Coronial recommendations: Fatal facts

A summary of cases and recommendations made between April and June 2015

Edition 45
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**APPENDIX A: FATAL FACTS WEB TOOL CATEGORY TAGS** 91
CORONERS’ RECOMMENDATIONS

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

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

Coronial recommendations: Fatal facts includes case summaries and recommendations for cases closed between April and June 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

<table>
<thead>
<tr>
<th>Case number</th>
<th>ACT.2010.46</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Intentional self-harm</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>45 – cases closed between April and June 2015</td>
</tr>
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</table>

Case summary
An adult male took their own life by hanging. At the time of death, they were subjected to a psychiatric treatment order.

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

The coroner found that the quality of care, treatment and supervision provided to the adult did not contribute to the cause of death.

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

- If Mental Health ACT [Australian Capital Territyr] team meetings are not held before every decision is made to apply for a psychiatric treatment order, or the continuation of such an order, they be held before every such decision is made and that all such team meetings be clearly recorded in the patient notes.
- Consideration be given by the Executive and the Legislative Assembly to the making of all necessary statutory amendments so as to mandate, in the case of a person in respect of whom a mental health order has been made under the Mental Health (Treatment and Care) Act 1994, the disclosure of that person’s mental health records to a person appointed as the person’s attorney under the Powers of Attorney Act 2006, or corresponding Act of a State or other Territory, or, if there is no such attorney, to the closest living relative or relatives of the person who demonstrate a legitimate interest in his or her welfare and a wish to be involved in his or her treatment, care and supervision.
- Where the ACT Civil and Administrative Tribunal is conducting proceedings in relation to an application for the making of a mental health order in respect of a person, it be required to notify any known person appointed as the person’s attorney under powers of attorney legislation and all known close relatives of the person who are, or are likely to be, concerned and interested in the person’s treatment, care and supervision.
- The relevant bodies in the Australian Capital Territory monitor the progress of the study into suicides occurring in Victoria between 2009 and 2010 being conducted by the...
Coroner’s Court of Victoria and the University of Melbourne and that its report be closely considered to determine whether any recommendations made in it should be implemented in the Australian Capital Territory, and whether a similar study should be conducted in the Australia Capital Territory and the direction that it should take.
NEW SOUTH WALES

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

<table>
<thead>
<tr>
<th>Case number</th>
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<tbody>
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<td>Additional categories</td>
<td>Child and infant death</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>45 – cases closed between April and June 2015</td>
</tr>
</tbody>
</table>

Case summary
A male child died due to drowning in a residential swimming pool.

The swimming pool where the incident occurred was located in a neighbour’s property. There had been a longstanding dispute about a suitable property fence. The fence in dispute was also a boundary fence for the in ground swimming pool. On the day of the incident, part of the boundary fence was lying on the ground. There was no other barrier between the pool and the property where the child resided.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the child’s death was preventable. The barrier around the pool was inadequate. The death would not have occurred had there been a suitable barrier.

The swimming pool had been the subject of past complaints to the council. The most recent complaint was related to barrier fencing. The council had no regular pool inspection system in place at the time of the incident.

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

To the Minister responsible for the administration of the *Swimming Pools Act 1992*:
- That consideration is given to increasing the maximum penalties applicable to breaches of the safety requirements of the *Swimming Pools Act 1992*.

To the Attorney-General:
- That consideration is given to the enactment of a criminal offence, analogous to that of negligent driving occasioning death, to apply in circumstances where a person dies as a result of the negligence of a third party with respect to the maintenance or use of a private swimming pool.
To [Council]:

- That consideration be given to allocating sufficient staff to properly implement all aspects of its swimming pools inspection program.
- That consideration be given to changing its website to include a statement under the section “Pool Fencing” that the cost of constructing and maintaining a boundary fence that forms part of a pool fence, is the responsibility of the pool owner.
- That consideration is given to supplying each swimming pool inspector with a device to record digital photographs as part of the implementation of the inspection program, and that such photographs be stored with the corresponding inspection record.
- That consideration be given to consulting with Hannah’s Foundation in relation to the production of pool safety information to be sent to swimming pool owners.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>NSW.2012.3106</th>
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<tbody>
<tr>
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<td>Additional categories</td>
<td>Adverse medical effects</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>45 – cases closed between April and June 2015</td>
</tr>
</tbody>
</table>

Case summary
A middle aged female died due to natural causes.
The adult was unwell and presented to hospital on two occasions in a 24-hour period before their death.

Coronial findings
The coroner found that the death was due to natural causes.
The coroner found that the adult had attended hospital three times for treatment, being sent home on two occasions within a 24 hour period. On the first occasion, they were seen by a doctor and prescribed medication for their symptoms. On the second attendance to hospital, they were treated for their symptoms by nursing staff only and told to return in the morning to see a doctor. Upon returning for the third and final time, they were found to have had pneumonia and despite medical intervention they continued to deteriorate.

The coroner found that on the second attendance to the emergency department, the adult should have been admitted for treatment.

Coronial recommendations
The coroner made the following recommendations related to this case:
- That the letter (attached) from the [health service] be circulated by the NSW [New South Wales] Health Department to all Area Health Services in NSW as recommended best practice for dealing with the advice on how and whom to contact to arrange an air retrieval or other transport of patients.
- That the Health Department make it clear that an air retrieval may be organised by a Registered Nurse and not just a Doctor. In this inquest there was a delay of over 2 hours from the Doctor determining [the deceased] should be moved to [location], and any contact being made with patient flow.
• That all locum doctors in regional NSW Hospitals receive appropriate advice and be made aware of the basic policies and procedures that apply to the relevant Area Health Service by either a Hospital Administrator or a Nurse Manager and in particular about local arrangements for movement of patients including:
  o the available hospitals and specialists;
  o the appropriate numbers to call for both urgent and non-urgent transfers (as there is a different contact point depending upon the condition of the patient); and
  o the advice can be oral or written but should NOT be a copy of the NSW Health Policy for Locum Doctors. If written it should be brief enough to be easily read (eg. dot points).

• That any person who presents twice in any 24-hour period to a Hospital Emergency Department MUST be admitted or MUST BE seen by a doctor before being sent home. In this instance [the deceased] was sent home in the early hours of the morning after a second presentation at [hospital], by very experienced nursing staff, with flu-like symptoms that turned out to be acute left lower lobia pneumonia. When she returned to hospital a few hours later she was critically ill and died just after [time]. Although she was probably fatally ill when sent home at [time] and admission at that time may not have saved her, the possibility is that she may have responded to treatment. In any event she would at least have had a better chance of survival if diagnosed earlier.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>NSW.2013.535</th>
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<tbody>
<tr>
<td>Primary category</td>
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<tr>
<td>Additional categories</td>
<td>Leisure activity</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>45 – cases closed between April and June 2015</td>
</tr>
</tbody>
</table>

Case summary

An adult male died due to a deep sea diving incident. The adult was a highly experienced and qualified technical diver. They were particularly interested and skilled at deep diving with closed circuit rebreathing apparatus.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult was using a closed circuit rebreathing apparatus that they failed to calibrate even though the unit was displaying a ‘Must Calibrate’ warning. The unit warning was overridden by the adult. The unit was displaying an error indicating the oxygen level was too high. It was also found that the oxygen cells of the unit were much older than recommended. The adult was able to manually override warning signals during the dive by pressing buttons on the wrist mount display.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That Ambient Pressure Diving consider:
  - Amending the user manual to warn divers that if a cell warning is reading a consistently high Partial Pressure Oxygen (PPO2) level, this may be an indication of impending oxygen toxicity and that a full diluent flush is needed to check;
  - Redesigning the cell warning alarm so that a sustained high PPO2 reading triggers an alarm that cannot be suppressed.
- That the International Association of Rebreather Trainers circulate a warning to users of closed circuit rebreathing units that a sustained high PPO2 reading should be checked by divers and not be assumed to be an aberrant or unserviceable cell.

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Coronial recommendations: Fatal facts

**Case number**
NSW.2013.689

**Primary category**
Law enforcement

**Additional categories**
Transport and traffic related

**Fatal facts edition**
45 – cases closed between April and June 2015

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**Case summary**

A young person died from injuries sustained in a motorcycle incident. At the time of the incident, the young person was being pursued by police.

The police recorded the motorcycle exceeding the speed limit. The police activated warning lights and sirens and attempted to catch the speeding motorcycle, following which the motorcycle collided with a post and rail fence.

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**Coronial findings**

The coroner found that the death was unintentional.

The coroner found that the police were acting according to the NSW [New South Wales] Safe Driving Policy (SDP) and it was necessary for them to engage in pursuit to catch up to the speeding motorcycle. The police also followed set guidelines and contacted police radio to notify of the commencement of the pursuit.

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**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] which highlight the dangers inherent in a police pursuit of a motorcyclist exceeding the designated speed limit be considered as part of the continuing review of the NSWPF Safe Driving Policy,
- That procedures be developed so as to ensure police officers responding to a death that arises as a result of or in the course of a police operation recognise and meet, in an adequate and timely manner, the legitimate needs of families experiencing grief as a result thereof.

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Coronial recommendations: Fatal facts

<table>
<thead>
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<th>Case number</th>
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<td>Law enforcement</td>
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<tr>
<td>Fatal facts edition</td>
<td>45 – cases closed between April and June 2015</td>
</tr>
</tbody>
</table>

Case summary

An adult male died from multiple injuries sustained in a fall from height.

Prior to their death, they had been released from prison into the custody of a detention centre and were facing deportation.

Coronial findings

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

The adult had recently been transferred from prison to the detention centre. The staff at the detention centre did not know that the adult had been on medication to treat mental and mood disorders whilst in prison. At the time, no medical records accompanied detainees on their arrival at the detention.

A mental health assessment was performed, however due to the nature of the adult’s confinement it was difficult to obtain a proper assessment. The coroner found that given the adult’s past, they may have benefited from a comprehensive psychological and psychiatric assessment and support whilst detained.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the NSW [New South Wales] Justice Health & Forensic Mental Health Network implement a procedure whereby a document in the nature of a “discharge summary” is prepared for patients being transferred from a NSW Corrections Centre to an Immigration Detention Centre, which summarises any current or recent medical conditions including mental health history and past attempts at self-harm and any current or recent medications of the patient.
- That the Department of Immigration and Border Protection implement a procedure whereby, prior to the transfer of any person from a NSW Corrections Centre to an Immigration Detention Centre, the person is requested to provide a signed consent to
the release of medical records, and whereby any signed consent is promptly forwarded to the relevant health service agency within the Immigration Detention Centre.

- That International Health and Medical Services revise its policies to require that consideration be given, in cases of persons transferred from a NSW Correctional Centre, to obtaining any relevant medical records especially where any health discharge summary provided by Justice Health includes information believed to be clinically significant.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>The coroner held a joint investigation into the following deaths which resulted from the same incident: NSW.2013.2033, NSW.2013.2034</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Water related</td>
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<tr>
<td>Additional categories</td>
<td>Leisure activity</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>45 – cases closed between April and June 2015</td>
</tr>
</tbody>
</table>

Case summary

Two adults were presumed deceased after they went overboard from a cruise ship. One of the adults had fallen into the ocean, and the other jumped overboard in an effort to rescue them.

The bodies of the two adults were never recovered.

Coronial findings

The coroner found that the deaths were unintentional.

The coroner found that the adults were only found to be missing when the ship docked the next morning and the pair did not disembark. At the time of the incident, there was no technology available that could have alerted the ship's crew to a person going overboard.

The coroner noted that the overboard procedures for passengers were detailed in pamphlets, but suggested a demonstration might be more suitable as passengers only read the pamphlets at their own discretion.

Coronial recommendations

The coroner made the following recommendations related to these cases:

- That [cruise ship company], as part of its passenger safety protocols, consider introducing a specific verbal briefing concerning Man Overboard procedures for passengers coming aboard its cruise ships.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>NSW.2014.862</th>
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<td>Animal</td>
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<td>Additional categories</td>
<td>Physical health</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>45 – cases closed between April and June 2015</td>
</tr>
</tbody>
</table>

Case summary
A middle aged male died from anaphylactic shock after being stung by a wasp.

The adult was severely allergic to wasp stings and carried an EpiPen with them to counteract stings.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the adult was stung by a wasp and quickly reacted. They were able to self-administer the EpiPen and contact emergency services. During the emergency call, the call disconnected and the operator could not reconnect.

The operator dispatched an ambulance for immediate response. There were two units available to respond, but both were some distance away. Upon arrival at the residence, an ambulance officer was confronted by two large dogs, which became agitated at the officer. The officer requested emergency assistance from the police. The officer was unable to proceed into the house until the second ambulance unit arrived and a second person was able to distract the dogs. The adult was found deceased.

The coroner found that the total time it took ambulance services to reach the person was confounded by availability of the ambulance units and the dogs at the property.

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

To the Minister for Health:

- That the NSW [New South Wales] Ambulance Service consider equipping its emergency vehicles with a stock of dog treats or a dog toy to be used to distract dogs if necessary when attending emergencies.
That the NSW Ambulance Service incorporate into its practice scenarios used in the training and professional development of paramedics a situation based on the facts of [the deceased's] incident.

That the NSW Ambulance Service through a suitable medium disseminate to its on-road and other staff a list of tips, based on [doctor's] advice, for calming apparently aggressive dogs.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
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<tbody>
<tr>
<td>Primary category</td>
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<tr>
<td>Additional categories</td>
<td>Mental illness and health, Drugs and alcohol</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>45 – cases closed between April and June 2015</td>
</tr>
</tbody>
</table>

Case summary
A middle aged male took their own life by drug toxicity.
They were suffering from mental illness at the time of their death.

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

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

- That the Minister for Primary Industries, Lands and Water consult with the Veterinary Practitioners Board for the purpose of amending the *Veterinary Practice Act 2003* to create a new provision addressing Impairment that operates as stand-alone provision within the Act and that sits outside of Part 5 Complaints and Discipline.

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.
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.2014.15

Primary category
Natural cause death

Additional categories
Law enforcement

Fatal facts edition
45 – cases closed between April and June 2015

Case summary
A middle aged male died from natural causes whilst in custody.
They also suffered from a number of medical issues as a child and adult.

Coronial findings
The coroner found that the death was due to natural causes.
The coroner found that whilst in prison, the adult had been seen by a medical practitioner on numerous occasions relating to chest pain within a short period. The prisoner had undergone many electrocardiogram tests which had varied results. It was noted that the prisoner’s blood pressure also fluctuated in this period from normal to very high.

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

- That the Northern Territory Department of Health ensure that all prisoners with electrocardiograms ("ECG’s") developing prolonged QTc intervals should be referred for further cardiac evaluation by a cardiologist.
- That the Northern Territory Department of Health ensure that all prisoners with recurrent chest pains, even those considered atypical, be referred for further cardiac screening and risk stratification.

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Coronial recommendations: Fatal facts

Case number: NT.2014.133
Primary category: Fire related
Additional categories: Child and infant death
Fatal facts edition: 45 – cases closed between April and June 2015

Case summary
A female child died as a result of burns sustained in a house fire.
The child was playing with their siblings in an upstairs room when a fire broke out. Despite attempts to rescue the child, they were unable to be removed from the house.

Coronial findings
The coroner found that the death was unintentional.
The coroner found that residence was owned and managed by the Northern Territory Department of Housing (Territory Housing). The residence did not have working smoke alarms. The property was equipped with battery operated smoke alarms. The maintenance of the smoke alarms was to be upheld by the tenants of the house.
The coroner found that the roof of the residence had been re-fitted prior to the fire. The roof was installed higher than the fire-resistant walls which allowed the fire to enter the roof cavity.

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

- Territory Housing install appropriate fire alarms such that it is not necessary to rely upon the tenants for their maintenance; and
- Territory Housing audit the building where this tragedy occurred and any others that might have undergone similar structural repair to ensure that the integrity of the fire walls has not been compromised.

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

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

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<th>Case number</th>
<th>QLD.2011.3690</th>
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</tr>
<tr>
<td>Fatal facts edition</td>
<td>45 – cases closed between April and June 2015</td>
</tr>
</tbody>
</table>

Case summary

An adult male took their own life by hanging whilst in custody.

Coronial findings

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

The coroner found that the adult did not display suicidal ideation or intent whilst under the care of the prison mental health service. The prison had allocated psychologists that were proactively involved in the adult’s care to alleviate stress and anxiety.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Queensland Government review the allocation of resources to the Prison Mental Health Service and Queensland Corrective Services to ensure that the capacity of staff in those agencies to respond to the mental health needs of prisoners is established at an appropriate level, and can then be adjusted to respond to fluctuations in the prison population.

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Coronial recommendations: Fatal facts

<table>
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<tr>
<td>Additional categories</td>
<td>Mental illness and health, Older persons</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>45 – cases closed between April and June 2015</td>
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</tbody>
</table>

Case summary

An older adult male died due to drowning.

The adult was subject to an involuntary treatment order and resided at a mental health facility. They suffered from dementia and were treated with a medication regime that enhanced their confusion and drowsiness.

The adult went missing from the ward and was subsequently found having drowned in a nearby waterway.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult was supposed to be on 15 minute checks and they were not restricted to remain in the ward. However, an error by nursing staff increased the interval to 30 minute observations.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That any future version of the patient physical observations forms utilised by nursing staff at [mental health facility] include information as to the patient’s observation regime as clinically recommended by their treating team. No doubt if there are changes to the policy of locked wards the observation sheets should also indicate whether patients are restricted to the ward or able to leave and for what periods.

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Coronial recommendations: Fatal facts

Case summary
A male child died due to drowning in a residential swimming pool.

The child was in foster care at the time of the incident and was unable to swim.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the foster carers were not aware of the child’s swimming ability prior to the child entering their care. The child was required by the foster parents to wear a floatation device whilst swimming in the pool. The child had been wearing a floatation vest prior to the incident, but had since removed it.

The foster carers were not given training about water safety nor what level of supervision would be appropriate for the children around the swimming pool. At the time of the incident, the foster carers had several children present at the home, which may have impacted their level of supervision. The carer was not in the pool enclosure but overseeing the children from a nearby deck.

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

I recommend that the Department of Child Safety consider:

- Updating the Child Safety Practice Manual to require Child Safety Officer’s (CSO) to record information pertaining to a child’s swimming ability in the Child Information Form;
- Providing training to all CSO’s in relation to the identification of water hazards, water safety and appropriate levels of supervision of children around water hazards;
- Requiring all foster care agencies to provide support workers and foster carers with training on the identification of water hazards, water safety and appropriate levels of supervision of children around water hazards;
• Amending the Household Safety Study form to include a requirement that water safety and supervision is discussed with foster carers and an appropriate publication (such as "The ABC of Pool Safety" published by the Department of Housing and Public Works) is provided to them at the time of completing the Study.
SOUTH AUSTRALIA

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

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<th>Case number</th>
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<td>Law enforcement</td>
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<td>Fatal facts edition</td>
<td>45 – cases closed between April and June 2015</td>
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</tbody>
</table>

Case summary

An adult male took their own life by hanging. They were a prisoner at the time of the incident.

Coronial findings

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

The coroner found that the death of the adult was avoidable. The adult was recognised as being at high risk of suicide. They were housed in a room suitable for inmates expressing intent self-harm. There were no hanging points and the cell was monitored by CCTV [closed-circuit television].

The coroner noted that the control room CCTV monitors only displayed footage of the adult’s room intermittently. Monitoring the CCTV was not the sole responsibility of one prison officer, but of all the officers in the control room.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Department for Correctional Services assign a dedicated officer(s) for the purpose of twenty-four hour constant, continuous monitoring of vision streamed by the cameras responsible for monitoring at risk prisoners in the observations cells of [prison area]. This recommendation is directed to the Minister for Correctional Services, the Chief Executive of the Department for Correctional Services and the Chief Executive of [prison].
Coronial recommendations: Fatal facts

<table>
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<th>Case number</th>
<th>SA.2011.1081</th>
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<td>Additional categories</td>
<td>Older persons</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>45 – cases closed between April and June 2015</td>
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</tbody>
</table>

Case summary

An older adult female died due to accidental neck compression.

The adult was a resident of an aged care facility and used a wheelchair. The adult was fatally injured when they滑 down their wheelchair and the chair’s lap sash caused asphyxiation.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the residential care facility had exhausted all other opportunities to avoid using the lap sash restraint on the wheelchair.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Federal Department of Health and Ageing issue a warning to all aged care facilities to note the risks inherent in the use of lap sash seatbelts. In my opinion their use should be discouraged. There are other, better methods for securing people in wheelchairs and these should be drawn to the attention of aged care facilities.

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

Case number | TAS.2012.231
Primary category | Natural cause death
Fatal facts edition | 45 – cases closed between April and June 2015

Case summary

A middle aged male died due to natural causes in a hospital setting.

The adult was critically unwell and despite all efforts, succumbed to their illness. The adult had undergone several operations on their lower limb.

Coronial findings

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

The coroner found that the doctor’s patient notes made it clear that the adult did not want to undergo an amputation of their limb, and did not wish to be dependent on others.

The decision was made to withdraw treatment based on an agreement with doctors and present family members. The adult’s partner held a different opinion regarding the discussion with doctors.

The hospital had a care plan in place to document such issues for the patient’s signature. However, the care plan was not utilised in this instance. Nonetheless, the coroner found that the doctor’s notes were well-documented and recorded the adult’s wishes accurately.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That documentation of patient’s wishes especially in regard to limitation of treatment and end of life decisions should be a standard process in all hospitals using a similar document to the [hospital] Goals of Care Plan.

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

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<th>TAS.2012.420</th>
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<tr>
<td>Primary category</td>
<td>Transport and traffic related</td>
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<td>Fatal facts edition</td>
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Case summary
An adult female died from multiple injuries sustained in a motor vehicle incident in which they were a driver.

On the day of the incident, the weather conditions were fine. The vehicle was mechanically compliant and the adult was driving in a safe manner.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the vegetation in front of the wire barriers at the scene impeded the intended purpose of the wire barrier. The wire barrier was intended to stop a vehicle from crossing over to the incorrect side of the road. The vegetation in the median strip reduced the safety of the wire barrier and contributed to the adult's vehicle flipping, thereby causing them more severe injury.

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

That the relevant agency, where medians strips are configured in a manner similar to that involved in this crash:

- Implement measures to ensure that vegetation that reduces the efficacy of the wire fencing as a safety barrier is not planted on such median strips;
- Implement and/or ensure the continuation of a program to remove all existing vegetation on such median strips where that vegetation reduces the efficacy of the wire fencing as a safety barrier.

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

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Case summary

An older adult female died due to aortic dissection.

The adult had recently been released from hospital following a sudden onset of stomach pain.

Coronial findings

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

Whilst in hospital, the adult was taken for a non-contrast CT [computed tomography] scan to identify if there was a dissection of the aorta. The radiologist reported that no abnormality was identified. The adult was later sent home after pain had subsided.

The coroner found that the radiologist failed to notice that the scan results indicated an indirect sign of aortic dissection.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the [hospital] undertake a review of the competencies of its radiological staff with a view to putting in place, if deemed necessary, processes for their updated training and the proper supervision or monitoring of their work.

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

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<td>Child and infant death</td>
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<td>Additional categories</td>
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<td>Fatal facts edition</td>
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Case summary
A female child died due to suffocation caused by bedding.
The child was exposed to family domestic violence several times.

Coronial findings
The coroner found that the death was unintentional.
The coroner found that the sleeping environment was dangerous for a child.
The coroner found that police responded to numerous call-outs for serious family violence to the child’s home from the time the child was in utero to the time they died. The cumulative harm policy used to protect children considered high risk was not applied.

Coronial recommendations
The coroner made the following recommendations related to this case:
- That Tasmania Police, when training or educating officers in family violence practices and procedures, include training and education as to:
  - the need for reporting officers to elicit from the complainant, where possible, the full extent of the details of the interaction, including what was actually said by the parties to the interaction, and thus whether the incident may be properly categorised as an “argument only” incident, or whether the incident may attract charges;
  - the ascertainment by reporting officers of whether there are children to the relationship, even if they are not present at the incident;
  - the correct completion by reporting officers on the FVMS [Family Violence Management System] of the names of the children and whether they were present, so as to ensure that an automatic CPS [Child Protection Services] referral is generated; and
  - that the supervising sergeant responsible for validating the FVMS report ensures as far as possible that the section for completion of the names of the children section is correctly completed, and that the incident details are as extensive as possible.
• That Tasmania police conduct checks on a regular basis to confirm that the FVMS referrals to CPS are being forwarded to and received by CPS.
Coronial recommendations: Fatal facts

Case number
TAS.2013.558

Primary category
Work related

Fatal facts edition
45 – cases closed between April and June 2015

Case summary
An adult male died due to an incident involving a vehicle they were working underneath.

The adult was a qualified mechanic. They had used a hydraulic trolley jack to lift the vehicle. At some point, the jack disengaged and the weight of the vehicle trapped the adult.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the jack carried a warning and instructions on correct use and safety. In this instance, the jack was not used in conjunction with jack stands. The coroner found that if jack stands had been used, death would not have occurred.

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

• That no person at any time work underneath a car or any piece of machinery supported only by a trolley jack.
Coronial recommendations: Fatal facts

Case number | TAS.2014.18
Primary category | Water related
Additional categories | Leisure activity, Physical health
Fatal facts edition | 45 – cases closed between April and June 2015

Case summary
An adult male died due to drowning whilst engaged in scuba diving.

The adult had previously acquired a level 2 open water diving qualification.

They suffered from high blood pressure and obesity, for which they were treated with medication.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the adult was obese and unfit and showed signs of overexertion walking from the car park to the beach and in the initial stages of the dive.

The coroner found there was no obligation for recreational divers to undergo medical testing after their initial entry medical assessment, and that ageing and weight gain were risk factors for scuba divers.

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

• That guidance provided by the South Pacific Underwater Medicine Society be applied both by divers and their medical advisors. In relation to age and fitness, the following recommendations are pertinent:
  o There is no upper age limit provided to undertake scuba diving however appropriate medical fitness standards should always be met. It is recommended that from the age of 45 years, all candidates should have regular assessments at no longer than 5 yearly intervals, with emphasis on evaluation of cardiovascular fitness and pulmonary reserves. Emergency situations may demand a high degree of fitness.
  o Consideration must be given to a diver having adequate reserves of physical fitness to cope with unexpected demands due to adverse weather or sea conditions, surfacing away from a boat, having to aid a distressed buddy or other emergencies.
Whilst all divers should undergo appropriate functional assessment during dive training, if the medical risk assessment reveals a probable lack of adequate physical fitness, this should be indicated in medical advice given.

- Obesity may imply a lack of physical fitness and also represents a possible hazard to divers by increasing the risk of decompression illness. The general medical risks of obesity should be discussed with the diver.
Coronial recommendations: Fatal facts

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<td>Drugs and alcohol</td>
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Case summary

An adult male died from heart failure complicated by intravenous drug use.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult had administered Ritalin tablets that were not prescribed to them. The coroner found that the method of administration was inherently dangerous.

Coronial recommendations

The coroner made the following recommendations related to this case:

In the findings published following an inquest, a case concerning a death resulting from the same practice [Coroner] recommended:

- That relevant agencies consider whether there is a need for a public education campaign with a view to reducing the harm caused by illicit diversion of psychostimulants, and in particular, to highlight the dangerous practice of intravenous injection of such substances; and
- That in developing updated guidelines for the issuing of authorities to prescribers, the Pharmaceutical Services Branch consider current evidence of the prevalence of and harm caused by diversion and misuse of psychostimulants in the community.

I respectfully repeat those recommendations.

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

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Case summary

An older adult male died due to terminal illness whilst in custody.

Their illness was progressive and had been appointed a public guardian.

The adult’s family member was estranged from them. As a result, they were only informed of the death by a person who was previously in custody with the adult.

Coronial findings

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

The older adult died from terminal illness.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the appropriate authorities consider an accepted practice whereby the next of kin of prisoners, whether or not they are in contact with that prisoner, are advised should the prisoner be diagnosed as suffering a serious or terminal illness.

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Coronial recommendations: Fatal facts

Case number: TAS.2014.336
Primary category: Water related
Additional categories: Leisure activity
Fatal facts edition: 45 – cases closed between April and June 2015

Case summary
An older adult male died due to drowning.

The adult was fishing in a boat on a river when they fell into the water. The adult’s boat was noted to be travelling in circles, and witnesses came to their aid.

The fall could have possibly been attributed to a cardiac event.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the adult had suffered a cardiac event prior to or just after falling into the water. As a result, they had not tried to inflate their personal floatation device (PFD).

The coroner found that the PFD was in a defective condition.

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

- That persons with older style PFDs investigate their serviceability, consider upgrading to the new model or investigate the retrofitting of the water immersion inflation capability.

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

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

Case number | VIC.2006.1590
Primary category | Work related
Fatal facts edition | 45 – cases closed between April and June 2015

Case summary
A middle aged male died when a free-standing gazebo collapsed and fell on top of them.
The adult was a builder and had been responsible for the construction of the gazebo.

Coronial findings
The coroner found that the death was unintentional.
The coroner found that the adult deviated from the structural engineer’s plans, altering the structural integrity of the gazebo. These alterations caused the gazebo to fall.

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

• That the Victorian Building Authority, in consultation with relevant stakeholders, develop a standalone practice note to alert and reinforce to builders their obligations under section 33 of the Building Act 1993.

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Coronial recommendations: Fatal facts

Case number: VIC.2007.3944
Primary category: Natural cause death
Additional categories: Law enforcement
Fatal facts edition: 45 – cases closed between April and June 2015

Case summary
An older adult male died due to natural causes whilst in custody.

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

The coroner found that the older adult had been feeling unwell whilst detained in police a holding cell and was not offered medical assistance. Once transferred to the custody centre, they were reviewed by custodial nurses but did not see a doctor until they were transferred to hospital.

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

- With a view to providing access to additional medical support to regional police stations with custodial facilities and providing support to existing Custodial Medical Officers and preventing like circumstances, I recommend that Victoria Police, if they have not already done so, review its' policy and/or arrangements with regionally based medical practitioners in the position of Custodial Medical Officer with a view to having at least two medical practitioners available for contact by the watch-house keeper/police station.

- With a view to improving access to medical attention/consultation by prisoners and preventing like circumstances, I recommend that the, current operator of the [custody centre] if they have not already done so, engage a medical practitioner to assist in the admission health assessments and in particular, should include but not be limited to, having a medical practitioner on site to review and prescribe medications to prisoners that have arrived into custody without their own prescription medication, to check vital observations that are not within a normal range and to provide additional input to management strategies for those prisoners suspected or known to be withdrawing from substances.
• With a view to supporting custodial registered nurses in their role of assessing, monitoring and recommending management strategies of prisoners suffering from or believed to be suffering from withdrawal from substances and preventing like circumstances, I recommend that the current operator of [custody centre] provide and/or arrange for formal training/professional development for its' custodial registered nurses in the area of drug and alcohol withdrawal.

• With a view to supporting custodial officers in their role of observing prisoners suffering from or believed to be suffering from withdrawal from substances and supporting custodial officers in making assessments about the welfare of prisoners suffering from or believed to be suffering from withdrawal from substances and preventing like circumstances, I recommend that the current operator of the [custody centre] provide and/or arrange for formal training/professional development for its' custodial officers in the area of drug and alcohol withdrawal.

• With a view to improving lines of communication between custodial centres including police cells, and in particular improving communication about the medical/mental health of prisoners moving between custodial centres, including police cells and preventing like circumstances, I recommend that the current operator of the [custody centre], if they have not already done so, provide training and instruction on accessing, navigating, viewing and entering data about prisoner welfare observations onto relevant computer modules/programs whether that be E*Justice, the Thin Blue Line or their current equivalents/replacements.

• With a view to improving lines of communication between custodial centres including police cells and in particular improving communication about the medical/mental health of prisoners moving between custodial centres including police cells and with the view of better informing staff at the [custody centre] about in-coming prisoners and preventing like circumstances, I recommend that the current operator of the [custody centre], if they have not already done so, mandate the accessing of computer generated prisoner welfare observations, including known medical information, by the reception custodial officer and the reception custodial nurse.

• With a view to improving outcomes for prisoners and supporting custodial officers in performing duties consistent with their training and preventing like circumstances, I recommend that the current operator of the [custody centre], if they have not already done so, implement a system whereby any prisoner assessed by the custodial nurse and/or doctor, as having an altered physical state and/or other concerns regarding their physical wellbeing, have their observations conducted and recorded by a custodial nurse instead of or in addition to, a custodial officer.

• The CCTV [closed-circuit television] footage from the cells at [police station] was inadvertently overwritten despite timely notification to the [police station] that [the deceased] had died in custody. With a view to improving the retention of CCTV footage in custodial centres including police cells and preventing like circumstances, I recommend that Victoria Police, if they have not already done so, review its' policies and
procedures regarding the retention of the same particularly in light of the notifications of a death in custody.
Coronial recommendations: Fatal facts

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<th>Case number</th>
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<td>Primary category</td>
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<td>Additional categories</td>
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<td>Fatal facts edition</td>
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Case summary

A young female died due to heroin toxicity.

At the time of their death, they were in the care of the Department of Human Services (DHS), and subject to a Custody to Secretary Order. A condition of the Order stipulated that they not attend a certain area, in which they later died. They were also a resident of a care facility managed by the DHS.

The young person had encountered the police (Officer A and Officer B) in the days prior to their death. Despite being provided with the young person’s date of birth, Officer A did not recognise their young age. The police did not conduct a Law Enforcement Assistance Program (LEAP) person check on them, and no further action was taken.

They were arrested the day prior to their death, and were interviewed at the police station in the presence of a DHS residential care worker. Upon release, the DHS worker could not convince the young person to return to the care facility, and did not have any protective intervener powers. In the absence of a safe custody warrant, the police did not assist the DHS worker, and the young person was free to leave.

They proceeded to purchase heroin and administer it in the presence of others. They were observed to be asleep or unconscious for a significant part of the next day. There was a significant delay in calling an ambulance, and they were pronounced deceased when ambulance officers attended.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the failure of Officer A to recognise the age of the young person resulted in a lost opportunity to confirm that they were underage, their status as a DHS client, the existence of numerous warrants to secure their welfare, their history of self-harming, and their history of offending and illicit drug-taking.
Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the Department of Health and Human Services ensure all of their workers, including Residential Care Workers, who have management and supervision of high-risk children be given Protective Intervener Powers to detain them when it is considered that they are at risk of immediate and extreme risk of harm. This power would apply to situations such as the one in which [the deceased’s Residential Care Worker] was faced with at the [location] Police station on [date].

- I recommend, with the aim of supporting the Department of Health and Human Services to undertake more informed risk assessments for High Risk Youth, that the Chief Commissioner of Police and the Department of Health and Human Services, if they have not already done so, establish a ‘working party’ between the two organisations to undertake a feasibility study to determine whether a warning flag for ‘high risk’ children under the care of the Department of Health and Human Services can be included on the LEAP database. Consideration must include, but not be limited to:
  - the criteria and name of the flag for ‘high risk’ children;
  - whether to do so would breach any privacy legislation and if so, whether the perceived risk(s) to the child outweighs privacy rights/principles;
  - how the information relevant to the flag would be maintained and updated;
  - the situations in which Victoria Police would be required to notify the Department of Health and Human Services if a ‘High Risk Youth’ is checked on LEAP; and
  - training of Victoria Police members and Department of Health and Human Services workers in relation to the flag.

- I recommend, if it has not already been done, the Chief Commissioner of Police provide Academy based training that includes the circumstances of [Officers A and B]’s interaction with [the deceased] on [date] to help prevent Victoria Police members from making the same or similar mistakes in the future such as those made by [Officer A].

- I recommend that the Minister for Health review section 162 of the Children Youth and Families Act 2005 with the view to amending the provision to include circumstances where a child has suffered, or is likely to suffer, significant harm as a result of drug taking, self-harm or other high risk behaviours. Such a review should include circumstances where a child is classified by the Department of Health and Human Services as a High Risk Youth. Consequences, of this amendment would expand the mandatory reporting requirements under section 184 of the Children Youth and Families Act 2005 and would have ‘caught’ the situation which confronted [Officers A and B] on [date].

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Coronial recommendations: Fatal facts

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Case summary

An adult female died following an emergency caesarean.

The adult presented to hospital in the final weeks of pregnancy after discovering they were bleeding. During the caesarean, it was found that they were suffering from placenta increta. There was significant bleeding following the removal of the placenta, and an emergency hysterectomy was performed. The bleeding continued and they were transported to a specialist hospital. They suffered a brain injury due to the bleeding and passed away some days later.

They had undergone caesarean sections for their previous pregnancies.

Coronial findings

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

The coroner found that the placenta increta should have been diagnosed at ultrasound earlier in the pregnancy and that given the history of previous caesareans, there was inadequate ultrasound examination of the placenta.

The coroner found that the decision of the doctor to not proceed with the hysterectomy immediately following the removal of the placenta resulted in the heavy bleeding and a delay that led to the development of a massive haemorrhage.

Coronial recommendations

The coroner made the following recommendations related to this case:

In order to prevent maternal deaths from placenta accreta/increta:

- The Royal Australian and New Zealand College of Obstetricians and Gynaecologists:
  - Develop a clinical guideline that defines a clear pathway for clinical practice when placenta accreta is discovered prior to or at delivery. The clinical guideline will determine the situation when placenta accreta is suspected or known; birth should occur in a place with the necessary medical facilities and expertise.
- Amend the 'Caesarean Delivery on Maternal Request' statement to include evidence of the potential risks associated with recurrent caesarean sections.
- Regional Imaging [location] Service redesign the ultrasound request form to include the relevant clinical information of previous caesarean section.

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Coronial recommendations: Fatal facts

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**Case summary**

A young male died after being struck by a train.

The young person had a long history of psychiatric illness. They had engaged with the Crisis Assessment and Treatment Team (CATT) in the days prior to their death.

**Coronial findings**

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

The coroner found that the death occurred in the context of mental health issues and personal matters.

The coroner found that the medical management and care provided by the CATT nurses was reasonable in the circumstances, and they worked within the existing parameters of their expanded practice roles.

The coroner found that the train driver took all reasonably practical steps to avoid the collision, and there was nothing they could have done to prevent it.

**Coronial recommendations**

The coroner made the following recommendations related to this case:

- To increase the validity and reliability of the diagnostic information recorded in the Client Management Interface/Operational Data Store (CMI/ODS), and to improve the safety of patients of public mental health services in Victoria, I recommend that the Department of Health and Human Services (DHHS) review the current system for recording a diagnosis within the CMI/ODS and make the following changes:
  - Provide a clear distinction between a provisional and formal diagnosis during all stages of an episode of care; and
  - Remove all provisional diagnoses from the Client Management Interface at the end of an episode of care that have not been made formal or validated, and that have not
been documented as a formal diagnosis that has been reported to and discussed with the patient.

- To enhance the knowledge of nurses who complete an Australian Nursing and Midwifery Accreditation Council (ANMAC) accredited course, are registered at beginner level and work in Victoria, I recommend that ANMAC review their Checklist for Mental Health in Pre-registration Curricula and include prompts for inclusion of information regarding:
  o Psychiatric diagnoses complexity, the impact of co-morbidities and implications of a diagnosis on clients and families;
  o The differences between a provisional, differential and formal diagnosis in psychiatry; and
  o The existence of both the International Classification of Diseases (Chapter V) and Diagnostic Statistical Manual, and their continued use in day-to-day practice in public mental health services.

- The Nursing and Midwifery Board of Australia (NMBA) submitted that Registered Nurses (RN’s) who are not Nurse Practitioners should avoid making medical diagnoses. To provide greater clarification to RN’s working in Victoria in crisis assessment services in public mental health services, and to their employers, I recommend that the NMBA work with DHHS, including the Chief Mental Health Nurse to formally:
  o Elucidate the responsibilities of RN’s working in crisis assessment services in public mental health services in Victoria in relation to making any psychiatric diagnosis (provisional or formal); and
  o Provide examples of the type of education, knowledge and experience a RN in Emergency Department CATT (ECATT)/CATT would be expected to have before completing a diagnosis.

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.
Coronal recommendations: Fatal facts

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**Case summary**

An adult male died at their home due to cardiac issues.

They had presented to hospital some days prior, but were released when no abnormalities were detected on their chest x-ray.

**Coronial findings**

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

The coroner found that a junior doctor reviewed the chest x-ray, but was unable to determine whether the x-ray was reviewed by a senior doctor with more radiology experience.

The coroner found that while medical staff would not necessarily have been expected to detect the abnormality on the chest x-ray, there were missed opportunities to diagnose the adult’s condition.

**Coronial recommendations**

The coroner made the following recommendations related to this case:

- I recommend the Department of Health disseminate to all Victorian Health Services a letter of [hospital] dated [date] to the Coroners Court of Victoria entitled Report to Coroner – [hospital] changes to procedures and systems, setting out the initiatives and improvements which have been implemented in the Emergency Department of [hospital] since the death of [the deceased] on [date].
Coronial recommendations: Fatal facts

**Case number**
VIC.2011.2229

**Primary category**
Mental illness and health

**Additional categories**
Natural cause death

**Fatal facts edition**
45 – cases closed between April and June 2015

**Case summary**
A middle aged male died of natural causes while an involuntary patient in a high dependency mental health ward. The nurses in the ward assumed the adult was sleeping.

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

The coroner found that there were many absences, inadequacies and inaccuracies in the recordings of observations of the adult, resulting in them not being discovered and treated.

The coroner found that there were shortcomings in the care provided to the adult, which did not equate to the appropriate delivery of care required for involuntary psychiatric patients.

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

- With the aim of minimising risk and preventing like deaths, I recommend that [mental health hospital] implement compulsory training (and ongoing refresher training) to inform staff about the new risk assessment and visual observation forms, policies and procedures implemented by [mental health hospital], and implement compulsory training about the Prompt system, including how to use it to access all current and future policies and procedures implemented by [mental health hospital].
- With the aim of minimising risk and preventing like deaths, I recommend that [mental health hospital] amend their definition of ‘visual observation’ so that it includes but is not limited to recording the patient's/client's activity level, and if the patient/client is assumed to be sleeping, that a notation of chest movements and/or other signs of respiration are recorded consistent with good clinical practice.

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

<table>
<thead>
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<th>VIC.2011.2861</th>
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<td>Law enforcement</td>
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<tr>
<td>Fatal facts edition</td>
<td>45 – cases closed between April and June 2015</td>
</tr>
</tbody>
</table>

Case summary
An older male took their own life by hanging.

The adult was due to attend court to answer criminal charges involving child-related sex offences on the day of the incident.

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

The coroner found that the adult’s case was among a number of deaths of persons who suicided while under investigation for alleged child-related sex offences.

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

**Recommendation one**
- Victoria Police is to be commended for the measures implemented following [Coroner]’s recommendation in the finding of [a similar death].
- In light of [inquest expert psychologist]’s report, Victoria Police should consider reviewing the training provided to officers involved with the interviewing of persons suspected of child related sex offences. Training should encompass an understanding of the psychological reactions of individuals arrested or interviewed for these types of offences. These reactions include, the loss of psychological defences, difficulties dealing with arrest, isolation, effects on those with children, community attitudes, ignorance of the criminal justice system, and cultural, linguistic and mental health issues. For further details about reactions see Attachment ‘A’ Excerpt from [inquest expert psychologist]’s Report to the Coroners Court of Victoria dated [date]. The purpose of training is to increase police awareness regarding the ongoing risk of self-harm among this cohort of alleged offenders while an investigation is in process.
Recommendation two

- A pamphlet is currently provided by Victoria Police to suspects regarding support information. This pamphlet should also include information about the police investigation, the judicial process regarding police charges, the potential involvement of other agencies, and how to seek appropriate assistance for well-being and mental health.
- Victoria Police is the obvious point of dissemination for such a pamphlet; however the material should be prepared in conjunction with relevant bodies, such as the Law Institute of Victoria, Victoria Legal Aid, and agencies such as Suicide Prevention Australia and beyondblue.

Recommendation three

- Victorian lawyers who act for persons who are investigated and charged with child related sex offences have an important role to play to prevent their clients from self-harming. Lawyers should also receive training to understand the psychological reactions of individuals arrested or interviewed for these types of offences. These reactions include, the loss of psychological defences, difficulties dealing with arrest, isolation, effects on those with children, community attitudes, ignorance of the criminal justice system, and cultural, linguistic and mental health issues. For further details about reactions see Attachment A’ Excerpt from [inquest expert psychologist]’s Report to the Coroners Court of Victoria dated [date]. The Law Institute of Victoria and Victoria Legal Aid should consider the provision of specific training for lawyers acting for this cohort of clients.
- Lawyers should be aware that the risk of self-harm does not necessarily abate after initial questioning regarding alleged offences but can develop over time. Many suicides occur before the first court date, therefore follow up contact should take place as that date approaches. The likelihood of self-harm may build as the court date approaches which can be months or years after the commencement of an investigation.
- Lawyers acting for those clients should reinforce the role of mental health professionals and encourage their clients to seek advice from their general practitioner. With a referral from their GP [general practitioner] for a mental health plan, they can receive six sessions with a psychologist, and, if approved after review, a further four sessions.
- I note the concerns expressed by the Law Institute of Victoria and Victoria Legal Aid that clients will sometimes either not act on a referral or attend appointments if a mental health plan is developed. Mandatory requirements as bail conditions can be problematic and not all people charged with child sex related offences are placed on bail. Services such as the Court Integrated Services Program (CISP) are utilised by lawyers for clients who are on bail, however CISP is not available once a matter proceeds beyond the Magistrates’ Court.
**Recommendation four**

- Magistrates and all judicial officers should be made aware that any person who is regarded as a suspect and being investigated or charged with child sex offences is an increased suicide risk.

- Many suicides take place before the first court date, and in this cluster, one took place after a court date. Judicial officers should be aware of the psychological reactions of individuals arrested or interviewed for these types of offences. These reactions include, the loss of psychological defences, difficulties dealing with arrest, isolation, effects on those with children, community attitudes, ignorance of the criminal justice system, and cultural, linguistic and mental health issues. For further details about reactions see Attachment 'A' Excerpt from [inquest expert psychologist]'s Report to the Coroners Court of Victoria dated [date].
Coronial recommendations: Fatal facts

Case number | VIC.2011.3213
Primary category | Child and infant death
Fatal facts edition | 45 – cases closed between April and June 2015

Case summary
A male infant died of unascertained causes.
Their parent placed them in a baby hammock while undertaking daily tasks. After a short
time, the parent found the infant to be cold and unresponsive. They were unable to be
revived.

Coronial findings
The coroner was unable to determine the cause of the deceased’s fatal injuries.
The coroner found that although the baby hammock did not meet the accepted safe
sleeping criteria, the factual circumstances of the death indicated that the hammock did not
contribute to the death.

Coronial recommendations
The coroner made the following recommendations related to this case:
• That Standards Australia develop an appropriate standard for baby hammocks,
  particularly in relation to design features affecting breathability, capacity to fall and safety
  labelling.
• That the Australian Competition and Consumer Commission (ACCC) support the
development of appropriate Australian Standards.
• That the ACCC update its ‘Keeping baby safe’ booklet on its website with material similar
to that on the Queensland Government website that alerts consumers to the potential
risks of baby hammocks and instructs them on their safe use, that being with the baby in
the supine position and for short supervised periods only.

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with the approval of the relevant State or Chief Coroner.
Coronial recommendations: Fatal facts

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<tr>
<td>Fatal facts edition</td>
<td>45 – cases closed between April and June 2015</td>
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</table>

Case summary

A young male died after being struck by a train.

They arrived at a train station with friends, and made comments regarding suicide. The young person ran towards the tracks and the friends were unable to locate them. The friends attempted to stop the train from departing the station, but were unsuccessful.

A friend of the young person had taken their own life in the same manner some weeks earlier.

Coronial findings

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

The coroner found that the train driver had limited time to understand the situation, and their response was understandable and appropriate.

Coronial recommendations

The coroner made the following recommendations related to this case:

- As part of the Victorian Suicide Prevention Framework, I recommend that the Department of Health and Human Services, Primary Health Networks, Municipals Association of Victoria, Victoria Police and the Chief Psychiatrist conduct a feasibility study on an information exchange process with the Coroners Court of Victoria.
- With the aim of assisting local communities to respond to youth suicide, I recommend that the Municipals Association of Victoria in consultation with the [local government area] develop a suicide prevention and post-vention response framework for local government, which has the ability to take into account various socio-demographic and geographic profiles of individual local government areas.

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Coronial recommendations: Fatal facts

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<td>Fatal facts edition</td>
<td>45 – cases closed between April and June 2015</td>
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</tbody>
</table>

Case summary

A young male took their own life by hanging. They had a history of suicide attempts.

Coronial findings

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

The coroner found that the death occurred in the context of a number of stressors in the young person’s life, including mental ill-health, drug use and contact with the justice system.

The coroner found that there was no evidence that they were impacted directly by the suicide of another young person, but that their decision to end their life should be considered in the context of the phenomenon of a contemporaneous increase in youth suicides in the local government area.

Coronial recommendations

The coroner made the following recommendations related to this case:

- As part of the Victorian Suicide Prevention Framework, I recommend that the Department of Health and Human Services, Primary Health Networks, Municipals Association of Victoria, Victoria Police and the Chief Psychiatrist conduct a feasibility study on an information exchange process with the Coroners Court of Victoria.
- With the aim of assisting local communities to respond to youth suicide, I recommend that the Municipals Association of Victoria in consultation with the [local government area] develop a suicide prevention and post-vention response framework for local government, which has the ability to take into account various socio-demographic and geographic profiles of individual local government areas.

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Coronial recommendations: Fatal facts

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<td>Fatal facts edition</td>
<td>45 – cases closed between April and June 2015</td>
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Case summary

A young male took their own life by hanging. A friend of the young person had taken their own life by hanging some weeks earlier.

Coronial findings

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

The coroner found that the death occurred in the context of a number of stressors in the young person’s life, including mental ill-health, drug use and breakdowns in intimate relationships.

Coronial recommendations

The coroner made the following recommendations related to this case:

- As part of the Victorian Suicide Prevention Framework, I recommend that the Department of Health and Human Services, Primary Health Networks, Municipals Association of Victoria, Victoria Police and the Chief Psychiatrist conduct a feasibility study on an information exchange process with the Coroners Court of Victoria.
- With the aim of assisting local communities to respond to youth suicide, I recommend that the Municipals Association of Victoria in consultation with the [local government area] develop a suicide prevention and post-vention response framework for local government, which has the ability to take into account various socio-demographic and geographic profiles of individual local government areas.
Coronial recommendations: Fatal facts

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

A young male took their own life by hanging. They had recently experienced a relationship breakup.

**Coronial findings**

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

The coroner found that the death occurred in the context of a breakdown in the young person’s relationship, and the consequent increase in isolation.

The coroner found that there was no evidence that they were impacted directly by the suicide of another young person, but that their decision to end their life should be considered in the context of the phenomenon of a contemporaneous increase in youth suicides in the local government area.

**Coronial recommendations**

The coroner made the following recommendations related to this case:

- As part of the Victorian Suicide Prevention Framework, I recommend that the Department of Health and Human Services, Primary Health Networks, Municipals Association of Victoria, Victoria Police and the Chief Psychiatrist conduct a feasibility study on an information exchange process with the Coroners Court of Victoria.
- With the aim of assisting local communities to respond to youth suicide, I recommend that the Municipals Association of Victoria in consultation with the [local government area] develop a suicide prevention and post-vention response framework for local government, which has the ability to take into account various socio-demographic and geographic profiles of individual local government areas.

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.
Case number: VIC.2011.4538
Primary category: Intentional self-harm
Additional categories: Geographic, Youth
Fatal facts edition: 45 – cases closed between April and June 2015

Case summary
A young female took their own life by hanging. They had attempted suicide in the days prior to their death.

The young person’s boyfriend and friend had both taken their own lives by hanging some weeks prior.

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

The coroner found that the death occurred in the context of a number of stressors, including mental ill-health, drug abuse, educational difficulties, and the recent suicides of two people close to them.

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

- As part of the Victorian Suicide Prevention Framework, I recommend that the Department of Health and Human Services, Primary Health Networks, Municipals Association of Victoria, Victoria Police and the Chief Psychiatrist conduct a feasibility study on an information exchange process with the Coroners Court of Victoria.
- With the aim of assisting local communities to respond to youth suicide, I recommend that the Municipals Association of Victoria in consultation with the [local government area] develop a suicide prevention and post-vention response framework for local government, which has the ability to take into account various socio-demographic and geographic profiles of individual local government areas.
Coronial recommendations: Fatal facts

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<th>Case number</th>
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<td>Child and infant death</td>
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<tr>
<td>Fatal facts edition</td>
<td>45 – cases closed between April and June 2015</td>
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Case summary

A male child drowned while swimming at the beach.

The child was not a strong swimmer. They attended the beach with friends and the friends’ parent. They were discovered floating face down in the water a short time later.

Coronial findings

The coroner found that the death was unintentional.

The coroner noted that drowning is a leading cause of death in children. The coroner noted that while there had been a widespread focus on the importance of adult supervision of children around water, a lack of swimming ability among children contributed to an increased risk of drowning.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I agree with and adopt the recommendation in the Life Saving Victoria 2013 report *Sink or Swim: the state of Victorian primary school children’s swimming ability* that swimming and water safety education should be a compulsory skill taught within the primary school curriculum to all Victorian children.
Coronial recommendations: Fatal facts

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<th>Case number</th>
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<tr>
<td>Fatal facts edition</td>
<td>45 – cases closed between April and June 2015</td>
</tr>
</tbody>
</table>

Case summary
A young male took their own life by hanging. They had a recent history of suicide attempts, and had been receiving 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’s mental health had declined in the year prior to their death.

The coroner found that there was no evidence that they were impacted directly by the suicide of another young person, but that their decision to end their life should be considered in the context of the phenomenon of a contemporaneous increase in youth suicides in the local government area.

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

- As part of the Victorian Suicide Prevention Framework, I recommend that the Department of Health and Human Services, Primary Health Networks, Municipals Association of Victoria, Victoria Police and the Chief Psychiatrist conduct a feasibility study on an information exchange process with the Coroners Court of Victoria.
- With the aim of assisting local communities to respond to youth suicide, I recommend that the Municipals Association of Victoria in consultation with the [local government area] develop a suicide prevention and post-vention response framework for local government, which has the ability to take into account various socio-demographic and geographic profiles of individual local government areas.

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Coronial recommendations: Fatal facts

Case number
VIC.2012.757

Primary category
Intentional self-harm

Additional categories
Geographic, Youth, Transport and traffic related

Fatal facts edition
45 – cases closed between April and June 2015

Case summary
A young male died after being struck by a train.

They were sentenced to a Community Based Order at the time of their death, but had repeatedly been absent from supervision, assessment and treatment.

Coronial findings

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

The coroner found that the death occurred in the context of significant stressors including interpersonal difficulties with family, the perpetration of family violence, contact with the justice system and illicit substance abuse.

The coroner noted the unacceptable protracted chronology of the response by Community Correctional Services in the breach of the young person’s Community Based Order. The coroner found that any delay in addressing breaches was a missed opportunity for effective rehabilitation and the prevention of further offending or deterioration in physical and mental wellbeing.

The coroner found that there was no evidence that the young person was impacted directly by the suicide of another young person, but that their decision to end their life should be considered in the context of the phenomenon of a contemporaneous increase in youth suicides in the local government area.

Coronial recommendations

The coroner made the following recommendations related to this case:

- As part of the Victorian Suicide Prevention Framework, I recommend that the Department of Health and Human Services, Primary Health Networks, Municipals Association of Victoria, Victoria Police and the Chief Psychiatrist conduct a feasibility study on an information exchange process with the Coroners Court of Victoria.
• With the aim of assisting local communities to respond to youth suicide, I recommend that the Municipals Association of Victoria in consultation with the [local government area] develop a suicide prevention and post-vention response framework for local government, which has the ability to take into account various socio-demographic and geographic profiles of individual local government areas.
Coronial recommendations: Fatal facts

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<td>Fatal facts edition</td>
<td>45 – cases closed between April and June 2015</td>
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</table>

Case summary

An adult male took their own life in a deliberate fall from height. They had a history of mental illness but had ceased treatment some months prior to their death.

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

Coronial findings

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

The coroner found that the incident location was a 'hotspot' for suicide deaths of the same nature.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that VicRoads urgently liaise with the incoming Victorian State Government and the Federal Government in relation to the implementation of their Policy in an effort to secure necessary funding to enable temporary public safety barriers to be installed on the [bridge] immediately to prevent jumping suicides at that location.
- I recommend that VicRoads urgently liaise with the incoming Victorian State Government and the Federal Government in relation to the implementation of their Policy in an effort to secure necessary funding to enable permanent public safety barriers to be installed on the [bridge] to prevent jumping suicides at that location.

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Coronial recommendations: Fatal facts

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

A young male died after being struck by a train. The railway track area they entered was not fenced.

The young person had a history of a brain tumour, which was removed the year prior to their death. They suffered a cognitive impairment as a result.

Coronial findings

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

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that consideration be given to fencing the southern side of the railway tracks between [location] and [location] stations and gating the steps to the track on the southern side of the tracks approximately [distance] of [station].

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Coronial recommendations: Fatal facts

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<td>Fatal facts edition</td>
<td>45 – cases closed between April and June 2015</td>
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Case summary

A middle aged male died when they were assaulted by their roommate.

They suffered from a psychiatric illness, and resided in a facility that catered for elderly people and people with mental ill health. The roommate was known to express homicidal ideation and threaten harm over many years, but had not acted on any of these threats.

The roommate told nursing staff they intended to kill the adult shortly before the incident. The nurse thought they were joking, and dismissed the situation. Some hours later, the roommate fatally stabbed the adult.

Coronial findings

The coroner found that the death was due to assault.

The coroner found that the death could have been prevented if the nurse acted in a preventative way following the threats made by the roommate. However, the coroner found that the nurse was not specifically trained on assessing risks posed by people with mental ill health.

The coroner found that the nurse had not been trained to recognise the risk posed by the roommate on this occasion as compared with previous occasions where similar threats were made.

Coronial recommendations

The coroner made the following recommendations related to this case:

- Given that 59 per cent of pension level Supported Residential Service residents were reported to have a psychiatric illness or disability, I recommend that the Department of Health and Human Services give consideration to mandating mental health training for staff (or at least for more senior staff) in Supported Residential Services. The training should be at least sufficient to enable staff to recognise serious threats, interpret threats and take appropriate action.
• I further recommend that the Department of Health and Human Services give consideration to incorporating in the Supported Residential Services compliance regime a requirement that proprietors insist on relevant staff undertaking such training.
Coronial recommendations: Fatal facts

Case number
VIC.2012.1615

Primary category
Intentional self-harm

Additional categories
Geographic, Youth, Transport and traffic related

Fatal facts edition
45 – cases closed between April and June 2015

Case summary
A young male died when they were struck by a train. They were observed by the train driver to run onto the railway tracks. The train driver was unable to avoid the collision.

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

The coroner found that there was no evidence that the young person was impacted directly by the suicide of another young person, but that their decision to end their life should be considered in the context of the phenomenon of a contemporaneous increase in youth suicides in the local government area.

The coroner noted the possibility that the young person was friendly with another young person who took their own life in the same manner the year prior.

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

- As part of the Victorian Suicide Prevention Framework, I recommend that the Department of Health and Human Services, Primary Health Networks, Municipals Association of Victoria, Victoria Police and the Chief Psychiatrist conduct a feasibility study on an information exchange process with the Coroners Court of Victoria.
- With the aim of assisting local communities to respond to youth suicide, I recommend that the Municipals Association of Victoria in consultation with the [local government area] develop a suicide prevention and post-vention response framework for local government, which has the ability to take into account various socio-demographic and geographic profiles of individual local government areas.

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Coronial recommendations: Fatal facts

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Case summary
A young female died when they were struck by a train. They were observed on the railway tracks by the train driver, who was unable to avoid the collision.

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

The coroner found that the death occurred in the context of interpersonal difficulties and a clear deterioration in the young person’s mental health in the year preceding their death.

The coroner found that the train driver took appropriate measures in applying emergency brakes, and it was not possible to avoid the collision. Despite the incident occurring in the same location as a number of other youth suicides, the young person’s actions had not been not impacted by any other death.

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

- As part of the Victorian Suicide Prevention Framework, I recommend that the Department of Health and Human Services, Primary Health Networks, Municipals Association of Victoria, Victoria Police and the Chief Psychiatrist conduct a feasibility study on an information exchange process with the Coroners Court of Victoria.

- With the aim of assisting local communities to respond to youth suicide, I recommend that the Municipals Association of Victoria in consultation with the [local government area] develop a suicide prevention and post-vention response framework for local government, which has the ability to take into account various socio-demographic and geographic profiles of individual local government areas.

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Coronial recommendations: Fatal facts

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Case summary
An adult female died at home due to unascertained causes in the setting of prescription medication use.

They were known to obtain prescriptions from multiple doctors and abuse prescription medications.

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

The coroner noted that police did not photograph the scene or seize the medication found.

The coroner noted that the police had updated their procedures and guidelines since the incident regarding the investigation of drug overdoses.

The coroner noted that positive developments had been made in Victoria towards the establishment of a real-time prescription monitoring system.

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

- The Royal Australian College of General Practitioners review the circumstances of [the deceased]'s death and consider how it can better educate doctors about the benefits of contacting state based drugs and poisons regulators before prescribing potentially dangerous or addictive drugs.

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Coronial recommendations: Fatal facts

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Case summary

An adult male died of unascertained causes after being transported to hospital in a police vehicle.

They suffered from a long-standing mental illness that was managed by mental health services within hospital. On the day of the incident, they suffered a psychotic episode and their family requested the Crisis Assessment and Treatment (CAT) team and ambulance attend. Due to the adult’s history of aggression and non-compliance, the police were also requested to attend and assist in the transport to hospital.

The adult advised they would not voluntarily go to hospital, and resisted strongly. Police handcuffed them, and they were transported to hospital in the police vehicle to maintain the safety of the CAT team and ambulance staff.

They were discovered unresponsive on arrival at the hospital. Resuscitation attempts were unsuccessful and they passed away a short time later.

Coronial findings

The coroner was unable to determine the cause of the deceased’s fatal injuries, however they died in the context of legal intervention.

The coroner found that the decision to transport them in the police vehicle was the option of last resort, and was undertaken when the CAT team and ambulance staff advised they did not propose to transport them to hospital themselves.

The coroner found that the camera in the police vehicle did not capture their face, thus the police were unable to appropriately monitor them. The coroner noted that enhanced digital recording systems within police vehicles were in planning at the time of the coronial investigation.

Coronial recommendations

The coroner made the following recommendations related to this case:
• When, as a last resort, Victoria Police have the onerous responsibility of transporting a mental health patient to hospital under circumstances such as those seen here, then the police officer who makes the decision to transport, prior to endorsing that decision, proactively enquire of family members, and others present, whether the person about to be transported has any medical conditions which may potentially compromise the patients wellbeing.

• Adopting an observation of [forensic pathologist who conducted autopsy], professionals (Victoria Police, Ambulance Victoria and Crisis Assessment and Treatment (CAT) teams under the umbrella of Department of Health) dealing with patients suffering a mental health episode who are, or are about to be restrained, be provided with a special warning, by way of practice direction, of the increased risk of death the condition poses.
Coronial recommendations: Fatal facts

**Case number**  
VIC.2013.2089

**Primary category**  
Mental illness and health

**Fatal facts edition**  
45 – cases closed between April and June 2015

**Case summary**

A middle aged female died at home due to unascertained causes.

The adult had a long history of mental illness and were cared for by a family member until shortly before their death. The adult's mental condition declined and they refused to engage with treatment. Their family member ceased communication.

They were discovered deceased in their home after being unable to be contacted for some months.

**Coronial findings**

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

The coroner found that it was likely the adult were deceased for some time prior to being found.

The coroner found that they had disengaged from clinical treatment some time before their death. The coroner found that their clinical management relied on self-reporting, and thus it was difficult for health services to maintain treatment.

**Coronial recommendations**

The coroner made the following recommendations related to this case:

- That the Royal Australasian College of General Practitioners consider including in its Standards for General Practices, a section providing guidance to general practitioners about continuity of care and patient follow-up specific to patients with mental health issues who are prescribed and receiving regular psychoactive medications.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2013.2551</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Intentional self-harm</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Mental illness and health</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>45 – cases closed between April and June 2015</td>
</tr>
</tbody>
</table>

Case summary

A young male took their own life by hanging while in a high security psychiatric hospital.

The young person had been arrested and charged with a criminal offence, and were transferred to the hospital a short time later for treatment.

They were discovered deceased in the bathroom.

Coronial findings

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

It was noted that the bathroom was usually locked, and nurses would unlock the door upon a patient’s request and lock it again immediately afterwards. The coroner found that on the day of the incident, the door to the bathroom was inadvertently left unlocked, or was unlocked specifically for the young person to access.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I note with approval that annual reviews are conducted at [the hospital] to seek to identify any further hanging points within the hospital. To assist this process and in consultation with the Clinical Director I recommend that an appropriately skilled analyst, who is otherwise independent of the hospital, be invited to join that review.

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.2013.3448
Primary category | Adverse medical effects
Additional categories | Older persons
Fatal facts edition | 45 – cases closed between April and June 2015

Case summary
An older male died in hospital.

The adult presented to hospital with a neck abscess, but their admission was complicated by diarrhoea. After some days in hospital, they were diagnosed with Clostridium difficile infection and underwent a sub-total bowel resection. They died some days later.

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

The coroner found that the hospital staff did not initially consider the possibility of Clostridium difficile infection. However, the coroner found that it was unable to be determined whether the adult’s clinical course would have been materially different if the infection had been diagnosed and treated earlier.

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

- I recommend that [the deceased]’s death be used as a case example for [the hospital] staff education programs to enhance clinical management and, in particular, ensure that medical practitioners and nursing staff caring for elderly patients on protracted courses of antibiotics are aware of the signs and symptoms of Clostridium difficile infection.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2014.186</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Transport and traffic related</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Water related, Leisure activity</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>45 – cases closed between April and June 2015</td>
</tr>
</tbody>
</table>

Case summary

A young female died following a boating collision. The young person was a passenger on a boat engaged in wakeboarding when it was struck by another boat. They sustained a serious head injury and subsequently died in hospital.

Coronial findings

The coroner found that the death was unintentional.

The coronial inquest focused on stricter rules and obligations regarding vessels and speed limits.

Coronial recommendations

The coroner made the following recommendations related to this case:

I adopt the following recommendations made by [police sergeant] regarding changes to be made to ensure safety and liability for boating vessels:

- Review of the Vessel Operating and Zoning Rules regarding speed and distance rules for towing activities with particular consideration of:
  - Narrow and confined waterways
  - Human factors and task liability on vessel operators
  - Vessel dynamics and ability (or inability) to decelerate or alter course
- More stringent boat license training including a component regarding estimating distance over water, followed by a practical assessment to test foundation knowledge and effectiveness of the learning. It should be emphasised that in the last 10 years, there have been numerous fatal vessel incidents where fully licensed boat operators have shown complete ignorance of the rules or safe vessel handling. The call for improved license training and testing has been subject of numerous Victoria Police recommendations but no real improvement has been seen.
- The term 'recreational vessel' be removed in the relevant legislation and publications and simply leave it as 'vessel' to lessen the implied notion that boat operation is akin to a...
hobby with lesser standards of responsibility than those faced by road users. An alternative may be to use the term 'private vessel' to create a distinction from a 'commercial vessel' if need be.

- An indictable offence of "operate a vessel in (a) contravention of the Prevention of Collisions Convention, or (b) that is an Unsafe Vessel causing death or serious injury' be created within the *Marine Safety Act 2010 (Vic).* This proposed offence should fit within Part 3.5, Division 2 of the Act.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2014.1844</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Transport and traffic related</td>
</tr>
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<td>Additional categories</td>
<td>Water related, Leisure activity</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>45 – cases closed between April and June 2015</td>
</tr>
</tbody>
</table>

Case summary
An adult male died when their boat crashed onto rocks. Despite a significant search operation, their body was never fully recovered.

Coronial findings
The coroner found that the death was unintentional.
The cause of the boat crash was unable to be determined.

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

- That Transport Safety Victoria progress the implementation of Emergency Position-Indicating Radio Beacons [EPIRB] and Personal Locator Beacons (preferably those with GPS [global positioning system] capability), amongst recreational boaters in Victoria, to ensure that each vessel has an EPIRB and that, at times of heightened risk, crewmembers wear Personal Flotation Devices, with at least one Personal Flotation Device per boat being fitted with a Personal Locator Beacon (preferably one with GPS capability).
- That Transport Safety Victoria considers promoting the use of Emergency Position-Indicating Radio Beacons and Personal Locator Beacons (preferably with GPS capability) within the Victorian recreational boating community, so that devices are carried by all recreational boats, not just vessels operating further than two nautical miles from the shore.

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

<table>
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<tr>
<th>Case number</th>
<th>VIC.2014.2984</th>
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<tr>
<td>Primary category</td>
<td>Transport and traffic related</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Misadventure, Youth</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>45 – cases closed between April and June 2015</td>
</tr>
</tbody>
</table>

Case summary

A young male died as a result of a train-related incident.

The young person broke into the rear end of the driver’s cabin on a train. The young person opened the side door of the cabin whilst the train was moving and leant out of the train. They struck a signal post and fell out of the train. They later died in hospital.

Coronial findings

The coroner found that the death was unintentional.

The coroner recommended more focus on the process of security on the trains.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Metro Trains Melbourne General Manager Fleet implement a system to manage authorised access through ‘smart’ keys and locks yet to be fitted to railway infrastructure and rolling stock. I am informed that the ‘smart’ key is equipped with a microchip that requires regular re-validation to ensure access security is maintained for authorised personnel only. I recommend that this proposal be entered as an action item in the MTM safety incident management system so that its progress may be followed to completion.
- That the MTM General Manager Fleet consider the feasibility of installing a system that detects the status of Comeng train cab doors and transmits that status to a Train Driver at the driving end. This should include detection of internal and external doors of all non-driving motor carriages as well as the semi-permanent recording of that status in VICERS while the train is active.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2014.5355</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Transport and traffic related</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Older persons</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>45 – cases closed between April and June 2015</td>
</tr>
</tbody>
</table>

Case summary
An older adult male died after they were struck by a car. At the time of the incident, they were crossing a road on their motorised mobility scooter. The older person fell from the scooter and struck their head on the road. They subsequently died in hospital.

Coronial findings
The coroner found that the death was unintentional. The coroner recommended changing the road intersection to enable vehicle drivers to have better view of pedestrians.

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

- Adopting the suggestion made by the Coronal Investigator, Leading Senior Constable [name], I recommend that if it feasible and if it not already been done, that VicRoads and the [local government area] give consideration to moving the stop line at the [intersection] 1.5 - 2 metres, thus providing a better vision of approaching traffic, especially from the driver’s left.

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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

<table>
<thead>
<tr>
<th>Case number</th>
<th>WA.2010.915</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Child and infant death</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Natural cause death</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>45 – cases closed between April and June 2015</td>
</tr>
</tbody>
</table>

Case summary

An infant died a few days after their birth.

The infant was non-responsive at the time of their delivery, but responded to medical attention. They subsequently died due to complications associated with their birth.

Coronial findings

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

The coroner recommended better record keeping of previous medical conditions.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the [health service] give consideration to improving the method of recording the result of the mandatory obstetric review required by Community Midwifery Program policy, so that it is easily accessible for all health professionals in the pregnancy record. I also recommend that the Community Midwifery Program Discharge Form be amended to include a section confirming the birth plan and the obstetrician who has approved it, as well as a section indicating whether the birth plan should be reconsidered due to any issues identified during the Maternal Fetal Assessment Unit admission.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>WA.2012.34</th>
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</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Geographic</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Child and infant death, Misadventure, Natural cause death</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>45 – cases closed between April and June 2015</td>
</tr>
</tbody>
</table>

Case summary

A female child died after they became lost in bushland.

The child and their guardian drove into bushland when their car broke down. They were unable to find their way back to safety.

Coronial findings

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

The coroner found that the child died due to heat stroke and dehydration following a few days of excess heat and a lack of food and water.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That Western Australian Police devise a public notice based on [doctor’s] annexure and take steps to ensure that copies of the notice are placed on public notice boards throughout Western Australia where there is potential for people to become stranded in remote areas.
- That Western Australian Police officers who service remote communities liaise with community leaders with a view to arranging for the training of community members about survival when lost or stranded.

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Case summary

A young adult female died due to natural causes.

The young adult presented to hospital where they were misdiagnosed with dehydration and gastroenteritis. They appeared to respond well to treatment, but subsequently deteriorated.

The young person was later diagnosed with septic shock. However, they had developed multi-organ failure, and attempts to resuscitate them were unsuccessful.

Coronial findings

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

The coroner found that there was evidence to support the treating doctor’s initial diagnosis but that there were multiple issues in the administration of the young person’s care.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend clinicians in remote settings consider their capacity to resuscitate patients with sepsis, when assessing a patient’s clinical presentation and the threshold for the administration of broad spectrum antibiotics, following the taking of bloods for diagnostic purposes.
- I recommend additional education and audits on use of the AORC in Paraburdoo to ensure appropriate use of those charts.
- I recommend user friendly flow charts summarising the guidelines and procedures in operation in rural and remote health services for the successful collection of bloods be placed in collection areas where they are not already in existence.

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## Appendix A: Fatal Facts Web Tool Category Tags

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