Fatal facts

Case number	QLD.2012.3493
Primary category	Transport and traffic related
Additional categories	Law enforcement
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

A young adult male died from injuries sustained in a motor vehicle collision in which they were a passenger.

Just prior to the incident, the driver of the vehicle in which the young person was travelling had accelerated to a high speed. They were driving dangerously after passing a police vehicle.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the driver of the vehicle was trying to evade police. As a result, they drove at excessive speed and in a dangerous manner. The coroner also found that the resulting police attempt at interception likely influenced the driver's decision drive erratically.

The coroner found that, at the time of the incident, the police had not activated lights and sirens or entered into a pursuit as defined by Queensland Police Service policy.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Queensland Police Service (QPS) pursuit policy be amended to ensure that a pursuit is considered to have commenced in circumstances where the QPS engage in extended following of a vehicle without the lights and siren being activated. This could be achieved by including a second limb, based on the definition in the Victoria Police Manual, so that a pursuit is taken to have commenced when police continue to follow a vehicle that is taking deliberate action to avoid being stopped.

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Coronial recommendations: Fatal facts

Case number	QLD.2013.545
Primary category	Misadventure
Additional categories	Mental illness and health
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

An adult female died from injuries sustained in a fall from a height.

The adult had suffered a rapid decline in their mental health in the week leading up to death. They attended the mental health unit at a hospital and were directed to the Emergency Department. The adult was triaged and was meant to be assessed within short period. However, their assessment was delayed, and no treatment was commenced. They absconded from the Emergency Department and were witnessed to take her own life a short time later.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult did not have the capacity to form the intention to take their own life due to their psychosis.

The coroner found that the adult was not seen nor treated during the wait that they had to endure at the Emergency Department, despite clearly being in a psychotic state. The coroner found that the death could have been prevented had the delay not occurred.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That [hospital and health service] consider the structure of the Department of Emergency Mental Health Team at [hospital] and in particular as to whether its leadership structure should include a position for direct psychiatric input and leadership.

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	QLD.2013.2666
Primary category	Transport and traffic related
Additional categories	Law enforcement
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

An older adult female died due to injuries sustained in a motor vehicle accident in which they were a driver. The incident was caused by the inattention of a driver of another vehicle.

Coronial findings

The coroner found that the death was unintentional. The coroner found that the offending driver was using their mobile phone at the time of the incident. They had been disqualified from driving, but had ignored court orders and continued driving.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the issue of a new mid-range driving offence be referred to the Attorney General to consider changing the law to introduce a new mid-range driving offence between the existing Criminal Code s.328A Dangerous Driving offence, and the Transport Operations(Road Use Management) (TORUM) s.83 Driving without Due Care and Attention offence, and in that review to consider whether it is appropriate:
 - to include a circumstance of aggravation for offending drivers:
 - who cause death or grievous bodily harm in the commission of the offence under s.83 TORUM [*Transport Operations (Road Use Management) Act*], and
 - where they were driving whilst unlicensed or their license was suspended, or
 - where they were driving whilst their license was disqualified; and
 - whether any recommended new mid-range offence, if any, should be legislated in the Criminal Code or the TORUM legislation.

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Coronial recommendations: Fatal facts

Case number	QLD.2013.3928
Primary category	Child and infant death
Additional categories	Transport and traffic related
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

A male child died on a rural property when they were struck by a reversing vehicle.

The child’s step-parent was re-fuelling the vehicle when the child exited the vehicle without their knowledge. The step-parent entered the vehicle and commenced reversing, inadvertently colliding with the child. The child had not been restrained in their car seat, and the child safety door locks were not activated.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the child was familiar with day-to-day farm life and being around farming machinery. As a result, they were typically not restrained in vehicles or placed in appropriate child car seats unless the vehicle was being driven on a public road.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the legislative requirement to restrain children in age appropriate child restraints be extended to include all circumstances where the child is in a motor vehicle which is moving, irrespective of whether or not the vehicle is on a road
- That appropriate authorities issue safety warnings and education to inform drivers that rear vision mirrors may not provide a full range view behind vehicles. Caution should still be exercised and drivers should not be overly reliant on these cameras.
- The addition of audible reverse alarms would also improve safety for small children.
- Dashboard indicators that child locks in rear seats were on/off would also assist and could be considered in the design of new vehicles.

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TASMANIA

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

Coronial recommendations: Fatal facts

Case number	TAS.2011.299
Primary category	Adverse medical effects
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

An adult male died from a chest infection caused by excess intake of their prescribed pain medication following recent surgery.

The adult had recently undergone a surgical procedure, following which they were in considerable pain, with increased difficulty in breathing and swallowing.

The night before their death, they had been transported by ambulance to hospital.

Coronial findings

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

The coroner found that the death was due to deficiencies in the patient’s medical care and management, and was preventable.

The coroner found that the specialist doctor involved in reviewing the adult’s radiology results should have appreciated their serious nature and realised that there were complications that had arisen from the surgery. Due to this oversight, the adult’s symptoms were misdiagnosed and they were inappropriately discharged from hospital.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the [Hospital] put in place processes to ensure that a patient’s ED [emergency department] notes are complete and in a form best able to aid the treating clinicians. This includes ensuring that where appropriate they include a copy of the ambulance records and that all clinician’s notes are made contemporaneously, where possible.
- That the [hospital] review its procedures for reporting of radiology. The review should focus on ensuring that:
 - The radiologist incorporate in each report, whether verbal or written, his/her interpretation of the image(s) when any moderate to significant finding is made;
 - That a notation is made of each radiology report made verbally, including its time and content and identifying the person to whom the report was made;

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- A system is put in place as soon as is reasonably practicable to ensure that all reports upon radiology are made in writing; and
- Otherwise ensuring that all radiological reports comply with the Royal Australian and New Zealand reporting guidelines.
- That the [hospital] review its processes with respect to the discharge of patients from ED with consideration being given to putting in place a structure whereby the consultant-in-charge or his/her delegate is aware of and has the opportunity to participate in all decisions to discharge.
- To the extent that it has not already been achieved, the Department of Health and Human Services take such steps as are necessary to have its Picture Archiving Communications System extended to the internet so that medical practitioners are able to view by lap-top or other portable device radiology images taken of their patients; and
- That medical specialists practising in Tasmania have in place a firm arrangement with their professional colleagues to ensure that specialist post-operative care is available to their patients during those times that they are unable to provide that care in person.

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	TAS.2014.328
Primary category	Water related
Additional categories	Leisure activity, Transport and traffic related
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

An adult male drowned in a lake after their boat capsized in rough weather.

They were fishing on the lake in a small boat with a friend when wind conditions worsened. The pair decided to return to shore, but the boat capsized. The pair began swimming to shore, and the friend lost sight of the adult. They were discovered deceased in the water some time later.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult was an experienced and safety conscious operator of small vessels, and that all the appropriate safety equipment was on board. Both occupants were wearing appropriate personal flotation devices.

The coroner found that the weather conditions changed abruptly, impeding their ability to return safely to shore.

Coronial recommendations

The coroner made the following recommendations related to this case:

- Although there is no certainty as to whether or not this tragic outcome could have been avoided if certain specific action had been taken, I make the following recommendations and comments, hopefully in order to heighten awareness to all boat users as to the dangers highlighted by this tragedy. The following matters are of relevance to all boat users:
 - Know the limitations of your boat. In this case it was a small boat unsuited to any adverse water conditions.
 - Ensure that someone knows where you are going and your planned return time. Had earlier action been able to have been taken in this case the tragic outcome might have been avoided.

- Check the weather forecast before launching a boat. Although conditions on this occasion may have been suitable when launching the boat, an operator must check what the conditions are likely to be for the duration of the expected trip.
- Safety equipment such as EPIRBs [emergency position indicating radio beacon] and flares must be carried in such a way as to be easily accessible upon the happening of a sudden event. EPIRBs should be mounted near the location of the boat operator so as to be accessible, even upon a boat overturning.
- All boat operators and occupants must be aware of the dangers associated with cold water immersion and take the appropriate steps to increase the chance of survival in those circumstances, in particular:
 - Be aware of the cold shock response your body will involuntarily take upon initial immersion. Guard against being underwater in the initial stages when your body will involuntarily gasp in response to the cold water immersion, and if you are submerged this could result in water inhalation and drowning at the initial stage.
 - In the initial stages be aware that there will be an increase in the rate of breathing and heart rate, with a need to stabilise these reactions.
 - Stay with the boat and do all that you are able to remove as much of your body from the water as is possible by climbing on to the boat.
 - Conserve energy.
 - If you are in the water and away from the boat, adopt a heat-escape-lessening posture (akin to curling up into a ball) in order to lessen the body area exposed to the water and therefore lessen the heat loss, or huddle together with others for the same purpose.

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VICTORIA

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

Coronial recommendations: Fatal facts

Case number	VIC.2006.101
Primary category	Electrocution
Additional categories	Work related
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

An adult male was electrocuted whilst acting in the course of their employment. They were using their truck to tip a load when the trailer of the truck came into contact with overhead power lines.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult was aware of the power lines before proceeding to tip the trailer. The coroner found that a qualified spotter was not used during the process.

Coronial recommendations

The coroner made the following recommendations related to this case:

- With the aim of minimising risks associated with contacting overhead power lines on farming and rural properties, I recommend that WorkSafe in consultation and collaboration with Energy Safe Victoria, Farmsafe Australia Inc and [electricity power suppliers], produce signage which alerts a visitor/contractor to the presence and risks of overhead power lines on a given property.
- With the aim of minimising risks associated with contacting overhead power lines on farming and rural properties, I recommend that WorkSafe in consultation and collaboration with Energy Safe Victoria, Farmsafe Australia Inc and [electricity power suppliers] undertake a feasibility study on how to best implement and roll-out a program for introducing the said signage including whether financial assistance can be provided or whether embodiment in legislation could be achieved to ensure the provision, construction and maintaining of said signage at all access gates on farming and rural properties where overhead power lines run through them.
- With the aim of minimising risks associated with contacting overhead power lines on farming and rural properties, I recommend that WorkSafe in consultation and collaboration with Energy Safe Victoria, Farmsafe Australia Inc and [electricity power

suppliers] hold an educational campaign in farming and rural communities on the roll-out of the said warning signage.

- With the aim of minimising risks associated with contacting overhead power lines on farming and rural properties, and with a view to ongoing compliance with the safety signage program recommended above, I recommend that Farmsafe Australia Inc in consultation and collaboration with WorkSafe develop a farm safety accreditation program as suggested by [inquest witness].
- With the aim of minimising risks associated with contacting overhead power lines on farming and rural properties, and with a view to ongoing compliance with the warning signage program recommended above, I recommend that Farmsafe Australia Inc in consultation and collaboration with WorkSafe develop a process for obtaining Dumpsite Certification, either separately or as an element of the farm safety accreditation program.
- With the aim of minimising contact incidents with overhead power lines by tipper truck trailers, I recommend that WorkSafe and Energy Safe Victoria invest in the evaluation of proximity warning devices to determine their efficacy, applicability and practicability to tipper trucks.

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Coronial recommendations: Fatal facts

Case number	VIC.2006.1426
Primary category	Electrocution
Additional categories	Work related
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

An adult male was electrocuted whilst acting in the course of their employment. They were using their truck to tip a load when the trailer of the truck came into contact with overhead power lines.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult was aware of the power lines before proceeding to tip the trailer. The coroner found that a qualified spotter was not used during the process.

Coronial recommendations

The coroner made the following recommendations related to this case:

- With the aim of minimising risks associated with contacting overhead power lines on farming and rural properties, I recommend that WorkSafe in consultation and collaboration with Energy Safe Victoria, Farmsafe Australia Inc and [electricity power suppliers], produce signage which alerts a visitor/contractor to the presence and risks of overhead power lines on a given property.
- With the aim of minimising risks associated with contacting overhead power lines on farming and rural properties, I recommend that WorkSafe in consultation and collaboration with Energy Safe Victoria, Farmsafe Australia Inc and [electricity power suppliers] undertake a feasibility study on how to best implement and roll-out a program for introducing the said signage including whether financial assistance can be provided or whether embodiment in legislation could be achieved to ensure the provision, construction and maintaining of said signage at all access gates on farming and rural properties where overhead power lines run through them.
- With the aim of minimising risks associated with contacting overhead power lines on farming and rural properties, I recommend that WorkSafe in consultation and collaboration with Energy Safe Victoria, Farmsafe Australia Inc and [electricity power

suppliers] hold an educational campaign in farming and rural communities on the roll-out of the said warning signage.

- With the aim of minimising risks associated with contacting overhead power lines on farming and rural properties, and with a view to ongoing compliance with the safety signage program recommended above, I recommend that Farmsafe Australia Inc in consultation and collaboration with WorkSafe develop a farm safety accreditation program as suggested by [inquest witness].
- With the aim of minimising risks associated with contacting overhead power lines on farming and rural properties, and with a view to ongoing compliance with the warning signage program recommended above, I recommend that Farmsafe Australia Inc in consultation and collaboration with WorkSafe develop a process for obtaining Dumpsite Certification, either separately or as an element of the farm safety accreditation program.
- With the aim of minimising contact incidents with overhead power lines by tipper truck trailers, I recommend that WorkSafe and Energy Safe Victoria invest in the evaluation of proximity warning devices to determine their efficacy, applicability and practicability to tipper trucks.

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Coronial recommendations: Fatal facts

Case number	VIC.2006.1546
Primary category	Electrocution
Additional categories	Work related
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

A middle aged male was electrocuted in the course of their work.

The incident occurred whilst the adult was acting as a spotter for the driver of a tipper trailer. The trailer came into contact with overhead power lines while tipping its load.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the driver was aware of the power lines before proceeding to tip the trailer.

The coroner found that the adult was touching the trailer at the time of the contact with the overhead lines, which indicated they were inappropriately positioned at the time they were acting as a spotter.

Coronial recommendations

The coroner made the following recommendations related to this case:

- With the aim of minimising risks associated with contacting overhead power lines on farming and rural properties, I recommend that WorkSafe in consultation and collaboration with Energy Safe Victoria, Farmsafe Australia Inc and [electricity power suppliers], produce signage which alerts a visitor/contractor to the presence and risks of overhead power lines on a given property.
- With the aim of minimising risks associated with contacting overhead power lines on farming and rural properties, I recommend that WorkSafe in consultation and collaboration with Energy Safe Victoria, Farmsafe Australia Inc and [electricity power suppliers] undertake a feasibility study on how to best implement and roll-out a program for introducing the said signage including whether financial assistance can be provided or whether embodiment in legislation could be achieved to ensure the provision, construction and maintaining of said signage at all access gates on farming and rural properties where overhead power lines run through them.

- With the aim of minimising risks associated with contacting overhead power lines on farming and rural properties, I recommend that WorkSafe in consultation and collaboration with Energy Safe Victoria, Farmsafe Australia Inc and [electricity power suppliers] hold an educational campaign in farming and rural communities on the roll-out of the said warning signage.
- With the aim of minimising risks associated with contacting overhead power lines on farming and rural properties, and with a view to ongoing compliance with the safety signage program recommended above, I recommend that Farmsafe Australia Inc in consultation and collaboration with WorkSafe develop a farm safety accreditation program as suggested by [inquest witness].
- With the aim of minimising risks associated with contacting overhead power lines on farming and rural properties, and with a view to ongoing compliance with the warning signage program recommended above, I recommend that Farmsafe Australia Inc in consultation and collaboration with WorkSafe develop a process for obtaining Dumpsite Certification, either separately or as an element of the farm safety accreditation program.
- With the aim of minimising contact incidents with overhead power lines by tipper truck trailers, I recommend that WorkSafe and Energy Safe Victoria invest in the evaluation of proximity warning devices to determine their efficacy, applicability and practicability to tipper trucks.

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Coronial recommendations: Fatal facts

Case number	VIC.2007.3848
Primary category	Intentional self-harm
Additional categories	Law enforcement
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

A young male died of plastic bag asphyxia while in prison.

They had expressed concerns for their safety and were therefore placed in a single occupant cell. They were discovered deceased by prison staff when they did not emerge from their cell.

They had previously attempted plastic bag asphyxia, which was recorded in their medical file.

Coronial findings

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

The coroner found that the young person suffered from a severe personality disorder and was therefore at a chronic or intermittent risk of suicide and self-harm.

The coroner found that despite the recording of the prior asphyxia attempt, there was no information available to correctional staff that the young person should not have access to plastic bags.

The coroner found that the young person should have been under more frequent supervision during their time in the single occupant cell.

Coronial recommendations

The coroner made the following recommendations related to this case:

- While I have addressed the issue of access to medical records and the flow of information across the [prison] campus above, I am conscious that records can be voluminous, and therefore their contents may be inaccessible, even when they are physically available. At inquest, [Justice Health representative] testified at length about the development of an electronic health record, and how it might assist access to prisoners' health information, even potentially allowing remote access. I am conscious that with the regrettable effluxion of time, [their] evidence may have been superseded, or overtaken by events.

- If the electronic health record has not been implemented, and/or voluminous electronic records still pose challenges to accessibility, I recommend that Corrections Victoria and/or Justice Health develop a comprehensive yet pithy summary of prisoners' health information, in consultation with all relevant stake-holders, that contains prescribed types of information, including suicide and self-harm (S.A.S.H) sensitive information, and is regularly updated, and readily available to all clinicians involved in the prisoner's clinical management and care, including psychologists.
- I recommend that Corrections Victoria and/or Justice Health take whatever steps necessary to mandate the use of such a document by any person or entity providing health care in any Victorian prison, whether privately or publicly operated.
- Further, and/or in the alternative, I recommend that Corrections Victoria, Justice Health and [prison] collaborate in the development, implementation and resourcing of a case management scheme for all prisoners with complex medical, psychiatric, behavioural issues, irrespective of any diagnosis. Such a case management plan should summarise in an accessible way the known chronic and acute S.A.S.H risks of the prisoner, including situational triggers, the clearest and most recent diagnosis available, particular symptoms, signs of relapse or deterioration, and characteristic behaviours and how to manage them.
- I recommend that Corrections Victoria and [prison] review S.A.S.H processes and/or practice to further discouraging the rapid or precipitous downgrading of a prisoner's at risk status. Specifically, as regards prisoners placed in the spine of [unit], consideration should be given to a requirement that any assessment of their risk by clinicians and/or the Risk Review Team should explicitly address the relative isolation and deprivation of their placement, and a requirement for an individually tailored, rather than homogenous observation regime.
- I recommend that Corrections Victoria and [prison] enhance S.A.S.H risk training for correctional officers about compliance with the need for meaningful interaction with at risk prisoners rated S3, emphasising the need for the interaction to be meaningful by reference to the prisoner's risk and aimed at enhancing their safety.

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Coronial recommendations: Fatal facts

Case number	VIC.2008.1015
Primary category	Water related
Additional categories	Child and infant death
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

A male child drowned in a creek.

They attended the creek with another child. Both children were recent migrants. They had no knowledge of Australian swimming conditions, and had not learned to swim.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that swimming programs for young people who have recently migrated to Australia are successful, but often lack funding or proper communication with the appropriate communities.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Department of Sports and Recreation in the State of Victoria, in partnership with the Federal Government Department of Immigration and Citizenship, seeks to examine how members of recently arrived immigrant communities to Victoria, might best be taught how to swim safely in open water and continue to provide support for that objective.

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Coronial recommendations: Fatal facts

Case number	VIC.2009.693
Primary category	Water related
Additional categories	Youth
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

A young male drowned in the ocean.

They attended the beach with their family. The beach was not patrolled and did not have a flagged area at the time of the incident. They were swept out to sea by a large wave and were unable to be rescued before they drowned.

The young person was a recent migrant to Australia, and they had not learned to swim in their country of origin.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that swimming programs for young people who have recently migrated to Australia are successful, but often lack funding or proper communication with the appropriate communities.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Department of Sports and Recreation in the State of Victoria, in partnership with the Federal Government Department of Immigration and Citizenship, seeks to examine how members of recently arrived immigrant communities to Victoria, might best be taught how to swim safely in open water and continue to provide support for that objective.

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Coronial recommendations: Fatal facts

Case number	VIC.2009.2346
Primary category	Falls
Additional categories	Older persons
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

An older female died in hospital. They had presented at hospital some days earlier following a fall at home. They were diagnosed with multiple rib fractures and discharged with a plan to see their usual doctor at a later date.

Some days later, they were discovered in their home by paramedics when family were unable to contact them. They had fallen and were unable to get up for some hours. They were taken to hospital, where they deteriorated and subsequently passed away.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult’s triage category on their first hospital presentation was inappropriate, despite not affecting the timeliness of them being attended by a doctor.

The coroner found that there was inadequate planning around the adult’s discharge from the hospital, and the documentation of the discharge planning process was lacking.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That [location] Health Services consider providing further education to staff about the triage of Emergency Department patients.
- That [location] Health Services consider allocating specific responsibility for the completion of the Discharge Tool within the Emergency Department, to ensure that adequate discharge planning occurs, and that the rationale for discharge decisions is apparent.

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Coronial recommendations: Fatal facts

Case number	VIC.2009.3843
Primary category	Adverse medical effects
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

A middle aged female died in hospital.

The adult had undergone abdominal surgery a year prior. They re-presented to hospital after a significant deterioration in their health. They underwent a further surgery, and the surgeon discovered the historical abdominal reconstruction had been incorrectly performed.

The adult was palliated and passed away a short time later.

Coronial findings

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

Shortly after beginning the second surgery, the surgeon discovered the aberrant reconstruction, and opined that the adult had no chance of survival. The surgeon spent time documenting their findings of the aberrant reconstruction for later referral and review.

The coroner was unable to determine if the aberrant reconstruction was the ultimate cause of the death. The coroner was unable to determine if the identification and reversal of the aberrant reconstruction could have prevented the death.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Royal Australasian College of Surgeons consider implementing a process of documenting, by way of photographs or video, and/or independent secondary corroboration (by a relevantly qualified professional) of any alleged observations of evidence of aberrant surgical reconstructions.
- That the Victorian Surgical Consultative Council educate Surgical Registrars and Surgeons on the importance of checking anatomical landmarks throughout and during the final stage of a Roux-en-Y procedure.

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Coronial recommendations: Fatal facts

Case number	VIC.2009.5538
Primary category	Electrocution
Additional categories	Work related
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

An adult male was electrocuted in the course of their work.

They were standing near a tipper trailer as their employer raised the tray. The trailer came into contact with overhead power lines and subsequently electrocuted them. The adult subsequently passed away in hospital.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the employer was aware of the overhead power lines, and had been successful in avoiding them many times before. The coroner found that the employer was familiar with the property and should have recognised the relevant hazards.

Coronial recommendations

The coroner made the following recommendations related to this case:

- With the aim of minimising risks associated with contacting overhead power lines on farming and rural properties, I recommend that WorkSafe in consultation and collaboration with Energy Safe Victoria, Farmsafe Australia Inc and [electricity power suppliers], produce signage which alerts a visitor/contractor to the presence and risks of overhead power lines on a given property.
- With the aim of minimising risks associated with contacting overhead power lines on farming and rural properties, I recommend that WorkSafe in consultation and collaboration with Energy Safe Victoria, Farmsafe Australia Inc and [electricity power suppliers] undertake a feasibility study on how to best implement and roll-out a program for introducing the said signage including whether financial assistance can be provided or whether embodiment in legislation could be achieved to ensure the provision, construction and maintaining of said signage at all access gates on farming and rural properties where overhead power lines run through them.

- With the aim of minimising risks associated with contacting overhead power lines on farming and rural properties, I recommend that WorkSafe in consultation and collaboration with Energy Safe Victoria, Farmsafe Australia Inc and [electricity power suppliers] hold an educational campaign in farming and rural communities on the roll-out of the said warning signage.
- With the aim of minimising risks associated with contacting overhead power lines on farming and rural properties, and with a view to ongoing compliance with the safety signage program recommended above, I recommend that Farmsafe Australia Inc in consultation and collaboration with WorkSafe develop a farm safety accreditation program as suggested by [inquest witness].
- With the aim of minimising risks associated with contacting overhead power lines on farming and rural properties, and with a view to ongoing compliance with the warning signage program recommended above, I recommend that Farmsafe Australia Inc in consultation and collaboration with WorkSafe develop a process for obtaining Dumpsite Certification, either separately or as an element of the farm safety accreditation program.
- With the aim of minimising contact incidents with overhead power lines by tipper truck trailers, I recommend that WorkSafe and Energy Safe Victoria invest in the evaluation of proximity warning devices to determine their efficacy, applicability and practicability to tipper trucks.
- With the aim of minimising contact incidents with overhead power lines by tipper truck trailers, I recommend that WorkSafe and Energy Safe Victoria invest in the evaluation of proximity warning devices to determine their efficacy, applicability and practicability to tipper trucks.
- I also recommend, that with the aim of minimising contact incidents with overhead power lines by tipper truck trailers, I recommend that WorkSafe and Energy Safe Victoria invest in the evaluation of methods to electrically insulate the tipper trailer in the event of power line contact by affixing a dry non-conductive material, as per the National Institute for Occupational Safety and Health's recommendation. This could be informed by the technical specifications for electrical insulation of elevated work platforms, as was contained in AS1418.10.

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.2010.2061
Primary category	Homicide and assault
Additional categories	Law enforcement
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

An adult female died when they were assaulted by their partner. The adult had a history of family violence but did not report their experience with their partner to any relevant services. They had been publicly threatened by their partner, but told witnesses they were too fearful to report these incidents.

On the day of the incident, the adult and their partner attended a petrol station. The partner inflicted fatal injuries on the adult and prevented any bystanders from assisting. The adult subsequently died in hospital.

Coronial findings

The coroner found that the death was due to assault.

The coroner found that the partner was not known to police at the time of the incident, and that the prior threats of violence were not reported to police at the time. The coroner noted that members of a victim’s social network can play a significant role in addressing violence and abuse. The coroner found that the circumstances of the adult’s death indicated a need for an effective mechanism for reporting suspected family violence in a timely manner.

Coronial recommendations

The coroner made the following recommendations related to this case:

- Crime Stoppers has developed the Say Something campaign, which urges young people who witness acts of violence to be brave and look out for their friends by reporting incidents of violence confidentially. A website and iPhone app are available to help empower young people to report crime easily and online without identifying themselves. I therefore recommend that Victoria Police, together with Crime Stoppers, conduct a trial extending the Say Something campaign to family violence.

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Coronial recommendations: Fatal facts

Case number	VIC.2010.3657
Primary category	Drugs and alcohol
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

An adult male died of multiple drug toxicity. They had been receiving methadone maintenance therapy (MMT) for a short time before their death.

The adult had previously received MMT, and were weaned off the treatment some years prior to their death. They recommenced MMT some days prior to their death, as they wished to address their illicit drug use.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult was only an occasional user of heroin at the time of their death, and overstated the frequency and quantity of their addiction to the treating doctor.

The coroner found that the initial dose of methadone given to the adult when they recommenced MMT was the highest initial dose permitted. This departed from the appropriate guidelines without a sound clinical basis for doing so.

The coroner found that the treating doctor was unfamiliar with many of the most clinically significant provisions of the guidelines stipulating the prescribing and use of methadone. In addition, the treating doctor’s clinical interview with the adult before commencement of MMT was perfunctory. The doctor did not make appropriate arrangements for review of the initiation of MMT.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Royal Australasian College of General Practitioners reminds its members who are methadone prescribers of the need to regularly review the National Clinical Guidelines and Procedures for the Use of Methadone in the Maintenance Treatment of Opioid Dependence to ensure that their practice accords with those guidelines, unless there is a sound and documented clinical basis for departure.

- That Drugs and Poisons Regulation (Department of Health and Human Service, Victoria) and its Drugs of Dependence Advisory Committee considers amending the Victorian Policy for Maintenance Pharmacotherapy for Opioid Dependence, to include a mandatory requirement that health practitioners prescribing methadone comply with the National Clinical Guidelines and Procedures for the Use of Methadone in the Maintenance Treatment of Opioid Dependence, unless there is a sound and documented clinical basis for departure.
- That Drugs and Poisons Regulation and its Drugs of Dependence Advisory Committee considers amending the Victorian Policy for Maintenance Pharmacotherapy for Opioid Dependence, to include a mandatory requirement that health practitioners prescribing methadone complete ongoing training in relation to the Victorian Policy for Maintenance Pharmacotherapy for Opioid Dependence, and the National Clinical Guidelines and Procedures for the Use of Methadone in the Maintenance Treatment of Opioid Dependence, at regular intervals, and that compliance be audited.
- That the Australian Health Practitioner Regulation Authority considers the circumstances in which [the deceased] died, and takes whatever action it seems appropriate in relation to [the treating doctor].

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.2011.1748
Primary category	Homicide and assault
Additional categories	Law enforcement
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

A middle aged male died following an assault while in prison.

They were assaulted by a fellow prisoner while in the day room of their unit. The assault was not witnessed by prison staff, and the area was not monitored by closed circuit television (CCTV). The adult returned to their cell, and their injuries were not detected by prison staff until many hours after nightly lockdown had commenced.

Coronial findings

The coroner found that the death was due to assault.

It was noted that the area in which the assault occurred was designed to be directly monitored by prison staff in the adjacent station. The coroner found that there was a significant failure in the monitoring of the prisoners within the day room, as prison staff were unaware of the assault. The prison had made appropriate changes by the time of the inquest.

The coroner found that there was inadequate observation of the adult by prison staff at the time of lockdown. The prison had made appropriate changes by the time of the inquest.

It was noted that CCTV was not present in the day room as it was expected that the area was monitored by the prison staff in the adjacent station. The coroner found that the presence of CCTV within the day room would assist with supervision to ensure the welfare of prisoners.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that Corrections Victoria install and operate CCTV cameras in the areas identified as day room one and day room two of the [unit] of the [prison].

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Coronial recommendations: Fatal facts

Case number	VIC.2011.4373
Primary category	Transport and traffic related
Additional categories	Water related, Older persons
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

An older male died in a vehicle incident in which they were a driver.

They lost control of their vehicle, and the vehicle was witnessed to make a loud, mechanical noise. The vehicle travelled backwards through a barrier, over the edge of a steep embankment and into a river.

The vehicle was submerged, and the adult was found deceased in the vehicle some time later.

Coronial findings

The coroner found that the death was unintentional.

An engineer opined that a failure in the vehicle’s transmission caused the wheels to lock up, and caused the loud noise heard by witnesses. As the vehicle’s transmission was not inspected, the coroner could not determine the reason the older person lost control of the vehicle.

The coroner found that the fencing barrier installed in the area was not sufficient to stop a vehicle.

Coronial recommendations

The coroner made the following recommendations related to this case:

- VicRoads should review the whole stretch of road along [road] and consider installing vehicle barriers at those points where it is possible that a vehicle that has left the road might enter the [river].

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Coronial recommendations: Fatal facts

Case number	VIC.2012.1862
Primary category	Transport and traffic related
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

A young female died in hospital following a vehicle incident in which they were a passenger.

The driver lost control of the vehicle after hitting a pot hole, and was struck by an oncoming vehicle. The road was very wet at the time of the incident, and the depth of water concealed the potholes on the road.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that neither the condition of the vehicle or the behaviour of the driver contributed to the crash. The coroner found that the collision occurred due to the road being in very poor condition at the time of the incident.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That VicRoads review their policy regarding the intervention level for pot holes, so that it be reduced from 100mm depth to approximately 50mm.

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.2012.4127
Primary category	Adverse medical effects
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

A middle aged male died due to an infection.

The adult had been admitted to hospital in the days prior to their death due to liver disease. They were treated and discharged, but returned to hospital shortly afterwards. Medical investigations were ordered, including an x-ray. The adult suffered a loss of consciousness and cardiac arrest. Resuscitation attempts were unsuccessful.

Coronial findings

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

The coroner found that the treatment provided by the hospital was reasonable in all of the circumstances. A review of the medical treatment found that the results of the x-ray were not provided to the treatment team until after the death had occurred. The x-ray results may have raised the possibility of another diagnosis and options for treatment.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That [hospital] examine its procedures for the review by a radiologist of x-rays and imaging performed after hours and on weekends to ensure timely review and prompt communication to the treating team.

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.2012.4210
Primary category	Intentional self-harm
Additional categories	Mental illness and health
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

An adult female took their own life by hanging.

The adult had a history of intentional self-harm, mental illness and substance use. In the days before the fatal incident, the adult was voluntarily admitted to an inpatient unit, and was assessed as presenting a low overall risk to themselves or others. Their belongings were searched on admission, however no items were confiscated. Two days after admission, the adult took their life in their room at the inpatient unit.

Coronial findings

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

The coroner found that the adult did not receive reasonable and appropriate management whilst at the inpatient unit.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that [mental health service] change its policy that presently allows patients of the [low dependency unit] to retain items that are capable of being used as a ligature to ensure that it complies with the Chief Psychiatrist Guideline on Criteria for searches to maintain safety in an inpatient unit - for patients, visitors and staff.
- I recommend that the cupboards in patient rooms of the [inpatient unit] be adapted to remove 'hanging points'.
- I note that I was advised by [mental health service] that a memorandum entitled "Removal of Hazardous Items in Inpatient Units" and dated 3 September 2014, which specifies [mental health service] search and seizure policy in relation to potentially dangerous articles (including scarves and other lengths of fabric) belonging to inpatients, was distributed to Nursing, Inpatient and Area Managers and Clinical Services Directors, among others. The Memorandum refers to the Chief Psychiatrist Guideline on the same

topic and links search criteria to individual clinical and environmental risk assessments throughout the course of an admission.

- I further note that I was advised by [mental health service] that cupboard doors in [inpatient unit] patient rooms were removed during ligature-point remedial works in 2013-2014.
- I recommend that [mental health service] reassess the current CRAAM [Clinical Risk Assessment and Management] guideline or policy regarding the level of engagement required for patients rated 'low risk'. Clear instructions should be developed for staff to produce consistency in:
 - The frequency of formal documented mental state examinations across each shift
 - The requirement for a formally documented and notarised rationale explaining determination of a patient's 'low risk' rating
 - The frequency, timing and recording of visual observation of patients.
- I recommend that [mental health service] provide focused and detailed training to the nursing and allied staff and medical staff of the [inpatient unit] concerning the static risk factors (including those specific to particular diagnosed conditions) and dynamic risk factors (including changes in perception and increased anxiety levels) of individuals with mental illness.
- I note that in the submission dated 16 October 2014, [director of inpatient unit] undertook to ensure that staff received further support and training on the importance of engagement and gaining a collateral history of patients.
- I recommend that [mental health service] provide focused and detailed training to the nursing and allied staff and medical staff of the [inpatient unit] about the procedure for escalation/referral to more senior staff of changes in mental state, dynamic risk factors for suicide (including changes in perception and increased anxiety level) of people with mental illness.

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Coronial recommendations: Fatal facts

Case number	VIC.2012.4677
Primary category	Water related
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

An adult female died whilst scuba diving.

The adult had completed scuba diving training, and was diving with a friend at the time of the incident. During previous dives it was noted that the adult had some issues with buoyancy control. When ascending from a dive, the friend lost sight of the adult, who then failed to resurface.

Search and rescue operations were undertaken but the adult’s body was not recovered.

Coronial findings

The coroner found that the body was not recovered and was satisfied that the person was deceased.

The coroner was satisfied that the evidence was sufficient to determine that the cause of death was drowning.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That consideration be given by Standards Australia and relevant stakeholders to amending the Australian Standards so as to require periodic assessment of qualified SCUBA divers in key techniques including, but not limited to, buoyancy control.
- That consideration be given by Standards Australia and relevant stakeholders to amending the Australian Standards so as to require Dive Charter operators to ensure divers carry a SMB [surface marker buoy] and are instructed to use it appropriately.

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Coronial recommendations: Fatal facts

Case number	VIC.2012.4962
Primary category	Leisure activity
Additional categories	Falls
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

An adult male died due to a skydiving incident.

At the time of the incident, the adult was undertaking their first solo skydive after completing the required training. They exited the plane correctly and successfully deployed the parachute, however stopped responding to the radio during the descent. The adult was found unresponsive over one kilometre from the landing site. Attending paramedics declared the adult deceased.

It was noted that their helmet worn had come off during the landing.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the helmet worn by the adult was compliant with regulations. However, the coroner questioned whether the current regulation adequately promoted safety for skydivers regarding helmet design standards.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the Victorian Tasmanian Parachute Council and the Australian Parachute Federation give formal consideration to adopting [forensic engineer's] recommendations that:
 - A helmet be required to be worn during any skydiving activity in Victoria
 - The helmet worn for skydiving activities must comply with a robust design standard (e.g. EN 966 or a newly mandated Australian Standard for skydiving helmets).

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

Case number	VIC.2013.5011
Primary category	Intentional self-harm
Additional categories	Weapon, Youth
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

A young adult male took their own life with a firearm.

They were last seen alive by family members, at which time nothing appeared out of the ordinary. The young person was found deceased in their room the following day.

Coronial findings

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

The firearm was an antique rifle owned by a family member, which used ammunition that was not commercially available. As such, the *Firearms Act 1996* did not apply and there were no legislative requirements as to storage of the rifle and ammunition.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Victorian Law Reform Commission consider whether the *Firearms Act 1996* requires amendment so that firearms currently classified as 'exempt' under this legislation are still subject to secure storage requirements.
- That the Licensing and Regulation Division (LRD) of Victoria Police implement an awareness campaign targeted at owners of firearms classified as exempt under the *Firearms Act 1996*. This campaign should involve the education of such owners as to the safe and secure storage of their weapons, including ammunition.

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Coronial recommendations: Fatal facts

Case number	VIC.2013.5227
Primary category	Drugs and alcohol
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

A middle aged male died due to severe pneumonia in the setting of alcohol and methadone toxicity.

The adult had no fixed address and was residing in a tent. They had a history of alcohol and substance use, and had been prescribed methadone in takeaway dosages.

Coronial findings

The coroner found that the death was unintentional.

The coroner considered the continued prescription of methadone to the deceased by their general practitioner to be an oversight. However, the coroner acknowledged the complexity of patient presentations faced by primary health care workers.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Victorian Department of Health and Human Services review the circumstances of [the deceased's] death, in considering whether the current takeaway dosing advice in the Victorian Policy for Maintenance Pharmacotherapy for Opioid Dependence provides sufficient criteria (rather than guidance) for the ongoing nature of permits for takeaway dosing of methadone, considering the practical realities of general practice medicine, including patient volumes, consequential time allocation, and the broad clinical discretion provided to General Practitioners that ultimately permit the circumstances surrounding [the deceased's] (and others') death.

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Coronial recommendations: Fatal facts

Case number	VIC.2013.5282
Primary category	Transport and traffic related
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

An older adult female died due to a motor vehicle incident in which they were a driver.

Whilst making a right turn at a complex intersection, the adult’s car travelled into the path of an oncoming vehicle, resulting in a collision. The adult was trapped in the vehicle for some time, and was later pronounced deceased in hospital.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult failed to pay due attention to the give way signpost and give way line at the intersection, and that the design of the intersection was a probable contributing factor to the incident.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that VicRoads review [intersection] with a view to upgrading the intersections with the aim of improving safety measures and preventing further serious injury and like deaths.

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Coronial recommendations: Fatal facts

Case number	VIC.2014.423
Primary category	Water related
Additional categories	Sports related
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

A young male drowned following a kayaking incident.

They were kayaking down a river when their kayak was seen to roll. They did not resurface. Bystanders came to the aid of the young person and emergency services were contacted. They were unable to be revived.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the young person deliberately rolled the kayak with the expectation that they would be able to right it. The young person was not wearing a life jacket at the time of the incident.

Coronial recommendations

The coroner made the following recommendations related to this case:

Late last year my former colleague [coroner] made two formal recommendations designed to promote awareness of life jackets and compliance with regulations by canoeist and kayakers. [They] recommended:

- To promote the awareness of and compliance with PFD [personal floatation device] regulations amongst human powered vessel occupant, I recommend retailers of canoes and kayaks, in consultation with Maritime Safety, consider the distribution of the Australia New Zealand Safe Boating Education Group's *Paddle Safe* brochure to consumers at point of sale for both online and face-to-face transactions.
- To promote awareness of and compliance with PFD regulations amongst human powered vessel occupants, I recommend that Canoeing Victoria, the Victorian Canoe Association Inc. and Victorian Sea Kayaking Club consider the distribution of the Australia New Zealand Safe Boating Education Group's *Paddle Safe* brochure to their members.

I am advised those recommendations have been acted upon.

As I am unable to say whether [the deceased] would have survived this accident had he been wearing a PFD this is probably not the best vehicle to adopt [those] recommendations. However, I propose to support those recommendations as their adoption would assuredly promote water safety and hopefully save lives.

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Coronial recommendations: Fatal facts

Case number	The coroner held a joint investigation into the following deaths which resulted from the same incident: VIC.2014.426, VIC.2014.427
Primary category	Weather related
Additional categories	Mental illness and health, Natural cause death
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

A middle aged male and female died due to complications of heat stroke.

The couple lived together and both suffered from schizophrenia. The parents of one of the adults conducted a welfare check and found both of the adults deceased. Their deaths occurred during a heatwave.

Coronial findings

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

The coroner found that the local mental health service that supported the couple did not have a heatwave plan in place and did not make contact with the couple in the week leading up to their deaths. The coroner found that the couple should have been advised about the dangers that the heatwave event posed to their death.

Coronial recommendations

The coroner made the following recommendations related to these cases:

- The Chief Psychiatrist issue a directive requiring all public mental health services to develop and introduce an appropriate guideline that identifies, among other things, the clinical responsibilities for case managed and at-risk clients at times of extreme weather conditions.

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Coronial recommendations: Fatal facts

Case number	VIC.2014.536
Primary category	Transport and traffic related
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

A middle aged male died due to injuries sustained in a cycling incident.

The adult was an experienced cyclist. They were cycling with a companion when they were struck by a vehicle exiting a driveway. A witness provided assistance and emergency services were contacted. However, the adult passed away at the scene.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the convex mirrors at the scene of the incident were ineffective in aiding vehicles pulling out of the driveway at that location. In addition, the coroner found that the road design resulted in cyclists being concealed from the driveway, and allowed for little time to avoid a collision.

Coronial recommendations

The coroner made the following recommendations related to this case:

- To place advisory signs along the [road] advising cyclists to use lighting at all times in order to improve visibility on the road.
- To complete an audit of the concealed driveways adjoining [road] and for 'concealed driveway' signs to be erected to alert traffic travelling along the road.
- Replacement mirrors to be erected across from the driveway of [address] to better assist safe entry and exit from the driveway.
- Improved vegetation control on the dirt embankment to eliminate vegetation reducing the view of North bound traffic whilst exiting from the driveway of [address].

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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.2010.1834
Primary category	Adverse medical effects
Fatal facts edition	44 – cases closed between January and March 2015

Case summary

An older female died following a dental procedure.

The adult was on long-term warfarin therapy and had recently undergone a tooth extraction procedure. They died as a result of blood loss from the extraction sites.

Coronial findings

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

The coroner found that the dentist who performed the procedure failed to apply the guidelines of Therapeutic Guidelines Limited and the Australian Dental Association.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I shall therefore arrange for a copy of this finding to be provided to the ADA [Australian Dental Association] with a suggestion that it consider advising its members to provide patients who undergo extractions, especially patients on warfarin, with written post-operative instructions as discussed above.

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APPENDIX A: FATAL FACTS WEB TOOL CATEGORY TAGS

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

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