Coronial recommendations: Fatal facts

A summary of cases and recommendations made between July and September 2015

Edition 46
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CORONERS’ RECOMMENDATIONS

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

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

*Coronial recommendations: Fatal facts* includes case summaries and recommendations for cases closed between July and September 2015.

AUSTRALIAN CAPITAL TERRITORY

The following cases summaries and recommendations relate to deaths reported to a coroner in the Australian Capital Territory.
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<table>
<thead>
<tr>
<th>Case number</th>
<th>ACT.2010.8</th>
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<tbody>
<tr>
<td>Primary category</td>
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<td>Additional categories</td>
<td>Leisure activity, Transport and traffic related</td>
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<tr>
<td>Fatal facts edition</td>
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Case summary

An adult male died due to a waterway collision between the jet ski they were riding and a motorised ski boat.

The collision occurred on a sharp bend. Both vehicle drivers held a maritime licence.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the surrounds played no part in the accident. However, the coroner identified a number of areas meriting consideration to increase the general safety of the area for use by members of the public.

Coronial recommendations

The coroner made the following recommendations related to this case:

- Consideration be given to dividing [location] reach into two separate sections to cater for the differing types of watercraft which regularly use the area and their differing activities. One possibility is to confine slower and less manoeuvrable vessels, such as water ski boats towing people on water skis, wake boards and ski biscuits, to the wider section of [river] between the northern and southern boat ramps and confine the faster and more manoeuvrable vessels, such as jet skis, to the narrower section to the south of the southern boat ramp.
- Consideration be given to the placement of navigation buoys and relevant signage on [river] from the approach to, and through, the two bends referred to above so as to assist watercraft to maintain, a course to the port side of the centre of the river.
- If not already in place, consideration be given to developing a more regimented approach to the management of [river], including regular risk assessments; protocols and arrangements for identifying and removing hazards prior to and during the water skiing season, and a greater monitoring of use of the area by recreational watercraft by either the relevant Australian Capital Territory Department or the Australian Federal Police.
• If not already in place, consideration be given to developing a more streamlined and effective method for booking [the river] for use by recreational watercraft so as to ensure that the number of users at any one time is limited to a safe number.

• A review of the relevant legislation be carried out to ensure that it is adequate and carries sufficient deterrents for the unlawful use of [river], and that members of the Australian Federal Police have sufficient powers to enforce relevant safety legislation, including the issuing of infringement notices and the carrying out of random alcohol and drug testing.
NEW SOUTH WALES

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

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<td>Leisure activity</td>
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<td>Fatal facts edition</td>
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**Case summary – NSW.2012.2974**

An adult male died due to drowning in a rock fishing incident.

The adult was fishing along a rock ledge when they were swept off the ledge by a large wave. The adult was later found deceased by a helicopter rescue diver.

**Coronial findings**

The coroner found that the death was unintentional.

The coroner found that the adult engaged in rock fishing regularly and wore equipment suitable for rock fishing, however did not wear a life jacket. The failure to wear a life jacket was a significant factor in the death.

**Case summary – NSW.2012.4559**

An older adult male died due to immersion.

The adult was a very competent rock fisher, and was rock fishing at the time of the incident. It was unknown how they came to be in the water.

**Coronial findings**

The coroner found that the death was unintentional.

The coroner found that at the time of the incident the older adult was not wearing a life jacket. The area in which they were undertaking rock fishing was not at the time patrolled by a council surf life saving club.

**Case summary – NSW.2012.4678**

An adult male died due to drowning as a result of a fishing incident.
At the time of the incident, the adult was rock fishing with two friends. The group were swept off the rocks by a large wave. The adult’s friends were able to climb onto the rocks, but did not re-enter the water to aid the adult as neither were competent swimmers.

The adult was deceased by the time they were rescued from the water.

**Coronial findings**

The coroner found that the death was unintentional.

The coroner found that at the time of the incident the adult was not wearing a life jacket. Had the adult been wearing a life jacket like one of their companions, their chance of survival after being swept off the rocks would have been greatly improved.

**Case summary – NSW.2014.54**

A middle aged male died due to drowning in a rock fishing incident.

The adult was fishing along a rock wall protecting the harbour. The area was commonly used for rock fishing. The adult’s body was discovered in the water by another fisher. It was unable to be determined how the adult came to be in the water.

**Coronial findings**

The coroner found that the death was unintentional.

The coroner found that there were no witnesses to the incident that preceded death. The adult was found in the ocean with their fishing gear nearby. They were not wearing a life jacket at the time.

**Case summary – NSW.2014.1591 and NSW.2014.2176**

A young male and an adult male died due to drowning in a rock fishing incident.

The two had been rock fishing as part of a group when one of their friends was swept into the water by a large wave. The two drowned in their attempts to rescue their friend.

The body of the adult was found in the ocean the next day. The body of the young person was never recovered.

**Coronial findings**

The coroner found that the death was unintentional.

The coroner found that group did not have life jackets with them. The only form of safety item they had brought with them was a safety ring. The beach where the group was rock fishing displayed warning signs about the dangers of rock fishing. It appeared that the signage was not read by the group.
Case summary – NSW.2014.3531
An adult male died due to drowning in a rock fishing incident.

The adult was rock fishing with their partner at the time of the incident. A wave swept over the area, washing the adult and two others present into a rock pool. Large waves made it difficult to get out of the rock pool, and the adult was subsequently found face down in the water. They were extracted from the water and emergency services were contacted. The adult was conveyed to hospital where they were found to have passed away.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult was wearing a compliant life jacket at the time of the incident. However, they had suffered head injuries which rendered them unconscious and resulted in their drowning.

Case summary – NSW.2014.2376
An adult male died due to drowning in a rock fishing incident.

The adult was rock fishing with a group of friends at night. The adult and a friend had approached the water’s edge to fill a bucket with water when they fell into the water. Emergency services were contacted and attempts were made to rescue the adult; however the adult was unable to be recovered.

The adult’s remains were discovered several months later.

Coronial findings

The coroner found that the death was unintentional.

The coroner was satisfied that the adult died due to drowning a short time after falling into the water.

Case summary – NSW.2015.473
A young male died due to a head injury and subsequent drowning in a rock fishing incident.

The young person was an experienced rock fisher. They were in a rock fishing area with friends when they were swept into a rock pool by a large wave. Their friends threw them a life ring, which they were able to stay with for a matter of minutes. The young person then appeared to lose consciousness and went out of sight.

Emergency services were contacted and a rescue operation commenced. The body of the young person was found in the water a few days later.
Coronial findings

The coroner found that the death was unintentional.

The coroner found that there had been swell warning issued for that particular stretch of the ocean on the day of the incident. The young person was not wearing a life jacket at the time.

Coronial recommendations

The coroner made the following recommendations related to these cases:

To the Minister for Justice and Police:

- I recommend the introduction of legislation requiring the mandatory use of life-jackets by those engaged in rock fishing including:
  - A requirement that the life-jackets comply with the Australian Standards
  - The consideration of a twelve month grace period
  - The legislation be introduced with a dedicated education campaign
  - The consideration of accompanying the introduction of mandatory life-jackets with initiatives to facilitate the wearing of appropriate life-jackets such as coupons or gift vouchers for free or subsidised life-jackets or life-jacket borrowing schemes for those engaged in rock fishing

To the Minister for the NSW [New South Wales] Department of Primary Industries:

- I recommend that consideration be given to schemes that might increase the uptake of the wearing of life-jackets such as coupons or gift vouchers for free or subsidised life-jackets or life-jacket borrowing schemes for those engaged in rock fishing.
- I recommend that consideration be given to utilising the fishing fee collection process to offer an “opt in” service that would provide alerts, education and other safety information regarding rock fishing.

To the Chief Executive Officers of [three councils] and National Parks and Wildlife Services:

- I recommend a review of the size and location of current signage relating to rock fishing and to consider the erection of further appropriate signage at known rock fishing sites warning of the hazards of rock fishing and promoting the wearing of life-jackets.
- I recommend considering the use of shock signage, indicating the number of deaths or serious injuries associated with rock fishing in a particular location, at identified locations of particular danger for rock fishing.

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<tr>
<td>Fatal facts edition</td>
<td>46 – cases closed between July and September 2015</td>
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Case summary
A middle aged male died due to a gunshot wound they sustained whilst employed as a security officer.

At the time of the incident, the adult was in the company of two other security guards tasked with replenishing cash in automatic teller machines.

The offender was unable to be identified.

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

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

- That the investigation of the death of [the deceased] be referred to the Unsolved Homicide Unit of the NSW [New South Wales] Police for further investigation in accordance with the policies and protocols of the unit.
Coronial recommendations: Fatal facts

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

Case summary

An adult male died due to a gunshot wound.

They were fatally shot in their place of work. Emergency services attended and the adult was conveyed to hospital. Despite attempts to resuscitate the adult, they were unable to be revived.

The identity of the assailant was unable to be established.

Coronial findings

The coroner found that the death was due to assault.

Coronial recommendations

The coroner made the following recommendations related to this case:

- The investigation into the death of [the deceased] should be referred to the Unsolved Homicide Unit of the NSW [New South Wales] Homicide Squad for further investigation in accordance with the protocols and procedures of that unit.
- That consideration be given to offering a substantial monetary reward for information leading to the conviction of any person or persons for the murder of [the deceased].
Coronial recommendations: Fatal facts

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<th>Case number</th>
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<td>Additional categories</td>
<td>Physical health</td>
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**Case summary**

A young female died when their implantable cardioverter defibrillator (ICD) failed to shock their heart into a natural rhythm.

The young person suffered from a congenital heart condition and as such was fitted with an ICD and a high voltage lead designed to automatically shock their heart into a normal rhythm if the heart became arrhythmic.

**Coronial findings**

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

The coroner identified a number of potential areas of improvement regarding the implantable device.

In 2010, the manufacturers of the ICD and lead released a warning regarding a potential fault in the leads.

**Coronial recommendations**

The coroner made the following recommendations related to this case:

To the Commonwealth Minister for Health, the Chief Executive Officer of the Therapeutic Goods Administration and the President of the Cardiac Society of Australia and New Zealand:

- I recommend that consideration be given to establishing a national registry of implanted cardiac devices that would capture full details of the cardiac device (eg. brand / model) and also details of the patient in whom such device was implanted.

To the Commonwealth Minister for Health and the Chief Executive Officer of the Therapeutic Goods Administration:

- I recommend that consideration be given, in consultation with the Cardiac Society of Australia and New Zealand, and manufacturers of implantable cardiac devices, to requiring mandatory reporting of failures of, or significant incidents concerning,
implanted cardiac devices by clinicians and allied health professionals including device manufacturers or their Australian agents.

To the President of the Cardiac Society of Australia and New Zealand:

- I recommend that the Society consider developing guidelines concerning the regular testing of implanted cardiac devices that do not have in-built, regular, painless, circuitry-testing capacity.
Coronial recommendations: Fatal facts

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

Case summary

A middle aged female died following treatment for cancer.

The adult was receiving chemotherapy treatment. They were advised to immediately attend hospital if they experienced chest pain.

Coronial findings

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

The coroner found that the death occurred due to a series of failures by both staff and systems in place at the hospital. These included:

- inadequate observations
- poor recording of notes and observations
- inadequate handover
- failure to recognise the adult’s deteriorating condition
- failure to initiate a Medical Emergency Team (MET) call at an appropriate time
- a lack of trained staff to perform an echocardiogram during weekends.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That [hospital] consider compiling and circulating, within the hospital, a list of personnel who have sufficient training, qualifications or experience to be able to perform urgent after hours bedside ultrasound or echocardiograms.
- That [hospital] give consideration to encouraging medical staff to take up training in bedside ultrasound.

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

An adult male died due to an unintentional drug overdose.

The adult was being treated by their doctor for drug dependence, depression and injuries associated with a suicide attempt.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the treating doctor prescribed the adult amounts of medication higher than seemed necessary. In addition, prescriptions issued by the doctor were filled and re-prescribed well before the previous script had run out or neared completion.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the Health Care Complaints Commission:

- I recommend that [the doctor’s] professional standards be reviewed.

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Case summary

An adult male died due to complications following surgery.

The adult had undergone surgery for the removal of a lung due to tuberculosis (TB). The adult was an immigrant to Australia. Prior to arriving in Australia, they were identified as having latent TB. Their TB became active whilst in Australia.

Coronial findings

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

The coroner found that immigrants diagnosed with latent TB were required to sign a health undertaking as part of their visa to ensure their medical monitoring during their first two years in Australia.

The adult was found to be compliant with these terms and conditions during this initial two year period. They completed their final assessment and were told to return if symptoms appeared. Their final assessment took place over the phone, and no physical examination was performed.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the NSW [New South Wales] Minister for Health:

- I recommend that pre-discharge interviews with patients being screened for tuberculosis (TB) be undertaken face-to-face and include a physical check for signs of possible active TB or risk factors for activation of TB. In this context, I also recommend that, when considering discharge, physicians reviewing patients’ most recent chest x-rays do so with the benefit of the radiologist’s report.
To the Minister for Immigration and the NSW Minister for Health:

- I recommend that their departments confer to find the optimal policy (or policies) for ensuring both that the health and welfare of temporary visa holders who are subject to TB health undertakings (or similar undertakings in respect of other public health risks) are protected, and public health is safeguarded.
Coronial recommendations: Fatal facts

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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 person died due to injuries sustained in a fall from height.

A fire had broken out in the young person’s unit. They caused themselves to fall from the unit’s balcony in an attempt to escape the fire.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the fire started on the balcony of the residence, but was unable to identify the cause of the fire.

There were no fire sprinklers installed in the residential tower.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the Minister for Planning (NSW [New South Wales]) and the General Manager of the Australian Building Codes Board (“ABCB”):

- That the Department of Planning (NSW) and the ABCB conduct research (jointly or individually), in consultation with Fire & Rescue NSW and the Australasian Fire and Emergency Service Authorities Council, into the off-setting of costs associated with installing fit-for-purpose sprinkler systems in new Class 2 and 3 buildings through the possible reform of other fire safety requirements.

To the General Manager of the Australian Building Codes Board (“ABCB”):

- That the ABCB consider amending the National Construction Code to provide definitions for the terms “substantially enclosed” and “direct egress” to ensure clarity and consistency of interpretation. That the ABCB consider amending the National Construction Code to require the installation of fit-for-purpose sprinkler systems in all new Class 2 and 3 buildings (buildings of a shared residential nature) in conjunction with

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the possible reform of other fire safety requirements to ensure this significant improvement in public safety is achieved in the most cost-effective manner. That the ABCB review the efficacy of the current requirements in the National Construction Code as regards smoke alarms and detectors in residential buildings to ensure their life safety function is not undermined by the high incidence of false alarms which are contributing to public complacency and the disabling of alarms.

To the Minister for Planning (NSW) and the Minister of Health (NSW):

- That the Department of Planning and the Department of Health develop (jointly or individually), in consultation with Fire and Rescue NSW, Australasian Fire and Emergency Service Authorities Council and the Australian Building Codes Board, the capacity to collect and publish data regarding fire-related injuries for use in the development of fire safety policies and reforms (and see below regarding the collection of non injury related economic cost data) That the Department of Planning and the Department of Health (jointly or individually) engage interstate counterparts with the objective of establishing the uniform collection and publishing of data on fire-related injuries for use in the development of fire safety policies and reforms.

To the Minister for Planning (NSW), the Minister for Emergency Services (NSW) and the Minister for Fair Trading (NSW):

- That a statutory regime be implemented for the accreditation and auditing of persons or entities that undertake annual fire safety checks and issue annual fire safety statements issued pursuant to the Environmental Planning and Assessment Regulation 2000. Consideration should be given to including Australian Standard AS1851 as part of the statutory regime as an option for meeting maintenance requirements for essential fire safety systems. That the ministers consider legislative reform to allow lawful powers of entry for appropriately authorised inspectors from the Department of Planning, Office of Fair Trading, Council or FRNSW [Fire & Rescue NSW] to inspect property in circumstances where a reasonable suspicion of unlawful occupancy is held.

To the Minister of Planning and the Minister for Emergency Services

- That consideration be given to implementing, in consultation with Fire & Rescue NSW, a statutory requirement that installations of new, or alterations of existing, fire hydrant systems be approved by Fire & Rescue NSW prior to the issue of an occupation certificate. That the Department of Planning, in consultation with Fire & Rescue NSW, develop the capacity to collect and publish data regarding the economic cost of fire including business interruption, property loss, displacement of residents, lost work time due to injuries including smoke inhalation injuries and associated business costs related to insurance payouts and premiums. That the Department of Planning, in consultation...
with the Fire & Rescue NSW, examine the development of a star rating system for new residential building fire safety systems (in addition to mandatory compliance with the NCC regime) with the objective of readily informing the consumer about the overall efficacy of the building’s overall fire safety systems and consider strategies to deter non-compliance with the fire safety requirements in residential buildings as provided by the National Construction Code and Environmental Planning and Assessment Act 1979, Environmental Planning and Assessment Regulation 2000. That the Minister for Planning (NSW), in consultation with the Minister for Emergency Services (NSW) conduct a review of the efficacy of the enforcement powers of FRNSW in relation to fire safety with a particular focus on the effective and proportionate escalation of powers to ensure timely compliance with orders and the consideration of extending or clarifying those powers as they relate to structural matters. That current changes proposed to clause 144 and clause 152 of the Environmental Planning and Assessment Regulation (2000) affecting the role of FRNSW in the assessment of alternative solutions be expedited so that FRNSW are better able to apply their resources on a risk basis when addressing building fire safety.

To the Managing Director, Sydney Water Corporation (“Sydney Water”):

- That Sydney Water consult with FRNSW prior to implementing any water pressure reduction program and consider alternative strategies for the maintenance of appropriate firefighting water to properties that may be required to incur significant retrofitting costs as a result of the program.
Coronial recommendations: Fatal facts

Case summary
A young male died due to injuries sustained in a motorcycle incident.

At the time of the incident, the young person was attempting a long distance jump on the motorcycle at a showground. The young person and their parent had extensive experience in freestyle motor cross and long distance jumping.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that there were several deficiencies in the planning for the jump.

The coroner found that the jump was poorly located, with no ambulance or first aid at the scene and the rider was not wearing any form of body protection. There was no documentation regarding the planning of the event and there was a lack of documented engineering calculations for the jump. There was no formal, documented risk assessment or risk management plan carried out, however, the showground association did not require the risk assessment or risk management plans prior to endorsing the event.

As the proper documentation was not received by the showground association, the jump was not considered as a ‘motorsport’ and as such was not overseen by local council or traffic committees.

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

- The [location] Agricultural and Horticultural Association management committee appropriately made the obtaining of public liability insurance coverage a condition of their consent for the record jump attempt to proceed on their land. However, their processes did not involve any cross checking to ensure that this had been secured. Accordingly, I recommend the association review those processes to address this shortcoming.
Having regard to the potential for danger to the public when long distance motor cycle jumps are attempted on public land or land readily accessible by the public, it is appropriate that those undertaking the activity be required to conform to safety standards applied to similar motor vehicle sports such as motocross racing. Accordingly, I recommend that when the *Motor Vehicle Sports (Public Safety) Act 1985* is reviewed, consideration be given to making such events subject to the licence requirements of the Act.
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Case summary

A middle aged female took their own life through ingesting excess medication.

The adult had a history of chronic pain and mental illness. Days prior to their death, the adult had been admitted to hospital for a drug overdose. They were treated and subsequently discharged. The adult was later unable to be located and police were contacted to report them missing. They were found deceased on the property where they had been staying.

Coronial findings

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

The coroner found that the adult had overdosed on medication several times within a short period before the fatal incident. After the first occurrence, they were placed into the care of a local mental health team. On the penultimate overdose, the adult was assessed in hospital and found to be at chronic medium risk of suicide. As a result, they did not meet the requirements for an involuntary admission to hospital.

They were released into family care with the intention that they would be reviewed within 24 hours by a mental health team. The coroner found that no information about follow-up care was conveyed to the family.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the NSW [New South Wales] Minister of Health, the [health district] and the [health district]:

- That consideration be given to the implementation of policy as follows:
  - Where a patient has attempted suicide and is being discharged from a general ward into the community following psychiatric review, a discharge document in relation to the psychiatric review be completed and approved by a consultant psychiatrist and the risk of further self-harm or suicide be clearly identified on the discharge summary as well as the reasons for that assessed risk.
Handover from the Community Mental Health Team to a private medical practitioner is to involve:
- A verbal handover;
- Transfer of written documents and a discharge summary including the hospital discharge summary;
- Recording of the next appointment;
- Follow up call to ensure the documents have been received; and
- The file of the patient is not to be closed until there is confirmation that the patient attended the private practitioner, completing handover.

Where a patient, who has attempted suicide, has been assessed to be discharged into the care of a family member and followed up by the Community Mental Health Team, in consultation with the patient, the family member or carer should be informed of the follow up/ discharge plan and give their consent for the patient to stay with them on that basis. If the patient does not consent to the clinician speaking with the family or carer, the clinician should review and reassess the patient's risk of harm. If a patient, upon being informed of the information to be provided to the family member or carer, objects to that information being provided and the clinician still intends to discharge the patient, the clinician should consider NSW Health Privacy Policy 11.2.1.3 and/or consult with the Privacy Contact Officer on how to proceed in relation to the patient receiving treatment.
Coronial recommendations: Fatal facts

**Case summary**

A young male took their own life by hanging.

At the time of the incident, the young person was incarcerated. They had been diagnosed with schizophrenia, for which they were receiving medication.

**Coronial findings**

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

The coroner found that the young person not reviewed by a mental health clinician when they first entered custody. They were placed on a waiting list but their appointments were not maintained. They were not seen by a mental health team upon transfer to a new correctional facility.

The young person received medication at their own request. Neither the appropriateness of providing the medication nor the dose at which it was provided was ever assessed.

The coroner found that the young person did not attend the prison clinic to collect their medication on several occasions. As per the Justice Health and Forensic Mental Health Network Medication Guidelines, the young person was to be followed up immediately about these absences, but this did not occur.

**Coronial recommendations**

The coroner made the following recommendations related to this case:

To the Minister for Health:

- I recommend that Justice Health review practices and procedures in relation to the transfer of inmates between correctional centres for the purpose of ensuring that any outstanding mental health reviews or existing appointments to see the Justice Health Mental Health Team be rescheduled at the new Correctional Centre.
- I recommend that the Drugs and Therapeutic Committee of Justice Health and Forensic Mental Health Network be provided with a copy of these findings and consider:
- Reviewing the current procedures as set out in 6.6.1 of the Medication Guidelines.
- Training Justice Health staff in relation to the requirements of 6.6.1 and 7.7.3 of the Medication Guidelines.
Coronial recommendations: Fatal facts

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the plane suffered engine failure and crashed to the ground as a result.

Coronial recommendations
The coroner made the following recommendations related to these cases:

To: The Chief Executive Officer – Civil Aviation Safety Authority (CASA)

- That CASA finalise the guidance material for Civil Aviation Advisory Publications 5.23 such that the guidance material is completed and released as soon as possible noting that the guidance material in question provides for multi-engine aeroplane operations and training to support the flight standard in Appendix A of s.1.2 of the CAAP relating to engine failure in the cruise;
- That CASA undertake public consultations in order to assist CASA in the development of a legislative proposal enabling CASA to compel the attendance of persons at compulsory sworn interviews to answer questions concerning specific aviation and safety measures where a reasonable suspicion exists that;
  - a significant safety risk exists or existed in an aviation operation; and
  - evidence of a witness or witnesses likely to have knowledge of an aviation safety risk cannot be obtained in any other way.

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

Case number: NSW.2013.4008
Primary category: Transport and traffic related
Additional categories: Drugs and alcohol, Law enforcement
Fatal facts edition: 46 – cases closed between July and September 2015

Case summary

A young male died due to injuries sustained in a vehicle incident in which they were a passenger.

At the time of the incident, the vehicle was being used by a group for hunting purposes. The vehicle rolled and the young person was trapped underneath. Emergency services were contacted and the young person was conveyed to hospital. They were found to have suffered unsurvivable injuries. The vehicle in which the young person was travelling had been modified for its use in hunting activities. The vehicle was being used on private land at the time of the incident.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that, prior to police arriving at the crash site, other people from the group righted the vehicle and removed alcohol and firearms from the scene. The driver of the vehicle was not alcohol or drug tested by attending police as the incident had occurred on private land and the police had no jurisdiction to conduct such tests.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the Minister for Roads, Maritime and Freight:

- I recommend that the Minister consider an amendment to the Road Transport Act 2013, Schedule3, to provide police with power to require a person to undergo a breath test, or supply a sample of blood or urine, where there is reasonable cause to believe that the person was driving a motor vehicle that has been involved in an accident on private land, and where that accident has caused serious injury or death.

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

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<td>Fatal Facts edition</td>
<td>46 – cases closed between July and September 2015</td>
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</tbody>
</table>

Case summary
A young male died due to injuries sustained in a motor vehicle incident in which they were a passenger.
The vehicle in which the young person was travelling was stolen and was being pursued by police. The driver of the vehicle lost control, causing it to slide into the path of oncoming traffic.

Coronial findings
The coroner found that the death was unintentional.

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

To the Minister for Justice and Police:

- I recommend that a copy of these findings be forward to the Minister for Justice and Police for consideration together with the recommendations in the matters of [three other deaths].

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

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<td>Fatal facts edition</td>
<td>46 – cases closed between July and September 2015</td>
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</table>

Case summary
A male child died due to injuries sustained in a motor vehicle incident in which they were a pedestrian.

The child was crossing a road when they were struck by a passing motor vehicle. They were unaccompanied at the time of the incident.

The child was conveyed to hospital where they subsequently passed away.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the child had exited the parked vehicle they had been travelling in and ran across the road in order to attend their after school activity.

Due to a nearby construction zone, the car parks at the front of the location were frequently occupied by workers. As a result, parents and carers of children attending the after school activity had to utilise car parks on the opposite side of the road. The operator of the after school activity had raised a petition for the local council to change the parking around the location from all day parking to limited time parking. The petition was accepted by the traffic engineer but rejected by the traffic advisory committee.

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

- That the [council] gives consideration to these findings and recommendations and brings them to the attention of their Traffic Advisory Committee.
- That the pedestrian safety improvements at intersection of [road] and [street] recommended in the Road Safety Audit Report Ref. 14138rsa be implemented as a matter of urgency.
- That consideration be given to conducting a further pedestrian safety audit and carrying out its recommendations in relation to the section of [street] between the intersection of [road].
[road] and [road] with regard to the safe crossing of [street] by users of [field], and the [building] and businesses, and access to [road] from [lane] and [street], with particular regard to the next stage of the development of the [accommodation] and its construction and the expected high density population. Such consideration to include whether pedestrian safety would be improved by traffic inhibitors such as a lower speed limit, a pedestrian crossing and both eastern and western facing signage alerting drivers to the presence of children and/or reclassifying [road] from being a “collector road” so that its vehicular access and speed zone are consistent with the area’s pedestrian safety.
Coronial recommendations: Fatal facts

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<th>Case number</th>
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<td>46 – cases closed between July and September 2015</td>
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Case summary

An adult male died due to electrocution and multiple injuries.

The adult had been pulled over in their vehicle by a police officer due to speeding. They were informed that their licence would be suspended and their vehicle seized. The adult walked away from the police officer and climbed up a high voltage power transmission tower. They were struck by arcing electricity from a high voltage power line above them, and subsequently fell to the ground.

Coronial findings

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

The coroner found that the police officer present radioed for assistance, and a request was made for fire and rescue services to attend and for the electricity company to be contacted.

The police officer did not provide additional details about the location or identifying number of the transmission tower. The radio operator tried to contact the electricity company; however they were unable to identify the company responsible for the tower.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the Minister and Commissioner for Police:

- That the Standard Operating Procedures for Police radio operators concerning notification and contact with electricity companies be amended to insert a list [four power companies];
- That the Standard Operating Procedures also be amended to instruct radio operators getting in touch with power companies concerning lines down or other electricity jobs that the power companies require:
  - The exact location of the tower or pole;
o The identifying numbers of the tower and power lines (to be obtained from notices on the tower or pole); and
o Whether the wires were previously strung between two poles or towers (pole to pole) or between a pole/tower and building.

- That the drop-down “Resources Menu” used by police radio operators be amended to include the contact details or shortcut telephone numbers of [four power companies].

To the Chief Executive Officer of [power company]:

- That to expedite verification of incoming calls from police or emergency services concerning lines down or other emergencies requiring de-energisation of power lines, [company] consider, if it is reasonably practicable, implementing an automatic incoming call identification system for those services.
NORTHERN TERRITORY

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

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<tr>
<th>Case number</th>
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<td>Drugs and alcohol</td>
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<tr>
<td>Fatal facts edition</td>
<td>46 – cases closed between July and September 2015</td>
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Case summary

A middle aged female died due natural causes.

The adult suffered from numerous substance abuse-related health issues. At the time of their death, they were being detained in a residential facility for the management of their substance abuse.

Coronial findings

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

The coroner found that a formal treatment plan for the adult was not prepared for a significant period of time after they were detained due to there being no senior treatment clinician at the facility for some time. A treatment plan was subsequently prepared by the locum doctor; however it contained no reference to the adult’s comorbidities due to their substance abuse. The locum doctor at the facility did not have the ability to access all the medical records from the adult’s previous hospital admissions.

There was a lack of documentation and sufficient notes regarding the adult, with notes often being recorded in an informal manner, rather than electronically.

The coroner found that the care of the adult was delayed whilst they were at the care facility due to them absconding numerous times. The coroner found that it was extremely difficult to treat the adult as they were detained at the facility against their will.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the Minister for Health:

- That authorized treatment providers under the Alcohol Mandatory Treatment Act be resourced and funded to provide full time medical trained staff including addiction specialists to assist in rehabilitation.
• That protocols be established to ensure that all authorized treatment providers under the Alcohol Mandatory Treatment Act have as part of their clinical and organizational governance; provision for the formal recording of all versions of care treatment plans prepared in relation to persons subject to an order and any changes to such care treatment plans together with details as to what risk and/or need has been identified to require such amendments.

• That protocols be established to ensure that all authorized treatment providers under the Alcohol Mandatory Treatment Act have as part of their clinical and organizational governance; provision for detailed and documented handovers of a person’s care between care providers during periods of extended absence of leave.

• That systems be established to ensure that locum doctors employed by the Department of Health are granted full access to all medical records held by the Department in relation to any and all designated patients.

• That protocols be established to ensure that locum doctors employed by the Department of Health undertake detailed and documented handovers of a patient’s care and treatment planning with formal acceptance between locum doctors of the same.

• That systems be established to ensure that scheduled reviews of a patient’s care and treatment automatically arise on their computerised file with such scheduled reviews requiring formal acknowledgement of having been undertaken and results recorded or formal alteration of the review date and the reasons why.

• That the promised independent evaluation mentioned in [this finding] take place as soon as possible.
Coronial recommendations: Fatal facts

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<td>Fatal facts edition</td>
<td>46 – cases closed between July and September 2015</td>
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</table>

Case summary

A middle aged male died due to natural causes whilst detained in a police watch house.

The adult had been arrested under a ‘paperless arrest’ scheme for public consumption of alcohol. The adult was conveyed to the police watch house, where they went to sleep in a cell.

A few hours later, they were checked by police and were found to have passed away.

Coronial findings

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

The coroner found that the ‘paperless arrest’ scheme resulted in the deprivation of liberty and unacceptable differential treatment.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That section 133AB of the Police Administration Act, creating the ‘paperless arrest’ regime, should be repealed.
- That the Government commission an independent expert inquiry into responses to alcohol misuse in the Northern Territory. This should form the basis for a plan to be developed by government working with stakeholders, including Aboriginal people, communities and organisations, to find solutions.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>The coroner held a joint investigation into the following deaths which resulted from similar incidents: QLD.2012.807, QLD.2012.3171, QLD.2013.1598, QLD.2013.2101, QLD.2013.3601, QLD.2013.4436, QLD.2013.4636, QLD.2014.50, QLD.2014.51</th>
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<td>Fatal facts edition</td>
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Case summary – QLD.2012.807

A middle aged male died due to injuries sustained when the quad bike they were riding crashed and rolled.

At the time of the incident, the adult was riding the quad bike as part of their employment. The quad bike had recently been removed from use at the place of employment due to being faulty. The adult was required to perform repairs on the quad bike.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the quad bike was not fit with any rollover protection safety devices. The quad bike was faulty, with the throttle cable being stuck in a full revolutions position.

The adult was not wearing any protective equipment at the time of the incident.

The adult was given no formal training about quad bikes through their employment. It was not known if they had read the quad bike manuals that they had access to during their employment.

Case summary – QLD.2012.3171

A male child died due to injuries sustained in a quad bike incident.

At the time of the incident, the child was riding an adult sized quad bike owned by their family. The child was found trapped underneath the quad bike, which had rolled over. Emergency services were contacted, however the child was unable to be revived.

Coronial findings

The coroner found that the death was unintentional.
The coroner found that the child was not as familiar with riding the quad bike as they were with slightly smaller quad bikes. The child was unsupervised at the time of the incident, and their riding of the adult sized quad bike was contrary to manufacturer instructions. They were wearing a helmet.

Case summary – QLD.2013.1598
An adult male died due to injuries sustained in a quad bike incident.
The adult was riding a quad bike for work purposes when they collided with a barbed wire gate. They were found lying to the side of the quad bike.

Coronial findings
The coroner found that the death was unintentional.
The coroner found that the adult was wearing appropriate protective equipment, though found it likely that their helmet was not fastened.

Case summary – QLD.2013.2101
An adult female died due to injuries sustained in a quad bike incident.
At the time of the incident, the adult was riding home from a party on a quad bike. The adult appeared to have fallen from the quad bike and sustained a head injury. They were conveyed to hospital where they underwent emergency surgery and subsequently passed away.

Coronial findings
The coroner found that the death was unintentional.
The coroner found that the adult likely lost control of the quad bike due to attempting to hold a bottle of alcohol in one hand while steering with the other. The adult was not wearing a helmet at the time of the incident.

Case summary – QLD.2013.3601
A young male died due to head injuries sustained in a quad bike incident.
The young person was riding a quad bike when it struck a hidden ditch. The young person was thrown from the quad bike, sustaining head injuries in the process. At the time of the incident, the young person was part of a group who were consuming alcohol and hunting on a private property.

Coronial findings
The coroner found that the death was unintentional.
The coroner found that the incident occurred on terrain where there were visibility issues. The young person was intoxicated, which would have impacted on their decision-making and capacity to react. They were not wearing a helmet.

The coroner found that the young person was likely riding the quad bike at a speed not suited to the conditions. They had no formal quad bike training but were considered an experienced rider by their family, having learned to ride at a young age.

Case summary – QLD.2013.4436

A female child died due to head injuries sustained in a quad bike incident. The child was riding an adult sized quad bike on a rural property when it rolled, causing their fatal injuries.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the child was riding an adult sized quad bike unsupervised. Adult sized quad bikes are not intended to be ridden by people under the age of 16. There were visible warnings on the bike and in the owner’s manual specifying that adult sized quad bikes are not intended to be ridden by persons aged under 16.

The bike was not fitted with rollover protection systems and the child was not wearing any protective equipment.

Case summary – QLD.2013.4636

An older adult male died due to head injuries sustained in a quad bike incident. At the time of the incident, they were moving cattle on their property. The precise cause of the incident was unable to be determined.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult was not wearing a helmet at the time of the incident.

Case summary – QLD.2014.50 and QLD.2014.51

An adult male and a male child died due to injuries sustained in a quad bike incident. At the time of the incident, the adult was driving the quad bike with the child as a passenger. The adult was attempting to climb an incident in a creek bed on private property when the quad bike rolled, causing both the adult and child to sustain fatal injuries.
Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult was intoxicated at the time of the accident, impacting their ability to react appropriately. The time of night and the terrain were also factors in the incident. The quad bike was not a suitable for the type of terrain, and was not fitted with a rollover protection system. The child was wearing a helmet, but not the adult.

It was not known if the adult had read the manual for the quad bike. There were warnings in the manual and on the bike itself indicating that passengers were not permitted on the quad bike.

Coronial recommendations

The coroner made the following recommendations related to these cases:

- It is recommended that Safe Work Australia, the Federal Chamber of Automotive Industries [FCAI], and the Australian Quad Distributors Association:
  - Work with AgriFood Skills Australia to develop an improved and standardised quad bike and side by side vehicle nationally accredited training package.
  - It is suggested that the starting point would be to adopt the 'off the shelf' Speciality Vehicle Institute of America's training packages already in existence, with additional components that focus on particular work environments in Australia.

- It is recommended that once an improved nationally accredited quad bike training package is developed, the Queensland government:
  - Introduce legislation to mandate the completion of the nationally accredited training by all quad bike riders and side by side vehicle drivers, through a certification or licensing scheme.
  - The scheme should investigate whether it is appropriate to provide some more limited standard of training for casual users, for example, in quad bike tourism operations operating in a controlled environment.
  - Subsidise the training, including subsidising Registered Training Organisations, to provide the training to remote areas in Queensland to decrease participation barriers; and
  - Launch an ongoing public awareness campaign about the importance of quad bike and side by side vehicle training in reducing serious injury and deaths.
  - It is suggested that the Speciality Vehicle Institute of America’s model legislation be considered as a starting point for the legislative regime.

- It is recommended that Safe Work Australia, the Federal Chamber of Automotive Industries and the Australian Quad Distributors Association:
  - Initiate the process of introducing an Australian Standard for quad bike specific helmets to meet the needs of the agricultural community.
It is suggested that the New Zealand standard entitled ‘All-Terrain Vehicle Helmets’ (NZS 8600:2002) be considered for adoption after further investigation is completed as to its appropriateness. The standard should provide that competitive recreational riders and road users must still wear helmets that comply with the Australian Standard for motorcycle helmets (AS 1698), or other similar international Standards.

It is recommended that the Queensland government:

- Direct the Queensland Department of Transport of Main Roads to amend their ‘Guideline’ relating to conditional registration for quad bike and side by side vehicle operation on roads and road related areas, to include mandatory helmet use. For road usage, helmets should comply with the Australian Standard for motorcycle helmets (AS 1698) or other similar international standards.

- Once an Australian Standard for quad bike specific helmets is implemented, it is recommended that the Queensland government:
  - Introduce legislation to mandate the wearing of helmets (which comply with the Australian standard) by all quad bike and side by side vehicle operators in Queensland; and
  - Launch an ongoing public awareness campaign about the importance of wearing helmets on quad bikes and side by side vehicles in preventing death and serious injury.
  - It is suggested that the Specialty Vehicle Institute of America's model helmet legislation be considered as a starting point for the legislative regime.

Noting that children between 6 - 16 are permitted to operate ‘youth sized’ quad bikes and side by side vehicles, according to the manufacturer's age recommendation for a particular vehicle, it is recommended that the Queensland government introduce legislation to:

- Prohibit children under the age of 16 from operating adult sized quad bikes and side by side vehicles;
- Prohibit children between the ages of 6 and 16 from operating a youth sized quad bike or side by side vehicle, that is not specified to be appropriate according to the manufacturer's age recommendation for that particular vehicle;
- Prohibit children under the age of 7 from being carried as passengers on adultsized side by side vehicles, as well as any child of whatever age if they are unable to sit with their back against the seat, feet flat on the floor and floor rests, and hands on hand holds; and
- Prohibit children under the age of 16 from being carried as passengers on adult-sized sit-astride quad bikes.
- It is suggested that the Specialty Vehicle Institute of America's age based model legislation be considered as a starting point for the legislative regime.
- It is recommended that the Queensland government support the introduction of the legislation with an ongoing public awareness campaign about the dangers of parents
and guardians allowing children to ride adult sized vehicles and 'youth sized' vehicles that are inappropriate for the age of the relevant child.

- It is recommended that the Queensland government:
  - Introduce legislation to prohibit carriage of passengers on quad bikes other than those specifically designed to carry an operator and a passenger; and
  - Launch an ongoing public awareness campaign about the importance of only carrying passengers on quad bikes and side by side vehicles that are designed to carry a passenger (to reduce the chance of loss of control and roll over) and to highlight the importance of carrying age appropriate passengers in accordance with the manufacturer's recommendations on vehicles that are designed to do so.
  - It is suggested that the Specialty Vehicle Institute of America's age based model legislation be considered as a starting point for the legislative regime.

- It is recommended that Safe Work Australia:
  - Manage or oversee the development of an Australian Standard, or the like, for crush protection devices fitted on sit-astride quad bikes in Australian workplaces.

- It is recommended that Safe Work Australia and the manufacturers of the Quadbar and Lifeguard:
  - Fund an independent survey study of all persons who currently use the Quadbar and Lifeguard crush protection devices to obtain 'real world' feedback regarding their effectiveness. (The study could also potentially be expanded to consider the estimated 10% of the New Zealand quad bike population who are believed to be utilising crush protection devices); and
  - Develop guidance for workplaces to assist them in conducting a more informed risk assessment as to whether a crush protection device is appropriate for their situation.

- It is recommended that the manufacturers of the Quadbar and Lifeguard crush protection devices:
  - Provide their customers with written guidance about what to do in the event of a roll over where their crush protection device is fitted.

- It is recommended that the Federal Chamber of Automotive Industries and the Australian Quad Distributors Association:
  - Initiate the process of developing an Australian Standard through Standards Australia, in consultation with relevant stakeholders, for the design, manufacture, import and supply of quad bikes and side by side vehicles to Australia.
  - It is suggested that the Australian Standard should be based on the US Standard.

- It is recommended that Safe Work Australia:
  - Consider whether a different safety standard is required for workplace and onroad quad bikes. If so, it is recommended that Safe Work Australia initiate the process of either an Australian Standard, or a Vehicle Standards Bulletin, in consultation with the industry and other relevant stakeholders.

- It is recommended that Safe Work Australia, and each of the State and Territory Work Health and Safety Authorities:
Contribute to the development of a quad bike and side by side vehicle star rating program, given that the program is focussed predominantly on reducing serious injuries and deaths in the workplace.

The University of New South Wales Transport and Road Safety Research team’s proposed quad bike and side by side star rating program should be considered as a good start for consideration of the program so long as it is ensured that it is evidence based (in consultation with the industry).

- It is recommended that the Australasian New Car Assessment Program:
  - Further develop and administer the star rating system once it has been established.

- It is recommended that the Queensland Police Service:
  - Introduce a standardised investigation template for all quad bike and side by side vehicle related fatalities, to supplement existing reporting to the Coroner. This should be developed through consultation with the Federal Chamber of Automotive Industries, the University of New South Wales Transport and Road Safety Research team and the Office of State Coroner;
  - Improve investigator training to cover specific issues arising in quad bike and side by side vehicle fatalities. This should be achieved by adding a module to the existing training regime in consultation with the FCAI and the UNSW TARS (University of New South Wales Transport and Road Safety Research ‘Quad Bike Performance Project’) team; and
  - Consult with all other State and Territory Police Services in an effort to encourage them to implement the same initiatives, so that a national approach is taken.

- It is recommended that all State and Territory Police Services:
  - Consider implementing the Queensland Police Service standardised investigation template and improved investigation training for quad bike and side by side vehicle fatalities, once completed.
Coronial recommendations: Fatal facts

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Case summary

An adult male took their own life by hanging whilst they were detained at a correctional facility.

The adult had previously attempted self-harm while incarcerated at other correctional facilities. They were under the care of a mental health assessment team and had been assessed as being at high risk of self-harm. As a result, they were placed in a cell that required visual and physical checks at half-hourly intervals.

Coronial findings

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

The coroner found that the required checks on the adult did not take place. At the time of the incident, the closed-circuit television [CCTV] camera in the exercise yard of the cell was covered. It had been covered the day before, and no attempt had been made by staff to remove the cover.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That [correctional facility] must ensure and the Agency remind all centres to ensure that each Risk Assessment Team (RAT) must, as part of its decision making, determine the adequacy of cell infrastructure, specific risks presented by proposed accommodation, and make recommendations about the suitability of any current or proposed cell accommodation for at-risk prisoners and, where appropriate or necessary, make recommendations for the Centre to appropriately mitigate against any inherent risks present in the cell infrastructure which are unable to be avoided.
- That [correctional facility] management carry out an audit of hanging points, and ensure that officers involved in RAT meetings (including both operational and health professionals) are aware of those risks so that strategies may be put in place to mitigate against those risks.
• That the Agency install covert microphones in the [correctional facility] master control, and in the [correctional facility] Maximum Security Unit (MSU) master control, if and when it is reopened.
• That the Agency install CCTV in the [correctional facility] MSU master control room, if and when it is re-opened.
• That the Agency conduct a review such that officers especially rostered to undertake observations should be persons who are familiar with the prisoner the subject of the observation regime or, if that is not possible, a person who is extremely au fait with at-risk indicators.
• That the Agency conduct a review such that the psychologist who undertakes an assessment of an at-risk prisoner ought to be present at the RAT meeting, unless the psychologist attending is also familiar and current with the prisoner under consideration.
• That [correctional facility] must ensure that RAT meeting members ought not make determinations without the actual observations logs for a prisoner presently under a regime of observations and under consideration. [Practices of communicating observation logs person-to-person] are apt to be insufficient to allow RAT meetings to make fully informed decisions.
• That the Agency conduct a review such that supervisors from the at-risk prisoner’s accommodation area are involved in the RAT meeting and, in addition, that these supervisors are sufficiently addressing the issue of environment risks for each at-risk prisoner discussed at the relevant RAT meeting.
• That [correctional facility] review its rostering to identify officers who have spent extended periods of time exclusively on night-shifts and exclusively in master control positions, and act to ensure that those officers are provided with varied rosters to ensure broader ongoing centre experience, for the safety of those officers and prisoners.
• That consideration be given for disciplinary action in respect of:
  o [correctional officer] for
    ▪ either deliberately or recklessly certifying in the observations log that he had undertaken observations when he could not possibly have done so; and
    ▪ informing [name] that he had undertaken observations of [the deceased] when he could not possibly have done so.
  o MSU Supervisors [name] and [name] for failing to ensure that the CCTV in the exercise yard of [the deceased] cell was uncovered.
• That [correctional facility] provide training on the management of at-risk prisoners to all relevant staff, including (without limitation):
  o Training to ensure that all officers in the Centre are current with their suicide prevention.
  o Training to ensure officers understand the necessity for handover documents to contain comprehensive information. Those documents have much greater utility if the comments fields are populated with, even brief, relevant information, which could assist officers. Officers should be reminded of the purposes of these sheets and
exemplar entries for the commentary section of those forms should be circulated to officers such that they may properly understand the kind of depth to which they are expected to condescend in completing these forms.

- Training to ensure that proper development of at-risk management plans by responsible officers. In this case there were no entries in the accommodation section.
- Training to ensure proper and vigilant implementation by officers required to comply with at-risk management plans. In this case, it directed a cell search for self harm objects, however the bird cage cover was allowed to remain and with that [the deceased] harmed himself.
- Training to ensure that all psychologists and mental health staff are aware of all relevant environment risks when conducting risk assessments.
- Training to ensure proper completion of the document titled "Instruction - At Risk Prisoner" by relevant staff.

• That all relevant [correctional facility] staff receive further training about at risk indicators and how to identify them, and that [correctional facility] implement stronger governance mechanisms for ensuring that all staff maintain current suicide prevention training and capability.
• That training by [correctional facility] should incorporate awareness of the importance of not being lulled into complacency by apparent improvements in the demeanour of an at-risk prisoner.
• Training should incorporate awareness of the increased suicide risk to prisoners in isolation, seclusion or administrative segregation.
• Training should incorporate information about environmental and operational factors that contribute to suicide.
• That urgent training should be undertaken for all relevant staff (especially those engaged in RAT meetings and those otherwise required to make recommendations for at risk prisoners) regarding suicide resistant bedding and clothing, and the assessment of the circumstances in which suicide resistant bedding and clothing should be issued.
• That further training (or refresher training) must be provided to all RAT members at [correctional facility] so that each member is aware of:
  o all matters that must be property assessed by the RAT meeting; and
  o whom, among the persons representing the various disciplines in attendance at the RAT meeting, is principally responsible for informing the other attendees about each matter to be assessed.
• That significant training (or refresher training) about how to conduct proper at-risk observations and how to case note those observations is required for all staff required to carry them out as part of their duties. This includes but is not limited to the following:
  o Training to ensure supervisors responsible for ratifying observations logs understand how to interpret observations instructions, how to ensure that officers for whom they are responsible are correctly adhering to instructions, and why it is not appropriate to
ratify observations compliance in observations logs until after the observations have been carried out.

- Training to ensure that all officers in the Centre understand the purpose of at-risk observations instructions sheets; including, relevantly, how to complete them, why it is necessary to complete them in a consistent fashion using consistent language, how to interpret them, how to apply them, how and when to escalate concerns and issues, and why it is necessary to be familiar with them.

- Training to ensure observation officers understand what kind of information should be included in case notes and observation log commentary, including an understating that property particularised information and statements of objective fact, rather than subjective assertions, are of greater assistance to those who have to rely on such information without the benefit of interviewing the at-risk prisoner in assessing and making recommendations for appropriate care regimes for at risk prisoners.
SOUTH AUSTRALIA

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

Case number: SA.2007.1056
Primary category: Natural cause death
Additional categories: Law enforcement
Fatal facts edition: 46 – cases closed between July and September 2015

Case summary
A middle aged male died due to cancer whilst imprisoned at a regional facility.

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

The coroner found that the adult had undergone medical examinations whilst incarcerated; initial test results indicated that further medical investigations were required.

The coroner found that the adult was not advised of the need for follow-up testing at a major medical facility due to their previous reluctance to travel to a metropolitan city.

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

- The Medical Director of the South Australian Prison Health Service assign to a senior medical officer or officers within the Service the responsibility of maintaining oversight of the medical treatment and investigation of those prisoners within institutions operated by the Department for Correctional Services who are suspected of suffering from a serious or life threatening illness, especially in circumstances where the medical treatment and investigation of such prisoners is being conducted by medical practitioners who are not employees of the Service.

- The Medical Director of the South Australian Prison Health Service remind medical practitioners, both employed within the Service or otherwise, who treat prisoners within institutions operated by the Department for Correctional Services of the need to carefully explain to prisoners who are for whatever reason reluctant to undergo important medical treatment or investigation of the possible consequences of the failure of the prisoner to undergo such treatment or investigation and in particular to identify to the particular prisoner the worst case scenario that such an investigation might identify.

- The Medical Director of the South Australian Prison Health Service remind medical practitioners, both employed within the Service or otherwise, of the need to make...
detailed notations in a prisoner patient’s clinical record of the decision made by the prisoner not to undergo recommended medical treatment or investigation and of the stated reason for the prisoner refusing to undergo such medical treatment or investigation.

• The Medical Director of the South Australian Prison Health Service and the Chief Executive Officer of the Department for Correctional Services be mindful of the fact that a refusal by a prisoner situated in a country correctional facility to undergo medical treatment or investigation that requires the prisoner to travel to [city] does not of itself mean that the prisoner cannot at least be compelled to travel to [city] and be accommodated in a correctional facility in [city].

• The Medical Director of the South Australian Prison Health Service and the Chief Executive Officer of the Department for Correctional Services make every effort to ensure that the conditions enjoyed by a prisoner in a country correctional facility are not in any way jeopardised by the need for the prisoner to travel to [city] and be accommodated in [city] correctional facility for the purpose of attending medical treatment or investigation in [city].

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 following a brain bleed caused by a ruptured aneurysm.

The adult had presented to multiple health services with symptoms over the three weeks prior to their death.

Coronial findings

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

The coroner found that the adult’s death was preventable due to a number of missed opportunities from multiple medical personnel to have diagnosed and treated the condition.

Coronial recommendations

The coroner made the following recommendations related to this case:

I make the following recommendations directed to the Chief Executive Officer of [the hospital], the principal clinician of [the hospital emergency department], the principal clinician of [neurosurgery department], the Chief Executive Officer or equivalent of the Royal Australian College of General Practitioners and the Chief Executive Officer or equivalent of the Australian College of Rural and Remote Medicine:

- That procedures within [hospital emergency department] dealing with the alignment of referral letters with presenting patients be regularly reviewed with a view to ensuring such alignment;
- That the principal clinician of [neurosurgery department] take the necessary steps to ensure that clinicians who are advised of the imminent arrival of a patient presenting with a suspected case of subarachnoid haemorrhage liaise appropriately and in a timely manner with clinicians at [hospital emergency department];
- That clinicians within [hospital emergency department] refer cases of suspected subarachnoid haemorrhage to clinicians within [neurosurgery department] and/or
[radiology department] in order to identify the most appropriate diagnostic measures to be instituted;

- That general practitioners referring patients suspected of suffering a subarachnoid haemorrhage be encouraged to verbally notify Emergency Departments of the expected arrival of their patients;

- That general practitioners who have referred patients suspected of suffering a subarachnoid haemorrhage to hospitals and emergency departments be encouraged to carefully scrutinise discharge summaries and letters to ensure that they are satisfied that all relevant diagnostic information has been taken into account, and in particular to carefully scrutinise and evaluate the discharge diagnosis. They should also be encouraged to query such diagnoses if they are not satisfied that they are adequate or accurate.
Coronial recommendations: Fatal facts

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Case summary

A middle aged male died from heart disease whilst imprisoned at a regional based facility.

Coronial findings

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

The coroner found that there was a lack of continuity of care for the treatment of the adult’s condition and commented that similar issues had arisen in previous coronial cases:

“The undesirability of a lack of continuity of care occasioned by the fact that different privately practising medical practitioners provide services to the Prison Health Service in country custodial situations has been the subject of coronial comment in the past. I refer to the findings in the matter of the death of [name]. In that Inquest the Court made a number of recommendations designed to promote more effective continuity of care in respect of prisoners with severe chronic conditions. Some of those recommendations are apt in respect of the current circumstances as identified in this Inquest. I repeat the first such recommendation herein”.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the Medical Director of the South Australian Prison Health Service assign to a senior medical officer or officers within the Service the responsibility of maintaining oversight of the medical treatment and investigation of those prisoners within institutions operated by the Department for Correctional Services who are suspected of suffering from a serious or life threatening illness, especially in circumstances where the medical treatment and investigation of such prisoners is being conducted by medical practitioners who are not employees of the Service.

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.

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Coronial recommendations: Fatal facts

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<td>Fatal facts edition</td>
<td>46 – cases closed between July and September 2015</td>
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Case summary
A middle aged male died from respiratory failure.

The adult was a resident of a mental health facility under a continuing detention order from the Guardianship Board of South Australia.

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

The coroner found that staff at the hospital where the adult died did not note the adult was a detained person at the time of their death.

The coroner found it concerning that the death was not immediately reported to the State Coroner as would be expected in a death in custody.

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

- I recommend that the Minister for Health institute policies and protocols to ensure that all deaths in custody are reported as required by the Coroners Act 2003. In particular, appropriate documentation should be prepared to ensure that medical staff recognises that detention, for the purposes of the Coroners Act 2003, can arise not merely by imprisonment at criminal law, or by detention under the Mental Health Act, but also by detention pursuant to the Guardianship and Administration Act.
Coronial recommendations: Fatal facts

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<td>Fatal facts edition</td>
<td>46 – cases closed between July and September 2015</td>
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Case summary
An adult male took their own life by hanging whilst imprisoned.

The adult was awaiting trial at the time of their death. They were geographically separated from their family despite requests to be relocated closer to them.

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

The coroner found that although the adult died by hanging, they had also ingested a potentially fatal quantity of a prescribed opiate based medication.

The coroner found that the adult had previously attempted self-harm however this had not been properly identified by correctional services employees or disclosed by fellow inmates.

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

- That the Department for Correctional Services continue to identify and eliminate hanging points from cells in all South Australian correctional institutions and, in particular, to replace all ventilation grilles, air-conditioning vents and similar with anti-ligature vents;
- That the Department for Correctional Services take the necessary steps to ensure that prisoners do not have an ability to hoard or stockpile excessive quantities of prescribed or illicitly obtained medication in their cells. In this regard consideration should be given to the implementation of random cell searches in order to deter such hoarding or stockpiling;
- That the Department for Correctional Services continue to develop operating procedures that will ensure that evidence of a prisoner who is suspected of having attempted self-harm is properly evaluated by the appropriate person or entity so as to eliminate the possibility that the attempt at self-harm will not be properly identified or acted upon. In particular it should be regarded as inappropriate for agency nursing staff to make any such assessment without other professional assistance;
• That the Department for Correctional Services implement procedures whereby prisoners on remand are regularly formally screened for risk of self-harm. Such screening procedures could occur at times when a remand prisoner is returned from Court or where some other identifiable adverse change of circumstance has occurred in respect of that prisoner. I repeat the recommendation made in the Inquest into the death of [name], namely that the Department for Correctional Services establish a panel to examine the feasibility of introducing a regime whereby inmates at South Australian correctional institutions are formally screened for risk of self-harm on a more regular basis than at the time of their entry into an institution;

• That in respect of a prisoner incarcerated in South Australia, the Department for Correctional Services routinely make enquires of the equivalent Departments in other States and Territories as to the history of risk of self-harm in respect of that prisoner during any period of incarceration in those other States and Territories;

• That the Department for Correctional Services educate the prison population in this State to the effect that genuine expressions of concern in respect of their fellow prisoners, as imparted to persons in authority, will not involve adverse consequences either to the prisoner who is the subject of the report or to the reporting prisoner;

• That the Department for Correctional Services give consideration to routinely accommodating remand prisoners at correctional institutions in close proximity to their families, taking into account the current stage which their matters have reached within the criminal justice system, the duration of the period on which they have been or are expected to be on remand, the availability of video conferencing as a means of securing their participation in court proceedings in which they are required to participate and the convenience of their legal advisers;

• That the Minister for Correctional Services give consideration to revising the South Australian response to recommendation 168 of the Royal Commission into Aboriginal Deaths in Custody to include remand prisoners within the recommendation’s field of operation, such that Correctional Services affect the placement and transfer of Aboriginal prisoners, both those on remand and those serving a sentence of imprisonment, according to the principle that, where possible, an Aboriginal prisoner should be placed in an institution as close as possible to the place of residence of his or her family.
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.

The young person had been attending therapy sessions at a Child and Adolescent Mental Health Service (CAMHS) prior to their death.

Coronial findings

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

The coroner found that although CAMHS was meant to provide a multidisciplinary service, the only meaningful therapy provided was conducted by a social worker, and that the CAMHS structure was unduly reliant on the efforts and skills of social workers.

The coroner found that no proper risk assessments were conducted and that the young person should have been referred to a psychiatrist.

Coronial recommendations

The coroner made the following recommendations related to this case:

The Court makes the following recommendations directed to the Minister for Mental Health and Substance Abuse and the Director of CAMHS:

- That CAMHS implement a genuine multidisciplinary team approach that possesses the following features:
  - the triaging of clients in the first instance should not be made on the basis of a telephone referral alone, but should be made after the client has been seen by a CAMHS therapist;
  - that the triage assessment, and in particular the decision as to the type of CAMHS therapist who will be responsible for the client’s care in the first instance, be made by the most senior therapist within the individual CAMHS facility;
  - that any practice or tendency for CAMHS therapists to operate as individual practitioners and not as part of a multidisciplinary structure should be curtailed with
immediate effect such that a client experiences input into their care from all
disciplines acting in concert, not merely from the one discipline acting alone or
multiple disciplines acting separately from each other;
o that CAMHS administrators have limited input into deciding the type of therapist that
might appropriately be assigned to a client’s care during the currency of a client’s
treatment, and that in any event any such decision should not be made by an
administrator unless that person is a psychologist or a psychiatrist and is a person
fully informed as to the client’s current and longitudinal history.

- That within the operations of CAMHS that in the event of any suicidal ideation and/or
  self-harm being identified in respect of a client, it be deemed mandatory for that client to
  be referred immediately to a CAMHS psychiatrist who should thereafter have continued
  oversight of the case;
- That all therapists within CAMHS who treat depressed young people be reminded that
  they must always be aware of the risk of suicide and to observe them closely for any
  signs of increased risk of suicide and that this approach is necessary regardless of the
  type of therapy provided and regardless of whether or not a formal diagnosis of a
  recognised mental illness has occurred;
- That within CAMHS all risk assessments and management plans for clients be referred to,
  unless compiled by a psychiatrist, to a therapist of the level of psychiatrist for the
  psychiatrist’s input and evaluation;
- That any practice or requirement that involves the need for a period of three months to
  transpire or for a set number of sessions to have occurred before a client can be
  considered for further intervention by more senior therapist, or be considered for
  medication. Any such referral should be based on clinical grounds as they exist in respect
  of the particular client. In any event, delay should be eliminated where the client’s clinical
  situation warrants an expedited approach to therapy;
- That CAMHS consider the evidence of [psychiatrist] and the materials that [they]
  produced to the Inquest in respect of a revised approach to the prescription of
  antidepressant medication to adolescents and that CAMHS revise its practices regarding
  prescription if it is considered necessary or appropriate in the light of that material. In
  particular, I recommend that the Director of CAMHS together with the Chief Psychiatrist
  give careful consideration to the recommendations set out in the Isacsson paper of 23
  January 2014 referred to herein;
- That CAMHS reinforce with its therapists the desirability for consultation with a client’s
  general practitioner or other private medical practitioner regardless of any perception as
  to whose obligation it may be to initiate such consultation. Such consultation should
  include, but not be limited to, discussion concerning the type of CAMHS therapist who is
  involved in the client’s care and its appropriateness, the type of therapy currently being
  administered or to be administered, the appropriateness of the client’s care plan and the
  appropriateness of the client’s risk assessment as well as discussion concerning the
  appropriateness of medication in respect of the particular client;
• That insofar as it is necessary, that the Minister for Mental Health and Substance Abuse provide the necessary resources to CAMHS to enable more frequent and more meaningful consultation between CAMHS therapists, such as social workers and psychologists, with CAMHS psychiatrists. If this requires the employment of a greater number of psychiatrists within the service then I recommend accordingly.
Coronial recommendations: Fatal facts

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<td>Fatal facts edition</td>
<td>46 – cases closed between July and September 2015</td>
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Case summary
A young female took their own life by hanging.
They had been attending therapy sessions at a Child and Adolescent Mental Health Service (CAMHS) prior to their death.

Coronial findings
The coroner found that the death was due to intentional self-harm.
The coroner found that CAMHS failed to provide an adequate service to the young person.
The coroner found that although CAMHS was meant to provide a multidisciplinary service, the only therapy provided was conducted by a social worker.

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

- That the current approach of CAMHS in which it fails to take proper advantage of the multi-disciplinary team approach be reformed so that therapists such as [name] are no longer operating as individual practitioners;
- That the number of psychiatrists employed within CAMHS be increased so that the current disincentive to refer a patient such as [name] is removed;
- That all services provided by CAMHS should be provided under the same level of consultant supervision as a surgical service in a public hospital. To be absolutely clear, I refer to supervision by a consultant psychiatrist.

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

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

A middle-aged male took their own life via the toxic effects of a gas.

The adult had been harassing their ex-partner since the end of their relationship, including unlawfully entering their home.

Coronial findings

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

The coroner found that they entered their ex-partner’s home with the intention of committing homicide and intentional self-harm.

The coroner found that no domestic violence risk assessment or domestic violence risk management plan was completed by South Australia Police (SAPOL) even though the previously reported situations were potentially as volatile as domestic situations.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend, as the State Coroner has recommended in the matter of the death of [name], that all aspects of domestic violence policing be characterised by a sense of curiosity, questioning and listening. Risk assessment must be actually applied, not merely recited as a mantra.
- I further recommend that in cases such as these, which for the purposes of SAPOL General Orders may not necessarily be characterised as involving violence or potential violence of a domestic nature, that all complaints of a similar nature be referred to police officers who have training in domestic violence risk assessment. At the very least, all such complaints should immediately be drawn to the attention of an officer of the rank of Sergeant or above.
- I further recommend that within SAPOL General Order Domestic Violence the definitions of ‘Domestic partner’ and ‘Close personal relationship’ be amended to encompass circumstances akin to those that existed between [name] and [name].
I further recommend that police be directed to carefully consider whether in a complaint made in the context of a domestic situation involves the commission of a criminal offence. I further recommend that investigations into offences committed in that context be given priority.
The following cases summaries and recommendations relate to deaths reported to a coroner in Tasmania.
Coronial recommendations: Fatal facts

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Case summary

An older male died from heart disease during surgery.

The adult was undergoing surgery for a fracture sustained in a recent fall whilst they were an inpatient. They had previously undergone surgery for a fracture repair following a separate fall incident.

Coronial findings

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

The coroner found that a falls risk assessment was not completed during the admission.

The coroner found that anaesthetic information from the surgery was not saved within the digital medical record.

Coronial recommendations

The coroner made the following recommendations related to this case:

- It is my recommendation that [hospital] immediately review its practice with respect to ensuring that all patients received into [hospital unit] promptly undergo a Falls Risk Assessment which assessment is properly recorded and fully implemented.
- The absence of an anaesthetist’s record in this instance prompts me to recommend that [hospital] review its record keeping practices so that a failsafe system is in place to ensure such critical information as the anaesthetic record is available upon all surgical procedures.

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 male died due to cardiac issues. They had a background of severe chronic obstructive pulmonary disease due to smoking and exposure to coal dust. A recent stroke was a significant contributing factor to their death. The adult had been receiving medical treatment for the stroke; however their ischaemic cardiomyopathy was not being actively treated.

Medical personnel deemed that the adult should be ‘not for resuscitation’ due to the effects of the stroke, however the adult had been responding positively to medical treatment whilst hospitalised.

**Coronial findings**

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

The coroner found that the seriousness and nature of the cardiac condition was not recognised and therefore an appropriate treatment and management regime was not instigated. The coroner found that the status of the ‘not for resuscitation’ order, once in place, was not reviewed at any subsequent time despite evidence of an improvement in the adult’s condition.

**Coronial recommendations**

The coroner made the following recommendations related to this case:

- This situation leads me to recommend that [the hospital] review its protocols with respect to ‘not for resuscitation’ orders with a view to putting in place a requirement that they be periodically reviewed, most particularly in circumstances where a patient is responding positively to treatment and the initial basis for the order may have become redundant.

*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.*

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Coronial recommendations: Fatal facts

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<td>Older persons, Physical health</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>46 – cases closed between July and September 2015</td>
</tr>
</tbody>
</table>

Case summary
An older male died from internal bleeding following a kidney biopsy procedure. They had been referred to hospital following test results that indicated acute renal failure.

Coronial findings
The coroner found that the death was due to complications of medical or surgical care. The coroner found that the standard practice of performing kidney biopsies for diagnostic purposes in Australia is three times greater than the biopsy rate for similar cases in the United States of America.

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

- I propose providing a copy of these findings to the Australian and New Zealand Society of Nephrology with a recommendation that it considers reviewing the practice of its members utilising kidney biopsies in cases such as this.

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

Case number | TAS.2014.112
Primary category | Transport and traffic related
Additional categories | Drugs and alcohol
Fatal facts edition | 46 – cases closed between July and September 2015

Case summary

A middle aged female died in a vehicle incident in which they were a driver.

The adult’s car drifted into oncoming traffic and collided with the rear of a truck. They were unable to regain control of the vehicle and collided with another vehicle.

The adult was observed to be driving in an unsafe manner prior to the collision.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the collision was solely caused by the actions of the adult.

The coroner found that it was possible they momentarily fell asleep at the wheel prior to the collision, and that the medications identified via toxicology could have contributed to their drowsiness.

Coronial recommendations

The coroner made the following recommendations related to this case:

- This tragic accident highlights the danger of the side effects of some prescribed medication and the accentuation of those effects when taking multiple prescribed medication. Added to this is the possibility of magnifying those side effects when using alcohol or illicit drugs. It is perhaps an excessive reaction to legally restrict a person’s ability to drive or use machinery or be involved in dangerous activities if they are prescribed medication that has a depressive effect on the central nervous system. However, medical practitioners prescribing such medication must ensure that their patient is made very aware of the side effects and the dangers thereby created, as demonstrated by this tragic event.

- I also strongly recommend that the [vehicle dealership] in [location] that has become aware of the possible defect with the seatbelt tensioning and airbag system in this [vehicle] ensure that full details of this matter and the inspection findings of [vehicle]
inspector] are relayed via their national distribution network to the vehicle manufacturer for assessment. Any remedial action that is deemed necessary in respect of this make and model of vehicle must clearly be taken as soon as possible.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>TAS.2014.478</th>
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</thead>
<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>46 – cases closed between July and September 2015</td>
</tr>
</tbody>
</table>

Case summary

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

The adult’s vehicle left the roadway and collided with a tree. They were declared deceased at the scene.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that it was likely the adult fell asleep at the wheel.

Coronial recommendations

The coroner made the following recommendations related to this case:

- This incident highlights the danger of driving whilst drowsy or whilst feeling tired. I note that this is a significant road safety message within this State and I recommend that the appropriate authorities maintain an emphasis on this aspect of road safety, especially in relation to interstate visitors who may seek to travel significant distances to maximise their visit to Tasmania.

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>TAS.2014.266</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Adverse medical effects</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>46 – cases closed between July and September 2015</td>
</tr>
</tbody>
</table>

Case summary

A middle aged male died due to sepsis following a surgery for cancer.

During the surgery, the adult’s duodenum was lacerated. The laceration was discovered some days after the surgery. The adult's condition declined and they passed away in the weeks following the surgery.

Coronial findings

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

The coroner found that perforation of the duodenum is a rare but known complication of laparoscopic-assisted oesophagectomy. The coroner found that the care and treatment provided to the middle aged person was reasonable and appropriate.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the authority responsible for health care in Tasmania investigate the establishment of a centralised oesophageal unit and, if considered feasible, take steps to bring about its implementation.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>TAS.2014.119</th>
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</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Natural cause death</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>46 – cases closed between July and September 2015</td>
</tr>
</tbody>
</table>

Case summary

A middle aged female died due to complications following a urinary tract infection.

The adult presented to their general practitioner with a urinary tract infection in the days prior to their death. They were prescribed antibiotics and booked in for a follow-up appointment a few days later.

The day before the follow-up appointment, the adult was discovered deceased in their bed.

Coronial findings

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

The coroner found that 5% of people who present with symptoms suggestive of urinary tract infection are suffering from pyelonephritis. The coroner noted that this case should serve as a reminder for general practitioners to consider pyelonephritis as a differential diagnosis in all suspected urinary tract infection cases.

The coroner found that the general practitioner did not consider a differential diagnosis at the time of their presentation, and thus missed an opportunity to correctly diagnose and treat the middle aged person.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I propose providing copy of these findings to the Tasmanian division of the Royal Australian College of General Practitioners with a recommendation that they be brought to the notice of its members.

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>TAS.2014.232</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Drugs and alcohol</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Mental illness and health</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>46 – cases closed between July and September 2015</td>
</tr>
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</table>

Case summary

A middle aged male died as a result of accidental drug toxicity.

They were suffering from depression and were prescribed a number of different medications at various times prior to their death.

Coronial findings

The coroner found that the death was unintentional.

The coroner found it likely the adult self-medicated with anti-depressants they had been prescribed over previous years.

Coronial recommendations

The coroner made the following recommendations related to this case:

- This tragic event highlights the danger that can arise where prescription medication is taken other than in accordance with expert direction. I would recommend that medical practitioners who are prescribing anti-depressant medication over an extended period where there are changes in the nature or type of such medication ensure that their patient destroys any unused prior prescription and that patients generally are made aware of the dangers including the risk of a fatal outcome should they mix such medication or take that medication at a level higher than the prescription directions.

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

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2007.3499</th>
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<tr>
<td>Primary category</td>
<td>Transport and traffic related</td>
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<tr>
<td>Additional categories</td>
<td>Location</td>
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<tr>
<td>Fatal facts edition</td>
<td>46 – cases closed between July and September 2015</td>
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</tbody>
</table>

Case summary

A middle aged male died when they were struck by a tram.

At the time of the incident, the adult was walking against a red light across a pedestrian crossing. A new tram stop had recently been installed at the location.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult was distracted at the time of the collision and put themselves in danger by entering the pedestrian crossing against the light. The tram driver had insufficient time to brake after the adult stepped onto the tracks.

The coroner found that the pedestrian crossing of the new tram stop was not safely designed to deal with the poor conduct of many pedestrians and the high level of use of the particular location.

Coronial recommendations

The coroner made the following recommendations related to this case:

- Having regard to all of the evidence and to Counsels submissions, I consider that the pedestrian conditions, which existed at the time of the accident and remain to the present time, call for a tram stop specific strategy to be employed to protect both pedestrians, as well as drivers approaching and departing in a southerly direction from this particular stop. I therefore recommend that when departing from the [location] stop in a southerly direction, that drivers are directed to use their tram warning gong continuously, until such point as the driver’s cabin has passed over the pedestrian crossing situated to the south of the platform ramp, and that they travel at a speed not exceeding 10 kmph until that time.

- I further endorse the recommendation made by [inquest expert] concerning the need for a review by VicRoads of Vic Roads Design note RDN 32 Accessible Tram stops in Medians, having regard to the lessons emerging from [their] own investigation and
report into this accident. If it is the case that review and adjustment to RDN 32 has not already occurred, then I recommend that a further such review now take place.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2010.118</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Transport and traffic related</td>
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<tr>
<td>Additional categories</td>
<td>Work related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>46 – cases closed between July and September 2015</td>
</tr>
</tbody>
</table>

Case summary

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

The adult was driving a fire tanker on a loose gravel road to a non-emergency situation with fellow fire brigade personnel. The adult lost control of the tanker on a sharp bend and over-steered the tanker. It collided with two trees, and the adult died at the scene.

The tanker was full of water at the time of the collision.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult’s driving was not appropriate in the circumstances, and contributed to the collision. At the time of the incident, there was no signage advising of a safe speed for the corner.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That [council], as the entity responsible for [road] at [location], conduct a risk assessment with the view to placing a sign at the beginning of the road within the municipality (in each direction) to alert drivers of [road]’s curves and undulations and therefore the dangers therein.

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.2015.1891</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Transport and traffic related</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Weather related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>46 – cases closed between July and September 2015</td>
</tr>
</tbody>
</table>

Case summary

A young female died due to multiple injuries sustained in a vehicle incident in which they were a driver.

They were fatally injured when their vehicle crashed into trees. The road was wet, visibility was poor and the young person was found to have a mobile phone in their hand or in their lap.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that local emergency services personnel had previously publically commented on the potential hazards posed by the stretch of road where the incident occurred.

The coroner found that collision data confirmed there had been an inordinate number of collisions on the road.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend VicRoads consider reducing the 100kph speed limit to 80kph for the entire 5.5km stretch of road referred to.
- I also recommend VicRoads consider, if it has not already done so, placing Chevron warning safety signage applicable to north bound traffic at this location.

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>The coroner held a joint investigation into the following deaths which resulted from the same incident: VIC.2012.262, VIC.2012.263</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Law enforcement</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Transport and traffic related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>46 – cases closed between July and September 2015</td>
</tr>
</tbody>
</table>

Case summary

Two adult males died as a result of a vehicle collision in which they were drivers of separate vehicles.

Police observed one of the vehicles being driven erratically, and attempted to pull over the vehicle. The vehicle sped off and police engaged in a pursuit.

The pursuit was terminated when the evading vehicle began travelling down the incorrect side of a freeway at speed. The vehicle collided head on with another vehicle travelling on the freeway.

The drivers of both vehicles died at the scene. The evading driver had a long history of mental health issues and criminal charges.

Coronial findings

The coroner found that the death of the evading driver was due to legal intervention, and that the death of the other driver was unintentional.

The coroner found that the police pursuit had multiple key decision making points, and should have been terminated sooner.

Coronial recommendations

The coroner made the following recommendations related to these cases:

- Police should never pursue a vehicle simply because it is fleeing. A pursuit should only be undertaken where police hold a pre-existing belief on reasonable grounds that intercepting the vehicle is necessary:
  - to prevent a serious risk to public health and safety; or
  - in response to a serious criminal offence that has been committed, or is about to be committed, which involves serious harm to a person or persons.
The current Victoria Police risk assessment model for police pursuits should be redeveloped and an alternative more appropriate model be adopted, such as the 'traffic light model', so as to guide police members as to what weight should be given to one particular risk factor over another. Any risk assessment model should be commensurate with appropriate industry practice in other safety critical environments.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2010.4693</th>
</tr>
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<tbody>
<tr>
<td>Primary category</td>
<td>Water related</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Transport and traffic related, Geographic, Leisure activity</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>46 – cases closed between July and September 2015</td>
</tr>
</tbody>
</table>

Case summary

A middle aged male drowned following a boating incident.

The adult was a passenger on a charter fishing vessel. The sea conditions were normal at the time the vessel departed, but soon changed. The operator of the vessel tried to negotiate the vessel over a large wave, when a second wave struck the side of the vessel, causing it to capsize.

The other passengers were thrown clear of the boat, but the adult became entangled in lines and ropes attached to the vessel. They were unable to extricate themselves and subsequently drowned.

The adult was not wearing a life jacket or a personal flotation device when they were found.

Coronial findings

The coroner found that the death was unintentional.

The coroner found it important for boat operators to have thorough and detailed knowledge of the area of their operation, including how quickly and to what extent the weather can change.

The coroner found that while the operator of the vessel had obtained a Local Knowledge Certificate, they may have underestimated or not understood the possibility of waves and tides combining to create the hazardous conditions that resulted in the vessel capsizing.

Coronial recommendations

The coroner made the following recommendations related to this case:

I make the following recommendations to Marine Safety Victoria, and where applicable, to Australian Maritime Safety Authority (AMSA):

- That the definition of [general location] area be widened and extended. I recommend that the inshore boundary of [general location] be as proposed by [inquest expert]. I
attach a map, setting out the alternative lines which would mark the boundary to the north and east of the current imaginary line running between [location 1] and [location 2]. The inshore boundary should be an imaginary line between [location 3] and [location 4]; alternatively it could be an imaginary line between [location 3], [location 5] and then onto [location 4]. A further alternative could be from [location 3] to [location 6] (although this would be a more complicated solution).

- I recommend that the Director, Marine Safety Victoria and/or Australian Maritime Safety Authority (AMSA) as the National Regulator, implement a voyage specific safety plan requirement for all commercial vessels/voyagers within the expanded [general location] area.
- I recommend that the Director, Marine Safety Victoria make a declaration pursuant to section 81 of the Marine Safety Act 2010 (Vic), declaring the expanded [general location] area as waters for which commercial vessel masters/coxswains are required to hold a Local Knowledge Certificate. The declaration should specify that the Local Knowledge Certificate requirement apply to commercial vessels of all sizes, and specify training and assessment requirements to be fulfilled by vessel masters/coxswains.
Coronial recommendations: Fatal facts

Case number
VIC.2014.6074

Primary category
Water related

Additional categories
Weather related, Leisure activity

Fatal facts edition
46 – cases closed between July and September 2015

Case summary
An adult male died after falling overboard from a sailing vessel.

The adult was attempting to untangle a sail line without wearing a lifejacket or safety harness. There were strong wind warnings were in place at the time of the incident. The body of the adult was never fully recovered.

Coronial findings
The coroner found that the death was unintentional.

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

- The current Victorian regulations provide for the compulsory wearing of the required grade of personal floatation device at any time of 'heightened risk'. With the aim of minimising risk and preventing like deaths, I recommend that the definition of 'heightened risk' within the Victorian Recreational Boating Safety Handbook and Marine Safety Regulations 2012 (Vic) be amended to reinstate the condition 'when there is significant likelihood that the vessel may capsize or be swamped by waves or the occupants of the vessel may fall overboard or be forced to enter the water', as was the case at the time of this tragic incident.

- With the aim of minimising risk and preventing like deaths, I further recommend that the definition of 'heightened risk' within the Victorian Recreational Boating Safety Handbook and Marine Safety Regulations 2012 (Vic) be amended to include whenever a strong wind warning is current. I further recommend that the 'strong wind warning' be based on the Bureau of Meteorology's definition of a strong wind warning (25-33 knots), as opposed to the Beaufort Scale.

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

Case number: VIC.2011.488
Primary category: Sports related
Additional categories: Work related
Fatal facts edition: 46 – cases closed between July and September 2015

Case summary
An adult male died after falling from their motorcycle during a race.

The adult was experienced in motorcycle racing, and was very familiar with the particular track. They fell from their motorcycle while overtaking a fellow rider, and collided with the tyre barrier on the edge of the track. They were declared deceased at the scene.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the tyre barrier was non-compliant with the Venue Standards, but that this was not identified during any inspections and checks prior to the race.

The coroner found that rider error caused the adult to fall from their motorcycle.

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

- The committee revising the guidelines should include a person who is an expert in drafting standards documents. This person might be someone who has previously worked for Standards Australia or some person with expertise in drafting technical manuals.
- Prior to issuing the new Track Guidelines Motorcycling Australia ought to obtain a peer review from an independent reviewer with recognised expertise in safety measures for motorsport venues.
- The guidelines should contain the relevant technical information for those charged with licensing venues.
- The guidelines should be written so that they are readily comprehensible to race officials who conduct venue checks prior to race meetings.
• Licensing officials and race state officials responsible for checking venues prior to a race meeting should have a kit which includes:
  o a copy of the Track Guidelines;
  o a copy of the track licensing conditions applicable to the particular venue;
  o checklist sheets generated for the particular venue and for the particular configuration of the venue;
  o contact details to enable the officials to readily obtain assistance in relation to any queries pertaining to the conditions applicable to the track or other issues which may arise in the field.
• Risk assessment documents and venue checklist documents should include the following question: “Are there any obstructions in the vicinity of the race which are not essential to the proper functioning of the race track?”
• Motorcycling Australia should compile a database of accidents, injuries and near misses (to be defined) occurring during any race meeting. The data is to be collected from reports filed by race officials after each event. The data should be analysed periodically to identify systemic problems at venues. This process should be developed in association with the medical data currently collected by RACESAFE.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2009.583</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Homicide and assault</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Mental illness and health</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>46 – cases closed between July and September 2015</td>
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Case summary

A middle aged male died following an assault perpetrated by an acquaintance.

The acquaintance had a lengthy history of mental ill health. In the weeks before the adult’s death, the acquaintance was accommodated and being treated in an acute psychiatric ward. Their daily medications were ceased upon discharge.

The acquaintance was seen a week after discharge to receive an anti-psychotic injection. The medical officer was not available, and the acquaintance was instead seen by a community team manager. The acquaintance displayed hostile and delusional behaviour during this consultation. The community team manager did not consider their behaviour to be a major risk warranting a response.

Coronial findings

The coroner found that the death was due to assault.

At inquest, the community team manager acknowledged that in hindsight, the medical officer would have taken action to remove the acquaintance from the community, or seek an opinion from a psychiatrist.

The coroner found that there were individual and systemic shortcomings in respect to the acquaintance’s admission. However the coroner found that the management of the acquaintance was reasonable and appropriate in the context in which they worked.

Coronial recommendations

The coroner made the following recommendations related to this case:

- Without undermining the important role of Prevention and Recovery Care (PARC), Community Residential Unit (CRU) and Secure Extended Care Units (SECU), I recommend consideration be given to adapting acute mental health units to incorporate a step down or recovery unit, within the acute setting which offers a therapeutic environment which
enables clinicians to treat the underlying serious mental illness, before safe discharge into the community.

- Without undermining the important role of Forensic Nursing clinicians, I recommend consideration be given to creating a forensic psychiatric specialist service along the lines of the former Forensicare Community Integration Program.
Coronial recommendations: Fatal facts

Case number
VIC.2014.851

Primary category
Homicide and assault

Additional categories
Child and infant death, Mental illness and health, Law enforcement

Fatal facts edition
46 – cases closed between July and September 2015

Case summary
A male child died when they were assaulted by their parent.

The parent was a respondent in a family violence intervention order at the time of the incident. The parent was fatally shot by police after the assault.

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

The coroner found that there were a number of missed opportunities for prior intervention with the parent.

The coroner found that there was no causative link between the system gaps and flaws and the child’s death, but made a number of comments and recommendations addressing public health and safety and the administration of justice.

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

State of Victoria

The following recommendations are directed to the State of Victoria through the agency of the Secretary of the Department of Premier and Cabinet.

1. I recommend that the State of Victoria undertake empirical validation of the Common Risk Assessment Framework (the CRAF), including consideration of other family violence risk assessment measures in other jurisdictions (for example, South Australian family safety framework), and the risk assessment tools based upon it, such as the L17, to determine the extent to which they accurately identify a:
   a. person’s (including a child’s) risk of being the victim of family violence;
   b. perpetrator’s risk of repeat and/or escalating family violence.

As part of this validation process, consideration should be given to whether:
c. greater weight ought be given to the victim’s own level of fear in assessing the risk posed to her and any children;

d. there should be a rating and/or weighting of risk factors to assist the person undertaking the risk assessment to identify the risk of family violence to women and/or children as low, medium or high. Any tool or system which rates or weights risk factors should be standardised across agencies dealing with family violence, taking into account the unique mandate of each agency.

2. Noting that some agencies use the CRAF, but that others do not, I recommend, the State of Victoria ensure all agencies, including the Magistrates’ Court of Victoria, operating within the integrated family violence system:

a. use the CRAF (once validated), including risk assessments aligned to the CRAF. This includes ensuring that those agencies that use external service providers (e.g. the Department of Health and Human Services (DHHS)) incorporate in service agreements with service providers, a requirement that the CRAF be used when dealing with family violence related matters;

b. undertake risk assessments that are reduced to writing, shared with, and accessible to all elements within the integrated family violence system dealing with a particular family, for the purposes of:

i. ensuring risk assessments are dynamic, collaborative, comprehensive and up-to-date. That is, once commenced, a risk assessment considers all the information available to all relevant agencies, is updated and maintained for a family where family violence has been indicated or reported;

ii. ensuring risk assessments are accessible by police officers when:

- making an application for a family violence intervention order;
- bringing charges against a perpetrator for family violence related offences;
- responding to a bail application for a person charged with family violence related offences;
- informing presiding magistrates of the outcome of relevant risk assessments.

iii. coordinating the response directed at perpetrators;

iv. coordinating the support given and safety planning provided to victims of family violence;

v. identifying common risk management strategies.

3. I recommend the State of Victoria, and where appropriate, in conjunction with the Office of the Victorian Privacy Commissioner, ensure all agencies operating within the integrated family violence system:

a. have clear rules and education about their respective capacity and obligation to lawfully share information between agencies and/or to members of the public;
b. implement clear policies with respect to the Privacy and Data Protection Act 2014 to inform respective staff members of the circumstances within which they may provide information to members of the public and other government agencies. Such policies must include circumstances where a police officer may inform a parent of any criminal charges laid against another parent (biological or other) or family violence intervention orders (FVIOs), of the same child which indicate a risk to that child; and
c. adequate training with respect to these policies.

As part of this process consideration should be given to whether the criteria and/or thresholds for sharing personal and/or health information are appropriately calibrated to allow for dynamic, up to date risk assessment in a family violence context.

4. I recommend the State of Victoria identify legislative, or policy impediments to the sharing of relevant information, and remove such impediments, so that all agencies, including the Magistrates’ Court of Victoria, operating within the integrated family violence system, are able to share relevant information in relation to a person at risk of family violence.

5. I recommend the State of Victoria ensure all agencies operating within the integrated family violence system are:
   a. clearly identified and their respective roles and responsibilities for responding to family violence are contained in legislation and/or documented in publically available policies;
   b. provided operational advice and assistance to develop clear policies, procedures and risk assessment tools aligned to the CRAF, to identify and manage a person’s:
      i. risk of being the victim of family violence; and
      ii. risk of perpetrating family violence.

6. I recommend the State of Victoria expand access to the Family Violence Court Division (FVCD) of the Magistrates’ Court of Victoria across the State. I note the operation of the Family Violence Court Division at [location] and [location] Magistrates’ Courts. I recommend also that the Court Integrated Services Program (CISP) be made available at those court locations at which the FVCD is applied. This would provide equitable, coordinated and integrated responses to families affected by family violence when dealing with the multiple jurisdictions with which they are engaged including family violence, crime, family law, child protection and Victims of Crime Assistance Tribunal (VOCAT). Most importantly criminal and family violence cases involving the same parties can be dealt with at the same time. I accept that there will always be need a tailor or modifying a program availability at certain court locations, depending on the case volume and case mix at that court. However, the point is that Magistrates’ Courts deal with an extremely high volume of family violence cases. Many of thousands of intervention orders are made annually. They are made to protect applicants. They are far more likely to be ultimately successful if magistrates are in a position to make orders
which combine protective elements, and the engage applicants and respondents with services (including the compulsory attendance by perpetrators men's behaviour change program) and, and, if necessary, with mental health treatment providers. The elements in the system should therefore include:

a. specialist family violence case management for all matters, involving families at high risk of family violence;
b. a Senior Specialist Family Violence Registrar to coordinate the listing of all matters for the one family and manage the family violence team of registrars;
c. registrars interviewing and initiating/processing in person applications have core competencies in family violence including risk assessment;
d. family violence Applicant and Respondent support workers and family violence trained CISP case managers at all courts;
e. the capacity to mandate perpetrators' timely access to and participation in Men's Behaviour Change Programs;
f. dedicated police prosecutors and civil advocates, family violence outreach workers and access to legal representation (for both applicants and respondents);
g. resourcing of the system to meet the requirement for legal representation (free legal aid) depending on demand at court locations.

7. I recommend that the State of Victoria, ensure all agencies operating within the integrated family violence system are sufficiently supported to provide their respective staff training and professional development to undertake CRAF based family violence risk assessments. Such training and professional development should include, but not be limited to, recognising, understanding; and responding to family violence. Each agency's staff, at all levels, should be educated in the dynamics of family violence, with specialist training provided to those employees whose primary role is to have contact with victims and perpetrators of family violence.

8. I recommend that the State of Victoria, implement Risk Assessment and Management Panels (RAMPs) in all police regions as soon as possible.

9. I recommend that the State of Victoria, ensure there is a process that triggers a compulsory referral to a Risk Assessment and Management Panel when a family violence agency and/or the Magistrates' Court of Victoria, assesses a person's risk for family violence as 'high'. Such a process should include, but not be limited to:

a. an initial case management conference during which the panel members use the CRAF to undertake a multi-agency case review and risk assessment of the affected person (and where relevant their children) using all information and all past risk assessments undertaken by the individual agencies;
b. immediate safety action plans;
c. longer term case management, including risk management strategies, for the affected persons, and establishment of ongoing case management of the care of the affected persons;

d. providing the referring family violence agency and/or the Magistrates’ Court of Victoria with details of the outcome in writing.

10. I recommend that the State of Victoria give consideration to the creation and resourcing of a Family Violence Advocate service to provide advocacy services for women and families modelled on the UK [United Kingdom] Domestic Advocate position.

Attorney General of Victoria

11. I recommend that the Attorney General review the *Bail Act 1977* and give consideration to the following legislative amendments:

   a. re-enact the former section 4(2)(c) of the *Bail Act* (as it appeared prior to the 2004 amendments to the *Bail Act*) to require bail to be refused where an accused person is in custody for failing to answer bail unless the accused person satisfies the court that the failure was due to causes beyond his or her control;

   b. require bail to be refused where an accused person is in custody for failing to answer bail in relation to family violence related offences unless the accused person satisfies the Court that the failure was due to causes beyond his or her control;

   c. ensure that bail conditions continue to operate until a warrant for arrest is executed. The new legislation should close the loop hole which presently results in persons who fail to attend Court to answer charges and a warrant is issued is subject to no bail conditions after their bail has been cancelled by virtue of the issuing of the warrant.

Family Law Council

12. I recommend that the Family Law Council consider the merits of amending section 68R of the *Family Law Act 1975* to provide that where a parenting order is suspended, revoked or varied pursuant to section 90 of the *Family Violence Protection Act*, that such suspension, revocation or variation operates until further order of a Court, and is not time-limited.

Chief Commissioner of Police

13. I recommend that the Chief Commissioner of Police amend Victoria Police Manual and other relevant operating instructions and if appropriate, the Code of Practice for the Investigation of Family Violence to require police officers:

   a. to provide all completed L17s relevant to an affected person to all relevant agencies operating in the family violence system;
b. completing an L17 to review previous L17s relating to the same offender and where possible to contact the authors of previous L17s to ensure information regarding risk is shared and considered;
c. to check Law Enforcement Assistance Program (LEAP) prior to completion of an L17 to ensure relevant criminal history, or other matters capable of affecting the risk assessment (including but not limited to other acts of violence with which the perpetrator has been charged, intervention orders obtained by other persons to which the perpetrator is the Respondent) are considered.

14. I recommend that the Chief Commissioner of Police cease to use the current definition of ‘recidivist’ family violence offender and develop criteria for identifying ‘high risk’ family violence perpetrators that require intensive management. The definition of ‘high risk’ should be uniformly applied and responded to in all police regions to bring about:

a. a warning flag in LEAP;
b. more intensive monitoring of the offender, including bail conditions;
c. execution of all warrants with respect to the offender to be treated as a priority.

15. I recommend that the Chief Commissioner of Police amend Victoria Police Manual and other relevant operating instructions and if appropriate, the Code of Practice for the Investigation of Family Violence to require:

a. a police prosecutor appearing in a remand/bail application to have available all previous L17s in relation to the offender to assist them in deciding whether to oppose bail and/or submissions with respect to bail conditions if bail is granted;
b. where practicable the informant in all family violence matters should be in court, or have communicated to the police prosecutor his or her views as to the future risk of family violence by the perpetrator, prior to any remand/bail application relating to the perpetrator;
c. all FVIOs be served on the Respondent with priority and where service cannot be effected substituted service from the Court be obtained within 24 hours;
d. all warrants issued in relation to family violence related incidents be executed with high priority and entered onto LEAP within 24 hours of issue;
e. a benchmark period for the:
   i. commencement of a prosecution of family violence offences;
   ii. authorisation of charges for the breach of an intervention order or family violence safety notice.
   f. police prosecutors, or other designated police officers to ensure affected family members are kept informed in relation to the progress and outcome of all FVIO proceedings, warrants, bail applications and criminal proceedings which relate to them and any other protected family members.
That whenever possible the same police prosecutor be assigned to both the criminal (including bail), and the family violence (civil) matters listed for Magistrates' Courts when the parties are the same in both - that is the applicant/victim and the perpetrator/accused.

Department of Health and Human Services (DHHS)

16. I recommend that the DHHS incorporate in its Intake Phase practice where family violence services report family violence, that Child Protection requests a completed CRAF as part of its risk assessment and analysis.

17. I recommend that the DHHS introduce a requirement that Client Relationship Information System (CRIS) notes include the full text of all CRAF risk assessments undertaken in relation to children for whom files are opened.

18. I recommend that the DHHS introduce a requirement that prior to, or when, undertaking a CRAF risk assessment, the DHHS obtain from Victoria Police all L17s relating to the child and their parents and any CRAF risk assessment undertaken by a specialist family violence service.

19. I recommend that the DHHS introduce process whereby all CRAF risk assessments which indicate high risk of family violence to a child be provided to Victoria Police for consideration of bringing an application for a FVIO.

20. I recommend that the DHHS discontinue the practice of asking women at risk of family violence to enter into undertakings, which require them to supervise or manage the behaviour of the perpetrator of the family violence.

21. I recommend that the DHHS include in its standard practice of working with reports of family violence, such as where one parent is believed to be non-protective, a professional case conference be convened before closing a file. Such a requirement must exhaust (all best) efforts to:
   a. interview the alleged perpetrator of family violence to determine whether harm in relation to a child has been substantiated;
   b. engage all agencies involved with the family to remediate the issue of services working in isolation and risk assessments being made with insufficient information;
   c. develop a comprehensive and robust safety plan with clear roles and responsibilities as required.

22. I recommend that where the DHHS assess one parent to be 'protective' but the other is not, that the DHHS provide support to the protective parent, including in court proceedings, to manage the risk posed by the non-protective parent including, (where relevant and appropriate) by recommending that the other non-protective parent have no contact with the child.
23. I recommend that the DHHS provide greater guidance to family violence agencies the circumstances in which a report to Child Protection should be made.

24. I recommend that the DHHS ensure its staff comply with its specialist practice resource 'Working with families where an adult is violent' (2014) to ensure:
   a. when assessing the protective capacity of the non-offending parent, by analysing the protective factors and ensuring they have been weighted against the history;
   b. assessing pattern and severity of harm perpetrated against them;
   c. undertaking a comprehensive risk assessment of the perpetrator and their behaviour and that the department can demonstrate a robust approach to locating perpetrators that are evading service involvement or have no fixed address.

Magistrates' Court of Victoria

In addition to Recommendation 6 above.

25. I recommend that the Magistrates' Court of Victoria simplify the 'Information for Application for an Intervention Order' form and integrate a checklist based on the CRAF for applicants to complete when making an application for a FVIO.

26. I recommend that the Magistrates' Court of Victoria implement training for Registrars who interview applicants and prepare FVIO documentation, to apply the CRAF to ensure appropriate risk information is identified and included in the Application for an Intervention Order.

27. I recommend that the Magistrates' Court of Victoria ensure its staff working in family violence matters receive specialist family violence training in relation to the CRAF and the process by which to undertake a risk assessment.

28. I recommend that Magistrates' Court of Victoria ensure its Applicant Support Workers complete the CRAF with the affected family member in Family Violence Intervention Order cases, and supply the completed risk assessment to Victoria Police.

29. I recommend that the Magistrates' Court of Victoria revise the form and content of FVIOs to ensure they are written in clear and unambiguous language. This should include clarity in relation to the operation of section 68R of the Family Law Act 1975.
Coronial recommendations: Fatal facts

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**Case summary**

An adult male died due to drug toxicity in their home.

The day prior to their death, the adult had been admitted to hospital due to a drug overdose. They were discharged from hospital following an observation period.

The adult had a longstanding history of illicit drug use and prescription drug abuse.

**Coronial findings**

The coroner found that the death was unintentional.

The coroner found that at no stage were they identified as a prescription drug abuser. The coroner found that given the evidence of drug seeking, this was a missed opportunity.

**Coronial recommendations**

The coroner made the following recommendations related to this case:

**Recommendation one**

- I recommend that the Royal Australian College of General Practitioners continue to develop the benzodiazepine prescribing section of its Good Practice Guide to Drugs of Dependence, basing its guidelines on best practice evidence rather than making concessions to the current reality of widespread sub-optimal prescribing.

**Recommendation two**

- In line with the recent recommendation published by [coroner] in Finding with Inquest into the death of [name], I recommend that the Victorian Department of Health progress the implementation of a Victorian-based real-time prescription monitoring system as a matter of urgency to prevent ongoing harms and deaths associated with pharmaceutical drug misuse and inappropriate prescribing and dispensing of pharmaceutical drugs.

**Recommendation three**
While the Victorian Department of Health continues with its efforts to implement a real-time prescription monitoring program for Schedule 8 drug dispensing, it also identifies the legislative and regulatory barriers that might prevent drugs listed in other schedules (particularly Schedule 4) from being monitored within the scope of the program. If any such barriers are identified, I recommend that the department considers what reforms are necessary so that in due course its real-time prescription monitoring program can be expanded beyond Schedule 8 drugs. This will enhance clinicians' ability to make appropriate clinical decisions about patients.

I note that the DHHS [Department of Health and Human Services] has responded to recommendations two and three as made in the [similar death] finding, however the responses indicate that issues are under consideration and no commitment to action has yet been made, therefore I reiterate recommendations two and three.

**Recommendation four**

- The Australian Government Department of Human Services review how Medicare Australia responds to medical practitioners’ Prescription Shopping Information Service queries, to ensure medical practitioners are not being unintentionally misled. In particular, the Department should consider whether Medicare Australia’s current practices ensure that a medical practitioner who calls the Information Service understands the limitations of the Service, including that many drug seekers do not meet the Prescription Shopping Program threshold for being identified as prescription shoppers.

**Recommendation five**

- The Australian Government Department of Human Services introduce a practice whereby when a medical practitioner contacts the Medicare Australia Prescription Shopping Information Service regarding a Victorian patient, the medical practitioner is informed that if there are concerns about the patient being a drug seeker, regardless of whether or not the patient is deemed to be a prescription shopper under the Prescription Shopping Program, the medical practitioner should make a notification to Drugs and Poisons Regulation at the Victorian Department of Health as required under the Drugs Poisons and Controlled Substances Act 2006 (Vic).
Coronial recommendations: Fatal facts

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Case summary

An adult male died due to drug toxicity in their home.

They had a longstanding history of illicit drug use and prescription drug and alcohol abuse.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that at no stage was the adult identified as a prescription drug abuser and that given the evidence of drug-seeking behaviour, this was a missed opportunity.

Coronial recommendations

The coroner made the following recommendations related to this case:

**Recommendation one**

- In line with the recent recommendation published by [coroner] in Finding with Inquest into the death of [name], I recommend that the Victorian Department of Health progress the implementation of a Victorian-based real-time prescription monitoring system as a matter of urgency to prevent ongoing harms and deaths associated with pharmaceutical drug misuse and inappropriate prescribing and dispensing of pharmaceutical drugs.

**Recommendation two**

- While the Victorian Department of Health continues with its efforts to implement a real-time prescription monitoring program for Schedule 8 drug dispensing, it also identifies the legislative and regulatory barriers that might prevent drugs listed in other schedules (particularly Schedule 4) from being monitored within the scope of the program. If any such barriers are identified, I recommend that the department considers what reforms are necessary so that in due course its real-time prescription monitoring program can be expanded beyond Schedule 8 drugs. This will enhance clinicians’ ability to make appropriate clinical decisions about patients.
I note that the DHHS [Department of Health and Human Services] has responded to recommendations two and three as made in the [similar death] finding, however the responses indicate that issues are under consideration and no commitment to action has yet been made, therefore I reiterate recommendations two and three.

**Recommendation three**

- The Australian Government Department of Human Services review how Medicare Australia responds to medical practitioners’ Prescription Shopping Information Service queries, to ensure medical practitioners are not being unintentionally misled. In particular, the Department should consider whether Medicare Australia’s current practices ensure that a medical practitioner who calls the Information Service understands the limitations of the Service, including that many drug seekers do not meet the Prescription Shopping Program threshold for being identified as prescription shoppers.

**Recommendation four**

- The Australian Government Department of Human Services introduce a practice whereby when a medical practitioner contacts the Medicare Australia Prescription Shopping Information Service regarding a Victorian patient, the medical practitioner is informed that if there are concerns about the patient being a drug seeker, regardless of whether or not the patient is deemed to be a prescription shopper under the Prescription Shopping Program, the medical practitioner should make a notification to Drugs and Poisons Regulation at the Victorian Department of Health as required under the Drugs Poisons and Controlled Substances Act 2006 (Vic).
Coronial recommendations: Fatal facts

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

A middle aged male died due to methadone toxicity.

The adult was a resident of a rooming house and acquired takeaway methadone bottles prescribed to a fellow housemate.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the death occurred in circumstances where the adult had consumed alcohol alongside methadone.

The coroner supported the following comments and recommendations made by another coroner in a previous case:

> It is evident that far too many Victorians have recently died by overdosing on diverted methadone that was dispensed as it takeaway dose to an opioid replacement therapy client. The frequency of deaths - at least 58 confirmed deaths between 2010 and 2013, and probably far more than this - is evidence that current regulation of access to takeaway methadone in Victoria does not adequately manage the risk of dose diversion. The longer-term trend in overall Victorian methadone overdose deaths, which were relatively stable at between 22 and 34 per year in 2000-2006, then increased steadily after access to takeaway dosing was expanded, reaching 70-74 deaths per year in 2011-2013, also evidences this concern.

Coronial recommendations

The coroner made the following recommendations related to this case:

- The Victorian Department of Health request the Advisory Group for Drugs of Dependence review the circumstances of the deceased death, when considering whether the current takeaway dosing advice in the Victorian Policy for Maintenance Pharmacotherapy for Opioid Dependence adequately balances client benefits with risks to public health and safety.
The Victorian Department of Health request the Advisory Group for Drugs of Dependence to consider the probable impact on pharmacotherapy clients and the broader public, of revising the Policy for Maintenance Pharmacotherapy for Opioid Dependence so that an opioid replacement therapy client is eligible to receive at most two takeaway methadone doses per week and no consecutive takeaway doses. Given the current significant harms associated with methadone takeaway dose diversion, the Advisory Group for Drugs of Dependence should ideally report publicly on its conclusions, so the Victorian public is informed as to the rationale for the Advisory Group and Department of Health's stance on access to takeaway methadone.
Coronial recommendations: Fatal facts

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

An older female died due to complications following a paracetamol overdose.

The adult had a history of dependence on over-the-counter codeine combination analgesics. They were discovered unresponsive in their home, and were transported to hospital. The adult’s condition deteriorated and they passed away some days later.

Coronial findings

The coroner was unable to determine the intent of the deceased.

The coroner found that it was more likely than not that the death was accidental.

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 a new 'cautionary and advisory' label (CAL) be included in the Australian Pharmaceutical Formulary, warning about the toxicities associated with excessive doses of paracetamol, and I recommend that the CAL be used whenever paracetamol/codeine combination products are supplied or dispensed.
Coronial recommendations: Fatal facts

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<td>46 – cases closed between July and September 2015</td>
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Case summary

A young male died after being struck by a train. They had a history of illicit drug use and suicide threats.

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 a relationship breakdown, drug use and an impending court case.

The coroner found 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.

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

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<td>Fatal facts edition</td>
<td>46 – cases closed between July and September 2015</td>
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Case summary

A young male died after being struck by a train. They had threatened suicide in the weeks leading up to their death, and were subsequently admitted to a mental health clinic. They were considered to be a high suicide risk.

On the day of the incident, the young person checked themselves out of the clinic for a short period of unescorted leave. After a long period had elapsed, the clinic attempted to contact them with no success. They were subsequently discovered to have been struck by a train.

A friend of the young person had taken their own life in a similar manner some months 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 in the young person’s life, including exposure to suicide, mental ill-health, drug use and interpersonal relationships.

The coroner found that the risk management and leave by the mental health clinic was inadequate. The coroner noted that changes to protocol and practice had been implemented at the clinic since the young person’s 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...
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Coronial recommendations: Fatal facts

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Case summary
An adult female took their own life by hanging. They were a voluntary psychiatric patient in hospital at the time of their death.

The adult presented to hospital with suicidal ideation. They were assessed as low risk and admitted to the low dependency unit. They were nursed on low risk observations, and there was no policy requiring the routine removal of potential ligatures.

The adult was discovered hanging during the first observation of the morning.

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

The coroner found that the risk assessments undertaken in the hospital leading up to the death were suboptimal, but that these risk assessments did not contribute to the death.

The coroner found that more frequent observations would not necessarily have prevented the death of the adult.

The coroner found that the hospital had changed their policy regarding potential ligatures since the adult’s death.

The coroner made the following comments:

- Whilst the intent of the policy Removal of Hazardous Items in Inpatient Units is clear, the wording is apt to confuse. The word ‘scarf’ has a common and innocuous meaning. Rather than use the word ‘scarves’ and then seek to define it to include potential ligatures that are not scarves, it would be preferable to use some other terminology, such as ‘potential ligatures’ and then give examples. In any event, dressing gown cords, shoelaces, belts and headphone cords should be specifically mentioned. Presently they are not.
- Further, the opening word ‘Notwithstanding’ in paragraph 6 of the policy has a tendency to undermine the absolute prohibition contained in the earlier paragraphs. A reader of
the document might reasonably enquire if paragraph 6 was intended to be a qualification of the earlier prohibition, or an additional power to search. Given paragraph 4 states the initial unpacking of items is not to be construed as a search, I am satisfied that paragraph 6 is not intended to detract from the force of the earlier paragraphs, however the document should be reworded to make this clear.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that [location] Mental Health re draft their policy Removal of Hazardous Items in Inpatient Units in line with the comments set out above.
Coronial recommendations: Fatal facts

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<th>Case number</th>
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Case summary

An older female died due to deep vein thrombosis some weeks after a fall from a step ladder.

As a result of the fall, the adult had their leg immobilised in plaster, and were discharged with crutches to aid mobility. They found the crutches difficult to use and subsequently spent significant time sitting and resting. The adult’s partner found them collapsed in their home and contacted emergency services. The adult was unable to be revived.

Coronial findings

The coroner found that the death was unintentional. The coroner found that the adult’s high body mass index and their age heightened their risk of deep vein thrombosis.

Coronial recommendations

The coroner made the following recommendations related to this case:

- The National Health and Medical Research Council should consider commissioning a working group, to collate and analyse evidence concerning thromboprophylaxis for outpatients who have a body mass index over 30. This would include those at increased risk of venous thrombo-embolism, such as people with trauma, requiring limb immobilisation. This evidence should be collated and analysed with a view to creating guidelines for hospitals and the health care system regarding their treatment and management of such patients.

- That Victorian Health Department should consider a public education campaign to raise awareness of the potential risk of venous thrombo-embolism and the importance of early mobilisation for people who have a body mass index over 30 and find themselves immobilised after discharge from hospital or for any other reason.

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.2014.3146
Primary category: Natural cause death
Additional categories: Older persons, Falls, Physical health
Fatal facts edition: 46 – cases closed between July and September 2015

Case summary
An older male died due to congestive cardiac failure.

The adult had recently undergone surgery for a fracture sustained in a fall. Their condition deteriorated following surgery, and they subsequently passed away.

The adult was receiving home-based palliative care due to their terminal illness and other health conditions at the time of their death.

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

The coroner found that alternatives to surgery were not considered in addressing the adult’s condition. In addition, the coroner found that the Royal Australasian College of Surgeons did not have guidelines recommending specific treatments for orthopaedic patients, including for patients who sustain significant fractures when they are close to death.

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

- The Royal Australasian College of Surgeons considers the need to develop guidelines for cases where end of life patients sustain significant fractures.
- That any such guidelines provide that the option of terminal (end of life) palliation be discussed with the patient and family in situations where surgical repair is likely to have little or no benefit to the patient.

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

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<td>Fatal facts edition</td>
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Case summary
An older male died due to head injuries sustained in a fall from a ladder.

The adult appeared to have been pruning a tall hedge when they fell off the ladder and onto a footpath.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that outside of the occupational setting, no one body or entity assumed responsibility for the implementation of prevention strategies to reduce falls from ladders.

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

- I recommend that the Department of Health and Human Services develops and coordinates a strategy and/or program with relevant stakeholders with the aim of implementing public health and safety measures targeted at preventing deaths from ladder falls.

- I recommend that the Department of Health and Human Services commence this strategy and/or program through a public education program including but not limited to the production and dissemination of safety information material such as pamphlets aimed at improving the public's awareness of the risks and dangers of domestic ladder use.

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.2014.5778</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Falls</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Older persons</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>46 – cases closed between July and September 2015</td>
</tr>
</tbody>
</table>

Case summary

An older male died due to head injuries sustained in a fall from a ladder.

The adult appeared to have been pruning a large tree when they fell off a ladder and onto a driveway.

Coronial findings

The coroner found that the death was unintentional.

The coroner had previously found in a similar case that, outside of the occupational setting, no one body or entity assumed responsibility for the implementation of prevention strategies to reduce falls from ladders.

Coronial recommendations

The coroner made the following recommendations related to this case:

I refer to and repeat the two recommendations I made to the Department of Health and Human Services as follows.

- I recommend that the Department of Health and Human Services develops and coordinates a strategy and/or program with relevant stakeholders with the aim of implementing public health and safety measures targeted at preventing deaths from ladder falls.
- With the aim of reducing serious injury and death from ladder falls in the domestic setting, I recommend that the Department of Health and Human Services commence this strategy and/or program through a public education program including but not limited to the production and dissemination of safety information material such as pamphlets aimed at improving the public's awareness of the risks and dangers of domestic ladder use.

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Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2013.4266</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Aged care</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Older persons, Physical health, Mental illness and health</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>46 – cases closed between July and September 2015</td>
</tr>
</tbody>
</table>

Case summary
An older female died due to choking on food in the aged care facility where they resided.

The adult suffered from dementia and were placed on a thickened fluid diet to assist with their swallowing issues. They were known to be occasionally resistant and aggressive due to their dementia.

On the day of the incident, a staff member observed the adult eating a slice of bread. The staff member was aware of the adult’s restricted diet and removed the bread. A short time later, the adult was observed to be choking, and staff members attempted to assist them. They resisted the assistance attempts, and soon collapsed. Staff did not attempt to resuscitate the adult as there was a ‘do not resuscitate’ order in place.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the care and management of the older person by the aged care facility was generally reasonable and appropriate.

The coroner found that there were shortcomings in the care provided to the adult in relation to supervising that they did not obtain food from other sources outside of the meals provided to them.

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 the emergency response training, including cardiopulmonary resuscitation training, that [aged care group facility] provided as a result of this incident, is undertaken annually by all [aged care group facilities].
• With the aim of minimising risk and preventing like deaths, I recommend that all changes made by the [aged care group] dementia unit, as a result of this incident, be implemented at all other [aged care group] dementia units.

• With the aim of minimising risk and preventing like deaths, I recommend that [aged care group] review the process for adding or updating information to the ‘Plan of Care’ document. Currently it is hand written by the reviewing practitioner. Care directions are confusing and not written chronologically with a legible name and date from the practitioner. This is an important care document and I recommend that it should be reprinted each time it is altered by a practitioner, with the new plans of care dated and set out chronologically.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2011.4597</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Adverse medical effects</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Natural cause death</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>46 – cases closed between July and September 2015</td>
</tr>
</tbody>
</table>

Case summary

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

The adult’s partner phoned a medical centre earlier that day and reported that the adult was suffering from chest pain. They were advised by the practice manager to attend the medical centre. The adult attended their general practitioner and underwent an electrocardiogram (ECG), which was normal. They were advised their pain was likely musculoskeletal pain, and were sent home.

Coronial findings

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

The coroner found that the adult should have been advised to call an ambulance after the initial contact with the medical centre, or the call should have been triaged to a nurse or doctor to assess the urgency of the situation.

The coroner found that the general practitioner’s assessment and treatment of the adult was lacking in that they incorrectly ruled out a cardiac cause for the chest pain, or in not having ruled out a cardiac cause they failed to appreciate the urgency of the situation.

The coroner found that if the adult had been transferred to hospital it is likely they would have survived. The coroner noted that had the adult been administered aspirin, this may have prevented the formation of the clot that proved fatal.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Royal Australasian College of General Practitioners considers the need to advise its members to implement protocols to give effect to the Heart Foundation’s Action Plan so that any patient calling a general practice with chest pain matching the description in the Action Plan is advised to call an ambulance.
• That the Royal Australasian College of General Practitioners considers the need to train its members in relation to the significance of the absence of pain and a normal ECG in determining whether a person is suffering an acute coronary episode.
• That the Royal Australasian College of General Practitioners considers the need to advise its members that any patient with chest pain matching the description in the Heart Foundation’s Action Plan should be immediately referred to an emergency department.
• That the Royal Australasian College of General Practitioners considers the need to remind its members of the importance of comprehensive clinical notes.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2013.4968</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Adverse medical effects</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Transport and traffic related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>46 – cases closed between July and September 2015</td>
</tr>
</tbody>
</table>

Case summary

A middle aged male died as a result of deep vein thrombosis following a vehicle incident in which they were a motorcyclist.

The adult was transported to hospital with a lower limb fracture after a vehicle collided with their motorcycle. Hospital staff applied plaster and they were discharged that day. Some days later, the adult returned to hospital via ambulance with complaints of lower limb pain and central chest pain. They were given analgesia and discharged.

Days later, they collapsed at home. Ambulance personnel were unable to revive the adult and they were declared deceased at the scene.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult died as a result of deep vein thrombosis. The adult’s recent lower limb fracture combined with immobility were risk factors for deep vein thrombosis.

The coroner found that the medical care and management of the middle aged person following the collision was reasonable and appropriate.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Department of Health and Human Services consider the need for hospital Emergency Departments to provide written information regarding the risk and symptoms of deep vein thrombosis and pulmonary embolism to patients who present with lower limb injuries requiring immobilisation, particularly if they have additional risk factors.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2013.5768</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Child and infant death</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>46 – cases closed between July and September 2015</td>
</tr>
</tbody>
</table>

Case summary
A female child died when they were struck by a falling tree branch.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the council did not have a formal tree management plan, but that this did not represent a causal factor in the death.

The coroner found that during the last inspection before the incident, there were sufficient features of the tree that warranted more than a ground inspection.

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

- All local government agencies should have a computer-based inventory of all trees for which they are responsible, which identifies the species of the tree and its location.
- All local government agencies should have a computer maintenance program that is linked to the inventory which provides dates and details (what was done and why) of all maintenance and inspection operations that are undertaken on the trees.
- All local government agencies should have a computer-based risk assessment system that is applied to all trees contained within the tree inventory. Such a system may incorporate the use of systems such as QTRA [Qualified Tree Risk Assessment] or TRAQ [Tree Risk Assessment Qualification], which are widely and readily available or another system which embodies the principles of risk assessment specified in the relevant Australian Standard.
- All local government agencies should have a formalised tree inspection protocol, which specifies the purpose of the inspection and what form the inspection takes (e.g. walk-by Visual Tree inspection, use of technological aids in the inspection process) and whether the inspection is ground-based, or from above. The inspection record should also indicate what further arboricultural works, if any, are recommended for the tree and why these works are recommended.
• All inspections must be undertaken by a qualified (Level 4 or above) arborist. We are generally of the view that a level 5 qualification or above is preferred, but this may not be applicable to all council-based situations at present.

• All and any inspection and assessment protocols should be clearly dated and indicate a clear time line for the next inspection/assessment. The inspection/assessment record should also indicate what further arboricultural works, if any, are recommended for the tree and by what date in the future these should be undertaken.

• In any tree inspection, tree assessment or risk assessment, it should be noted that the anatomy of a branch and of an epicormic shoot are quite different. The term "branch" should only be applied to tree structures that have a proper branch anatomy and epicormic shoots should be clearly identified as such in any assessment or inspection procedures.

• All and any inspection protocols should involve components that assess the trunk and canopy components (above-ground) and root system (below-ground) of the tree. Inspection protocols should involve the use of relevant criteria that allow proper assessments against these criteria to be made at the time of inspection.

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Coronial recommendations: Fatal facts

Case number
VIC.2012.4470

Primary category
Natural cause death

Additional categories
Child and infant death, Adverse medical effects

Fatal facts edition
46 – cases closed between July and September 2015

Case summary
A female infant died shortly after birth due to an infection in the setting of a complex labour.

The birth occurred in a regional hospital. The infant’s mother had a high body mass index (BMI) which posed a risk in relation to the anaesthetic. The birth was overseen by the hospital’s specialist obstetrician and a locum obstetrician.

Coronial findings

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

The coroner found that the specialist obstetrician was unaware of the regional hospital’s policy to transfer patients with a high BMI to a tertiary hospital.

The coroner found that the locum obstetrician did not appreciate the severity of the abnormality in the mother’s cardiotocography trace leading up to the birth, or the implications for labour. The coroner was unable to determine to a requisite level that the locum obstetrician’s clinical management of the infant’s mother caused the infant’s death.

Coronial recommendations

The coroner made the following recommendations related to this case:

- To improve the quality and consistency of cardiotocograph interpretation across hospitals and to ensure that locum obstetricians who do not have the benefit of obtaining continuing professional development within any one hospital, I recommend that the Royal Australian and New Zealand College of Obstetricians and Gynaecologists consider whether it would be both beneficial and feasible to implement a program whereby locum obstetricians are required to demonstrate current competency in fetal surveillance monitoring to maintain their accreditation.

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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>The coroner held a joint investigation into the following deaths which resulted from the same incident: WA.2007.309 &amp; WA.2007.358</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Weather related</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Geographic</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>46 – cases closed between July and September 2015</td>
</tr>
</tbody>
</table>

Case summary

An adult male and an adult female died due to multiple injuries sustained when a severe tropical cyclone struck their residences.

The two adults were residing in separate temporary accommodation in a remote location.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the temporary accommodation had been incorrectly built according to non-cyclonic area standards.

The coroner found that there were numerous occasions where the wind region error could have been identified to ensure accommodations were built according to the correct wind region requirements.

Coronial recommendations

The coroner made the following recommendations related to these cases:

- I recommend that the Western Australian Government consider introducing mandatory inspections in Wind Regions D and C in order to achieve greater construction compliance with the applicable building standards set out in the Building Regulations 2012.
- I recommend that the Australian Building Codes Board explore methods by which a large scale electronic map that is prepared in accordance with the smoothed coastline and the delineated wind regions be made accessible through the Web. This map is to be updated if and when the Australian Standards change the delineated wind regions.

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Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>WA.2012.1745</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Natural cause death</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>46 – cases closed between July and September 2015</td>
</tr>
</tbody>
</table>

Case summary

An older male died due to an undiagnosed gastrointestinal haemorrhage.

The adult attended a hospital emergency department with symptoms but was discharged home. Their condition was misdiagnosed as gastroenteritis.

Coronial findings

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

The coroner found that the lack of ready access to the adult’s medical information may have indirectly contributed to the death.

Coronial recommendations

The coroner made the following recommendations related to this case:

- If it is not already doing so, the Western Australian Department of Health, take steps to attempt to identify and have in place a means of giving clinicians in emergency departments timely access to patients’ health information from all sources.

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