Coronial recommendations: Fatal facts

A summary of cases and recommendations made between October and December 2015

Edition 47
DISCLAIMER
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CORONERS’ RECOMMENDATIONS

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

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

Coronial recommendations: Fatal facts includes case summaries and recommendations for cases closed between October and December 2015.

Previous summaries and recommendations are available at: https://www.ncis.org.au/publications/fatal-facts/
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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Case summary
A male adult took their own life by hanging whilst incarcerated.

The adult was being held in custody at a prison facility and had been placed in a health ward due to accommodation issues.

They had a history of mental illness which was complicated by substance abuse.

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

The coroner found that health wards are inappropriate to accommodate individuals with symptomatic mental illness.

The coroner found that the health wards had design (and other) features that elevated the degree of risk involved in accommodating detainees who were mentally ill, particularly when accommodated on their own.

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

- I recommend that ACT [Australian Capital Territory] Corrective Services engage a suitably qualified expert to provide a report to the Attorney-General as to the effectiveness of changes to practice and procedures relating to the management of “at risk” detainees that have been made since October 2012, and to report on the implementation of the recommendations made in the internal review into [the deceased's] death.

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Case summary
A female adult died due to a spontaneous post-partum brain bleed. They had a medical history of a blood-clotting disorder and a family history of hypertension.

Coronial findings
The coroner found that the death was due to natural causes. The coroner found that the obstetrician did not appropriately treat the acute pregnancy induced hypertension.

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

- That all nursing staff, midwives, general medical practitioners and specialist obstetricians involved in the treatment and care of pregnant women undertake specific training with respect to pregnancy induced hypertension (pre-eclampsia) and the risks that condition presents to pregnant women antenatally and post-partum. This training should include familiarity with the SOMANZ (Society of Obstetric Medicine of Australian & New Zealand) guidelines in place at the time and the WHO (World Health Organisation) recommendations regarding treatment and care of patients with pregnancy induced pre-eclampsia.
- That literature such as the Pre-eclampsia Foundation Brochure (which sets out the risks of pre-eclampsia to pregnant women) be provided by practitioners who have the care and treatment of pregnant women to all pregnant women under their care.
- That a patient’s complete notes should be sent with the patient at the time of their discharge from the birthing suite onto the ward.
- The taking of contemporaneous notes is to be encouraged when any significant event occurs. In my view this should be routine for all staff treating a patient, including the medical staff.

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Case summary

An older adult male died from haemopericardium due to ruptured dissection of aorta. The adult had been feeling unwell with chest pains. At the time of their death, they were undergoing surgery due to the dissection.

Coronial findings

The coroner found that the death was due to natural causes. The coroner found that the adult died whilst under anaesthetic.

Coronial recommendations

The coroner made the following recommendations related to this case:

- A review of the requirements of section 34A of the Coroners Act 1997 limiting the power of a Coroner to dispense with a hearing.

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NEW SOUTH WALES

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


Primary category: Transport and traffic related

Additional categories: Work related, Child and infant death, Location

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Case summary – NSW.2009.836

A middle aged male died due to drowning in shallow water after the quad bike they were riding rolled.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that death occurred when the adult was rendered unconscious after rolling their quad bike. The adult was not wearing a helmet at the time of the incident.

Case summary – NSW.2011.4990

An adult female died due to positional asphyxia when the quad bike they were riding overturned and pinned them against a tree.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult was an inexperienced rider. The quad bike had been purchased second hand from a dealer and the adult was not told of any risks associated with quad bikes.

Case summary – NSW.2012.1648

A male child died due to injuries sustained when the side-by-side vehicle (SSV) they were driving rolled, pinning them underneath.

Coronial findings

The coroner found that the death was unintentional.
The coroner found that the child was not supervised at the time they were driving the SSV, and that children under the age of 16 did not have the maturity or capability of driving such vehicles safely. These warning messages were printed on the vehicle and in the user manual.

The child was not wearing a seatbelt. The SSV model was not fitted with an interlock device that restricted the speed limit when the vehicle was in use without the seatbelt engaged. The SSV did not have protective side mesh fitted.

**Case summary – NSW.2012.2867**
A female child died due to head injuries sustained when the quad bike they were riding rolled.

**Coronial findings**
The coroner found that the death was unintentional.

The coroner found that the child was driving the quad bike with multiple passengers. Warnings detailing carrying passengers and children driving the quad bike were displayed on the vehicle and in the operator's manual. The child was not wearing a helmet at the time of the incident.

**Case summary – NSW.2013.1476**
An older adult male died due to asphyxiation when the quad bike they were riding overturned, pinning them underneath.

**Coronial findings**
The coroner found that the death was unintentional.

The coroner found that the adult was working on their property at the time of the incident. They were spraying weeds using a spray unit attached to the quad bike. The coroner found that additional weight on the back of quad bikes could cause instability on certain terrain. The adult was not wearing a helmet at the time of the incident and the quad bike was not fit with rollover protection.

**Case summary – NSW.2013.3900**
A middle aged male died due to asphyxiation after the quad bike they were riding rolled and landed on top of them.

**Coronial findings**
The coroner found that the death was unintentional.
The coroner found that the adult was working on their farm at the time of the incident. The adult was riding the quad bike in a side-saddle position, impacting its stability. The quad bike was not equipped with rollover protection and the adult was not wearing a helmet.

Case summary – NSW.2014.2618

A young male died due to asphyxia when the quad bike they were riding rolled, trapping them underneath.

The young person had a high blood alcohol level at the time of the incident.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the young person was heavily affected by alcohol, impacting their ability to control the vehicle and react accordingly. The incident occurred at night and visibility was restricted due to darkness. The quad bike was not fitted with a rollover protection system and the young person was not wearing a helmet.

Case summary – NSW.2014.3330

A middle aged male died due to asphyxia when the quad bike they were riding rolled over, trapped them underneath.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that there were no witnesses to the incident and it was unclear why the quad bike had rolled. The bike was not fitted with a rollover protection system.

A moderate level of alcohol was detected during toxicological examination.

Case summary – NSW.2015.255

A male child died due to asphyxia when the quad bike they were riding rolled and landed on top of them.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the child was granted permission by their caregiver to ride the adult-sized quad bike, but was not of an appropriate age or size to be able to control the quad bike correctly. The quad bike was not equipped with rollover protection and the child was not wearing a helmet.
Case summary – NSW.2012.1777

An older adult male died due to chest compression when the quad bike they were using rolled down a slope and came to rest on top of them.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the quad bike had become lodged on a rock as the adult was attempting to ride a steep hill. The adult was in the process of trying to dislodge the bike when it rolled backwards. The adult had previously been involved in other quad bike incidents.

Coronial recommendations

The coroner made the following recommendations related to these cases:

- That SafeWork NSW [New South Wales], in collaboration with Safe Work Australia, and Work Health and Safety Authorities in other States and Territories, develop, implement and support a safety rating system which provides independent information for the assistance of prospective purchasers of new quad bikes, side-by-side and related vehicles for the workplace environment.
- That the [manufacturer], and [manufacturer], collaborate with Safework NSW, and other Work Health and Safety Authorities, to assist in the development and implementation of the safety rating system.
- That the [manufacturer], [manufacturer]and the Australian Quad Distributors Association take steps to develop Australian Standards through Standards Australia, in consultation with other relevant stakeholders, relating to the design, manufacture, importation and supply of quad bikes, side-by-side and related vehicles.
- SafeWork NSW, Safe Work Australia, the [manufacturer], [manufacturer], the Australian Quad Distributors Association, and the National Farmers Federation, in consultation with other relevant stakeholders, work to develop an improved and standardised nationally accredited training package for the operation of quad bikes, side-by-side and related vehicles.
- That SafeWork NSW, Safe Work Australia, the [manufacturer], [manufacturer], the Australian Quad Distributors Association, and the National Farmers Federation, in consultation with other relevant stakeholders, work collaboratively to improve the uptake of training in the operation of quad bikes, side-by-side and related vehicles.
- That the [manufacturer], [manufacturer]and the Australian Quad Distributors Association work with their members to promote, at point of sale, the uptake of training in the operation of quad bikes, side-by-side and related vehicles.
- That consideration be given, by the NSW Law Reform Commission and the NSW Attorney-General, to the introduction of legislation requiring mandatory training and/or
licensing of all persons using quad bikes, side-by-side and related vehicles. e) That SafeWork NSW give consideration to providing and promoting rebates to employers for the costs of providing training courses for employees concerning the safe use of quad bikes, side-by-side and related vehicles.

- That the [manufacturer], [manufacturer] and the Australian Quad Distributors Association in consultation with SafeWork Australia take steps to develop an Australian Standard through Standards Australia relating to the design and manufacture of helmets for use with quad bikes, side-by-side and related vehicles.
- That until an Australian Standard for helmets is issued, SafeWork NSW consider adopting and promoting the use of helmets which comply with New Zealand Standard NZS 8600:2002.
- That the [manufacturer], [manufacturer], and the Australian Quad Distributors Association work to promote the importance of helmets, and the range of suitable helmets, at point of sale.
- That SafeWork NSW conduct a campaign, aimed at farming and other workplaces, to promote awareness of the criminal liability which may attach to persons and corporations who fail, in the course of a business or undertaking, to provide and enforce the use of helmets by persons using quad bikes, side-by-side and related vehicles.
- That consideration be given, by the NSW Law Reform Commission and the NSW Attorney-General, to the introduction of legislation requiring the use of a suitable helmet by all persons using quad bikes, side-by-side and related vehicles.
- That SafeWork NSW, SafeWork Australia, and the manufacturers of the “Quadbar” and “Lifeguard” Crush Protection Devices, collaborate and attempt to reach agreement to conduct an independent survey study to assess the benefits, risks and general efficacy of Crush Protection Devices.
- That any Australian Standard for side-by-side or related (ride-in) vehicles that is developed in accordance with recommendation 2 above, include a requirement for the fitting of a suitable occupant retention system and design measures aimed at encouraging seatbelt use.
- That consideration be given, by the NSW Law Reform Commission and the NSW Attorney-General, to the introduction of legislation requiring the use of a seatbelt by all operators and passengers in side-by-side or related (ride-in) vehicles.
- That SafeWork NSW and Safe Work Australia conduct a campaign, aimed at farming and other workplaces, to promote awareness of the possible criminal liability which may attach to persons and corporations who expose children to risk by allowing them to use adult-sized quad bikes, side-by-side or related vehicles.
- That consideration be given, by the NSW Law Reform Commission and the NSW Attorney-General, to the introduction of legislation prohibiting any child under 16 years from using an adult sized quad bike, side-by-side or related vehicle.
- That SafeWork NSW conduct a public media campaign to increase awareness in persons engaged in rural activities in NSW, of the following matters:
The risk of death or serious harm from being crushed or asphyxiated in rollovers and other accidents involving quad bikes, side-by-side and related vehicles;

The risk of death or serious harm from head injury where a helmet is not worn in accidents involving quad bikes, side-by-side and related vehicles;

The risk of death or serious harm where seat belts are not worn in accidents involving side-by-side and related vehicles;

The risk of death or serious harm to children who use adult-sized quad bikes, side-by-side and related vehicles;

The risk of death or serious harm to those who operate quad bikes, side-by-side and related vehicles without proper training;

The risk of death or serious injury in carrying passengers on quad bikes and side-by-side that are not specifically designed to carry a passenger, or in carrying more passengers than the vehicle is designed to carry;

The risk of death or serious injury to those who operate quad bikes, side-by-side and related vehicles whilst under the influence of alcohol, or in a reckless or careless manner.

That Safe Work Australia and the National Farmers Federation consider conducting a public media campaign to increase awareness in persons engaged in rural activities in NSW in respect of the matters outlined above.
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<td>Fatal facts edition</td>
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Case summary

A young male took their own life by hanging. At the time of their death, they were experiencing an acute mental illness.

The young person was a prisoner at the time of death. Prior to being incarcerated, they had not experienced any mental health issues.

Coronial findings

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

The coroner found that the young person died while they were suffering from psychosis. The coroner found that the young person was under the care of the mental health team at the prison; however, due to deficiencies in patient notes, communication and handover, the prisoner’s mental health was not appropriately addressed.

Coronial recommendations

The coroner made the following recommendations related to this case:

The Chief Executive Justice Health & Forensic Mental Health Network:

- When there is a handover of patient care, a note of that handover should be recorded in the patient’s case file;
- In the event that there is no opportunity for direct handover from clinician to clinician (e.g. a gap of a day or more), the patient should be recorded on the incoming clinician's Patient Administration System (PAS) waiting list as an appointment, as part of the handover;
- The current Policy 1.360, Continuum of Care, Segregated Custody, be amended to make it clear and unambiguous that it also applies to directions for protective custody; and
- There be education of nurses in their obligations under the Justice Health segregated custody policy (applying the current Crimes (Administration of Sentencing) Regulation 2014 clause 289) as to the scope of the duty required, including making a record of the observations, when seeing protective custody inmates.
• That consideration be given to the use of telehealth as an emergency measure for psychiatric review in situations where a psychiatric review is urgently required and a patient cannot be seen face to face, or where staff envisage a prolonged period on the MHSU [Mental Health Screening Unit] waitlist before the patient is transferred and admitted.

The Commissioner Corrective Services NSW [New South Wales], Department of Justice:

• I recommend that based on the fact that the regulations require Justice Health to monitor inmates subject to protected custody and segregated custody directions, a revision be made of current Corrective Services NSW, Section 14, Segregated and Protective Custody policy (Exhibit 1, Volume 6 Tab 73, attachment 7) at clauses 14.7.4 and 14.7.7 to ensure that the requirement to notify Justice Health of a direction is included.

Both the Commissioner of Corrective Services NSW, Department of Justice and the Chief Executive of Justice Health and Forensic Medicine Health Service:

• I recommend consideration be given to whether a revision should be made to the OIMS [Offender Integrated Management System] system to include notification to Justice Health in the form of an alert (via the Justice Health PAS system) of a protective custody or segregated custody or confinement direction, when it is made.

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

A female adult took their own life by hanging whilst on duty as a police officer.

The adult had a history of work-related mental illness and had previously attempted an act of self-harm whilst on duty that had not been investigated by their employer.

Coronial findings

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

The coroner found that the mental illness was mostly brought about and exacerbated by the adult’s employment as a police officer.

The coroner found that there was an organisational culture of widespread ignorance of both the rules and/or the ability to recognise conflicts of interest within the police force.

Coronial recommendations

The coroner made the following recommendations related to this case:

I make the following recommendations to the Minister and Commissioner of Police:

- That the Commissioner revise relevant policies and procedures, including the Injury Management Standard Operating Procedures, to require that any known act that has been identified as an act of suicide or attempted suicide by an officer of the NSW [New South Wales] Police Force is:
  - reported to the Region Commander or equivalent officer within 24 hours of the incident coming to notice;
  - that that officer then ensures that a P902 report form is submitted as soon as practicable and;
  - that the incident is then subject to a safety investigation in accordance with the procedures encapsulated in the P901/P902 process.
- That the P901/P902 process in respect of suicides and attempted suicides should include investigation not only of the incident itself but also, if the injured officer has suffered
from a pre-existing injury, should result in an urgent reassessment of the case including diagnosis, treatment and ongoing management of the injured officer.

- That, in relation to attempted suicides and other serious psychological injuries, consideration be given to obviating the risk of conflict of interest by having the investigation carried out by an independent officer, such as an officer from another specialist unit or command, rather than by the injured officer's supervisor.

- That assessments by Police Medical Officers (PMO) and police psychologists of officers suffering psychological injuries should ordinarily include, when reasonably practicable, consultation with the officers' treating clinicians to ensure that the PMO and psychologist:
  - obtain a full understanding of the officers' histories;
  - undertake risk assessments on a fully informed basis; and
  - provide advice to commanders and injury managers that is based on the best available information. In cases where the reason for the assessment is that supervisors or commanders are concerned for the officer's safety from self-harm, consultation with the treating clinicians should be considered a priority for the purposes of assessment.

- That where Injury Management Advisers (IMA) or treating clinicians have difficulties engaging officers suffering psychological injuries in appropriate treatment programs, consideration be given to holding regular case conferences with relevant staff including supervisors, IMAs, and clinicians to assess progress, identify problems and to investigate possible solutions. Such a process might also include engaging with spouses, partners, welfare officers, support persons and others as the case may be.

- That urgent consideration be given by the NSW Police Force both to amending the Conflict of Interests Policy (see next recommendation) and to ensuring that all senior officers are educated in the fundamental principles concerning conflicts of interest and in recognising and resolving potential conflicts.

- That the NSW Police Force 'Procedures for Managing Conflicts of Interest' be amended so as to add the words "or other ongoing intimate" after the word "domestic" on pages 12 (final dot point) and 24 (fourth paragraph), and to add the words "or other persons in an ongoing intimate relationship" after the word "spouses" on page 24 (fourth paragraph).

- That the Commissioner take steps to provide further training and instruction regarding the operation of the 'Procedures for Managing Conflicts of Interest' (in the amended form as suggested above) so as to raise awareness of the requirement to identify, and manage, the potential conflict of interest which may arise where a domestic or other intimate relationship exists between two police officers.

- That in decision-making meetings in which an injured officer might want or require support because his or her interests are at stake, a support person who is independent of the supervisor or commander making the relevant decisions, and who is specifically
nominated by the officer, and who is willing to act in the role, ought to be made available at those meetings if reasonably practicable.

- That consideration be given to amending the Critical Incident Guidelines to remove the distinction between incidents in which officers use their service weapons to attempt or commit suicide and those in which other lethal methods are used on the basis that the implement is a means to a common end.
Coronal recommendations: Fatal facts

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</table>

Case summary

A young male took their own life by hanging.

The young person had a history of mental health issues, illicit drug use and contact with law enforcement and the juvenile justice system.

On the night of the incident, the young person spoke to a friend while in a state of distress. They were subsequently found deceased at their property.

Coronal findings

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

The coroner found that the young person was offered support across a broad range of local services, but rejected most of these offers.

The coroner found that the young person may have benefited from greater coordination amongst the services, and a sharing or pooling of resources and information being made available to each provider.

Coronal recommendations

The coroner made the following recommendations related to this case:

- To the Federal Minister responsible for the Department of Health
  - That consideration is given to the creation of a Headspace centre in [location].

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<table>
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Case summary – NSW.2013.1247

An adult male died due to an assault.

The adult was a prisoner at the time of the incident, and was assaulted by their cellmate.

Coronial findings

The coroner found that the death was due to assault.

The coroner found that the prisoners in surrounding cells had heard evidence of the assault, but had not called for help. The coroner found that the fear of retribution and the culture of silence amongst prisoners resulted in the non-response to the assault.

The coroner found that there were no prison staff monitoring the pod in which the two adults were housed at the time of the assault.

The coroner found that the adult had previously thwarted their cellmate’s suicide attempts, but had not reported the cellmate’s attempts to prison staff.

Case summary – NSW.2013.1248

An adult male took their own life by hanging.

The adult was a prisoner at the time of the incident, and had fatally assaulted their cellmate immediately prior to their death.

Coronial findings

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

The coroner found that the adult had previously attempted suicide, but their attempts were thwarted by their cellmate. These attempts were not reported to prison staff.
The coroner found that the mental health assessment performed at the prison relied solely on the self-reporting of the adult, which proved to be inaccurate and incomplete. The coroner found that the patient information system available to staff was lacking.

Coronial recommendations

The coroner made the following recommendations related to these cases:

- To the Minister for Justice I make the following recommendations:
  - That the Department of Justice (Corrective Services) investigate and implement a system for ensuring the greater safety during B Watch of inmates being held in the [prison], [location] by improving the capacity of correctional staff to monitor unsafe activity within the pods during that watch.
  - That the Department of Justice (Corrective Services) give a Male Inmates Handbook to all male inmates received at the [prison], [location] and that it implement a system of recording that each inmate has received the handbook.
  - That the Department of Justice (Corrective Services) implement a system of recording entries to and exits from pods by correctional staff during B Watch.
Coronial recommendations: Fatal facts

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Case summary

An adult female died due to drowning.

The adult was travelling with their child and partner at the time of the incident.

The adult’s body was subsequently found in a creek.

Coronial findings

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

The coroner found that the adult died from drowning but that the events surrounding their death were unclear due to inconsistent evidence given by the adult’s partner.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the Commissioner, NSW [New South Wales] Police:

- That this case be referred to the Unsolved Homicide Team.

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

Case summary

A female child died due to acute rheumatic heart disease.

The child was initially diagnosed with asthma at a geographically isolated hospital emergency department.

Coronial findings

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

The coroner found that locum medical officers and other health professionals are often unprepared for the particular health conditions they may encounter if they are not experienced in working in remote parts of the state.

Coronial recommendations

The coroner made the following recommendations related to this case:

I make the following recommendations to the Minister for Health:

- That NSW [New South Wales] Health consider adopting or adapting the CARPA (Central Australia Rural Practitioners Association) Manual for use in remote hospitals and health services in remote areas in the state, especially those in areas with large Aboriginal communities.
- That the Local Health District trial the use of the CARPA Manual in remote hospitals and health services, especially those in areas with large Aboriginal communities.
- That the Local Health District expand its ‘Quick Medical Orientation to [hospital] Survival Kit for the First 48 Hours’ to include specific reference to NETS (Newborn and Paediatric Emergency Transport Service) and also to local Aboriginal services.
- That the Local Health District also amend other health service ‘survival kits’ in use in the region in similar fashion as appropriate.
- That the Local Health District develop a briefing document (or documents) for locums and new staff that will assist in orientating them in relation to the specific local health and relevant social issues that they are likely to encounter upon their arrival in remote
hospitals and health services, especially the particular health issues that members of local Aboriginal communities may face.

- That NSW Health consider the two-way video consultation system in use between remote regions of Western Australia and Perth with a view to learning whatever lessons, if any, that may usefully be applied in NSW.

I recommend to the Minister for Family and Community Services:

- That, if the evaluation of the trial of the mobile team demonstrates that it is successful, the department continue the program as a permanent feature of its work in the region.
Coronal recommendations: Fatal facts

**Case number**
NSW.2012.5352

**Primary category**
Natural cause death

**Additional categories**
Physical health

**Fatal facts edition**
47 – cases closed between October and December 2015

**Case summary**
An adult male died due to cardiac issues in the presence of Addison’s disease.

The adult had presented to a hospital emergency department with limb pain, abdominal pain, nausea and vomiting in the days before death. A cortisol test was ordered, but due to staffing at that time, no endocrinologist was available to read the results.

The adult was deemed fit for discharge into the care of their general practitioner as the medical conditions for which they had presented to hospital had improved considerably.

The adult was later found deceased in their home.

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

The coroner found that the adult had undiagnosed Addison’s disease. There were no notes made about the cortisol test and the possibility of Addison’s disease on their file. Due to the computer system in use and the lack of patient notes, the discharging doctor was unaware that a cortisol test had been ordered, that results were pending and that Addison’s disease was a possible diagnosis.

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

To the NSW [New South Wales] Minister for Health

- I recommend that the NSW Ministry of Health consider publishing a Patient Safety Watch to Local Health Districts with the aim of increasing awareness of the potentially catastrophic outcome of undiagnosed adrenal insufficiency/Addison's disease.
- I recommend that the NSW Ministry of Health Chemical Pathology, Chemical Stream, continue with the proposed implementation of a state-wide critical results notification policy and the development of a state-wide guideline for notifiable thresholds for all critical results, including cortisol.
I recommend that the NSW Ministry of Health provide a procedure whereby abnormal cortisol test results are sent to the Department of Forensic Medicine and to the State Coroner as a matter of course in circumstances where the relevant hospital has become aware of the patient's death.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>NSW.2013.3786</th>
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</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Drugs and alcohol</td>
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<tr>
<td>Additional categories</td>
<td>Law enforcement</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>47 – cases closed between October and December 2015</td>
</tr>
</tbody>
</table>

Case summary

An adult male died due to methylamphetamine intoxication while being restrained in a confined space. At the time of the incident, the adult was in police custody.

The adult had been driving their vehicle while intoxicated, and had been involved in a vehicle incident. Police attended and the adult was handcuffed and escorted to a police van. Upon arrival at the police station, the adult was unable to stand or walk, and was placed on the floor of a charge dock. They were subsequently found to be unresponsive. Despite attempts to resuscitate the adult, they were unable to be revived.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that positional asphyxia could not be excluded as a major contributory factor to the death. The coroner found that there was insufficient room in the charge dock for the adult to lay straight, which posed a threat to the adult’s ability to breathe.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the NSW [New South Wales] Minister for Police

- That this matter be investigated and reviewed by the New South Wales Police Professional Standards Command.
- That the NSW Police Force reviews the implementation of policies and training (including continuing professional development programs) dealing with ill or intoxicated detainees.
- That the Code of Practice for Crime be revised so as to include:
  - A clear demarcation of responsibility for persons in custody, including when and in what circumstances a custody manager assumes responsibility for a detainee from arresting police;
  - The importance of promptly removing persons from police vehicles upon arrival at a station so that they can be appropriately monitored and assessed;
In the event of delay in removing persons from police vehicles, the need for face to face monitoring whether by the custody manager or a delegate;

- The circumstances in which it is inappropriate to place an ill or intoxicated person in a dock;
- The inappropriateness of dragging detainees who are unable to walk by reason of illness or intoxication;
- The appropriate procedure for the transport of ill or intoxicated detainees from public places to either a police station or hospital in circumstances where medical attention is required.

- That the review give consideration to providing further training and/or undertaking further steps to improve the implementation of Police policies in relation to the following:
  - That if a detainee is incapable of sitting upright without assistance and communicating verbally by reason of illness or intoxication, medical assistance should be sought (including by calling an ambulance);
  - That detainees should not be placed in the dock where, by reason of illness or intoxication, they are unable to sit upright without assistance;
  - That detainees with a diminished level of consciousness should not be placed in a dock with their hands handcuffed behind their back;
  - That no detainee should be placed on the floor of the dock or in a confined space that may restrict their movement and ability to breathe;
    - The need to closely monitor ill or intoxicated detainees for fluctuations in consciousness levels.

- That consideration be given to introducing a requirement that all custody managers and shift supervisors likely to be involved in the supervision of custody arrangements complete the safe custody course;

- That all NSW Police Stations with custody facilities should clearly display a poster or other document that provides guidance to officers in relation to:
  - the care and assessment of detainees including in relation to levels of consciousness of detainees
  - risk factors arising in relation to detainees suffering from intoxication or medical conditions;
  - a reminder that all police officers, regardless of rank, are able to call an ambulance whenever they consider appropriate.

- That NSW Police seek to develop and implement a policy or memorandum of understanding with NSW Health and NSW Ambulance regarding the transportation and care of intoxicated detainees

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>NSW.2015.53</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Water related</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Leisure activity</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>47 – cases closed between October and December 2015</td>
</tr>
</tbody>
</table>

Case summary
An adult male died due to drowning in a river. The adult was attempting to ride an inflatable device down shallow rapids at the time of the incident. The adult and their companions were unable to swim.

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 Local Government and the [council]:

- That [company] provide information in writing to patrons upon arrival which details:
  - The nature of the [river], for example varying and changing depth, strong currents and fast flowing water.
  - The risks associated with swimming and the use of water craft.
  - Availability of life jackets and a recommendation that such devices are used in the river by inexperienced swimmers.
  - Advise to campers about what to do in the event of a water emergency.
  - The document should contain a CAUTION to the effect that ‘If you cannot swim we advise you not to enter the water’ and that patrons enter the water at their own risk.
- That [company] ensure all employees have:
  - current training and certification in first aid relevant to how to respond to a possible drowning incident, and
  - in the procedures to be adopted in the case of an incident or emergency resulting from water activities.
NORTHERN TERRITORY

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>NT.2014.90</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Misadventure</td>
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<tr>
<td>Additional categories</td>
<td>Falls, Location, Work related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>47 – cases closed between October and December 2015</td>
</tr>
</tbody>
</table>

Case summary

A young female died due to injuries sustained when they fell from a cliff edge in a national park.

The young person was part of a guided tour group of the area at the time of the incident. The tour guide suggested that members of the group could climb down to a rock ledge to take photographs and gave guidance on how to reach the rock ledge. The young person was fatally injured when they fell from the ledge.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that during the tour guide's training, they were instructed on how to advise tourists to safely reach the rock ledge. The coroner found that advice in the tour company's training guidebook regarding participants' closeness to the cliff edge was missed or not adequately understood.

The tour company had previously come under the scrutiny of the Northern Territory Parks and Wildlife Commission (the Commission) for putting customers at risk by allowing them to pose for photographs on cliff edges.

The coroner found that there was significant signage at the location and throughout the park regarding cliff safety.

The coroner noted the following Six Point Plan developed by the Commission:

1. **Amend the permit conditions to prohibit the use of photo’s depicting dangerous activities for marketing purposes.**
2. **Amend the permit conditions for tour operators doing regular tours at [national park] to require all tour guides operating in that Park to have completed an induction course conducted by the Commission.**
3. **Amend the permit conditions for tour operators doing regular tours at [national park] to require all tour guides sign an acknowledgement form before a Ranger or other officer of**
the Commission relating to their knowledge and understanding of permit conditions, heat management plan, park safety rules and their employer’s, and their own, obligations, including section 19(2), 28 and 29 of the Work Health and Safety (National Uniform Legislation) Act, and of the penalties that can be imposed for failure to comply.

4. Monitor compliance of permit conditions by measures including the following:
   i. Social media and web site monitoring
   ii. Informal debriefing of park visitors
   iii. Using un-uniformed people to accompany or observe tour group activities.

5. When reports of conduct constituting breaches of permit conditions are received, initiating high level direct contact between Commission officers and permit holders involved to require them to immediately take effective steps to ensure there are no further instances of such conduct. Also, when such reports are received, notify NT [Northern Territory] Worksafe of the information obtained.

6. Sending a letter to all permit holders who conduct tours in the [national park], informing them of a zero tolerance policy for breaches of permit conditions jeopardising the safety of tourists in the park and for using photographs depicting dangerous activity for marketing purposes. The letter will also remind permit holders of their duties under sections 19(2) and 27 of the Work Health and Safety (National Uniform Legislation) Act, as well as the penalties involved, and advising them that the Commission will pass on all reports of such activities to NT Worksafe for action by that regulatory authority.

The coroner noted that a question regarding recent incidents at the national park had been removed from recent permit applications for tour operators, and that there was a need to take the past performance of tour operators and staff into account when re-issuing permits.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the Parks and Wildlife Commission implement as soon as possible the changes outlined in the Six Point Plan presented to the inquest.
- I recommend the Parks and Wildlife Commission consider my comments herein [...] in relation to the form and content of applications for permits and renewal of permits with a view to improvement.
- I recommend that the [tour company] continue with the strategies presented to the inquest for the better control and understanding of their systems and improved training for their guides.

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>NT.2014.124</th>
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<tbody>
<tr>
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<td>Animal</td>
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<td>Additional categories</td>
<td>Leisure activity, Geographic, Water related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>47 – cases closed between October and December 2015</td>
</tr>
</tbody>
</table>

Case summary

A middle aged male died as a result of a crocodile attack.

At the time of the incident, the adult was camping with a group and had been fishing on a river in a small boat. The adult had returned to the riverbank and was standing in their boat when they were attacked by a crocodile and dragged underwater.

The adult was found to have been eaten by the crocodile.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the area was not listed as a registered camp ground for the national park and was not patrolled or surveyed by park rangers.

The coroner found that the adult’s boat was small and lacked stability. There were no warning signs or messages displayed in the area regarding the dangers of poor boat stability or small boat size. At inquest, the Northern Territory Parks and Wildlife Commission indicated its intention to add key messages to their documentation regarding the risks posed by crocodiles to users of small boats.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the [Northern Territory] Parks and Wildlife Commission:
  - provide information to the public about the increased risks of boating and fishing on [region] waters by reason of crocodile attack including the importance of the stability and the size of the vessel;
  - provide information to the public on how those risks can be reduced.
- That [national park]:
  - add the key messages noted [in this finding] to their messaging and warnings;
o provide information to the public about the increased risks of boating and fishing on [region] waters by reason of crocodile attack including the importance of the stability and the size of the vessel;

o provide information to the public on how those risks can be reduced.
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 the same incident: QLD.2012.4375, QLD.2012.4438, QLD.2012.4439, QLD.2012.4440, QLD.2012.4441</th>
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<tbody>
<tr>
<td>Primary category</td>
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<td>Additional categories</td>
<td>Drugs and alcohol, Youth</td>
</tr>
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<td>Fatal facts edition</td>
<td>47 – cases closed between October and December 2015</td>
</tr>
</tbody>
</table>

Case summary

Five young persons died in a vehicle collision. A vehicle driven by one young person (Vehicle B) collided at speed with a secondary stationary vehicle (Vehicle A) in which the other four young people were sitting.

Vehicle A was experiencing mechanical issues, and was parked in the shoulder lane of the freeway. The young people were waiting in Vehicle A for roadside assistance. Vehicle B entered the freeway at high speed, struck a guard rail, and then collided with Vehicle A. Vehicle A caught fire and the occupants were trapped within. All five young persons died at the scene.

Coronial findings

The coroner found that the deaths were unintentional.

The coroner found that the driver of Vehicle B had a high blood alcohol concentration, was heavily affected by tetrahydrocannabinol (THC), and was driving at excess speed. They were restricted from late night driving and were in contravention of the imposed curfew when the collision occurred.

The coroner noted that the occupants of Vehicle A did not call the Traffic Management Centre, as they were unaware of its existence.

Coronial recommendations

The coroner made the following recommendations related to these cases:

**Traffic Management Centre contact number and services**

- The Department of Transport and Main Roads (DTMR) conceded that the contact telephone number for the Traffic Management Centre was not well signed on the [freeway]. Given the importance of this telephone number, particularly in coordinating the Motorway Breakdown Response Service and the declining use in emergency
telephones, consideration should be given to increasing the permanent and temporary signage displaying the Traffic Management Centre contact number on the [freeway], including the possibility of having the number printed on the metal guard rail. DTMR should also consider increasing the public awareness of the Traffic Management Centre telephone contact number and services provided, particularly the Motorway Breakdown Response Service, through the use of marketing material and other such means.

- The DTMR should consider reviewing ways of improving the efficiency and effectiveness of the Traffic Management Centre messaging system, so when motorists first contact the service, they can immediately speak to an operator in the event they are in a dangerous situation, rather than first listening to recorded information about road and traffic conditions.

**Roadside assistance**

- Whilst DTMR’s Motorway Breakdown Response Service is certainly vital in reducing the risk posed to motorists who breakdown on a major roadway, it only operates in a very limited area. I would recommend that DTMR engage in further consultation with [insurance company] and motor vehicle insurers in Queensland with the aim of creating an efficient, viable roadside emergency assistance service for all of Queensland. In making this recommendation I am very mindful of the tyranny of distance in such a large State and of the expense such a service would entail.

**Education campaign**

- Although DTMR’s Initiative and Breakdown Action Safety Plan are yet to be endorsed as formal policy, it is clear that addressing the safety risks posed to motorists who breakdown, is a definite priority for DTMR. Both documents appear to acknowledge the need for greater public awareness of what a motorist should do to ensure their safety and the safety of others in the event of a breakdown, and to reduce the high safety risks posed to motorists in such a situation. Examining and improving the manner in which breakdown response is managed by DTMR and other external roadside assistance providers, also appears to be central to DTMR’s future strategy. Both DTMR and [insurance company] are to be commended for their joint endeavours in this regard.

- I recommend that DTMR continue to prioritise this issue by way of a public awareness campaign directed at breakdown safety for motorists, and to continue to expedite finalisation of the aforementioned Breakdown Action Safety Plan and Initiative.

**Driver training and education**

- I recommend that there be an emphasis placed on defensive driving and the dangers of driving under the influence of drugs and alcohol in the driver training of learner drivers.

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

<table>
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<th>Case number</th>
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<tr>
<td>Fatal facts edition</td>
<td>47 – cases closed between October and December 2015</td>
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Case summary

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

The tug boat the adult was aboard capsized while towing a barge during a two-tug towing configuration.

The harbourmaster of the port had put in place a Marine Execution Plan (MEP) for the safe passage of vessels in and out of the port. The towing configuration was to be undertaken in accordance with the MEP on the day of the incident. The adult was on the primary towing tug.

The captains of the tugs decided to depart from the MEP, which resulted in the primary tug being pulled sideways by the barge, causing it to roll and capsize. The adult was in the wheelhouse when the primary tug capsized, and they were unable to escape.

The adult was on the tug in the role of assessing pilot, and was at no point the master or in charge of any vessel.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the MEP was a detailed, researched and considered document that was appropriately implemented by the harbourmaster. The coroner found that the masters of the tugs failed to adhere to the MEP, and after this failure there were a number of departures from what were considered appropriate work practices. The coroner found that the length of the towline, the type of towline, and the speed of the tugs were particularly relevant factors.

The coroner found that the emergency remote release for the tow hook was obscured within the wheelhouse, making it difficult to reach in an emergency.

Coronial recommendations

The coroner made the following recommendations related to this case:

ncis@ncis.org.au | +61 3 9684 4442 | ncis.org.au
• One recommendation which was evident from the evidence was that the wheelhouse emergency tow hook release needs to be in a position where it can readily be reached by the master whilst they remain at the helm. The inquest was shown a number of photographs showing one located in an overhead position on the ceiling of the wheelhouse, just forward of the helm. I was advised that it is not a very difficult exercise for the cabling of the emergency release to be plumbed this further distance, and the emergency release positioned there. That is one safety aspect that the relevant authorities should investigate, and implement, as it certainly appears a reasonable and practicable solution. Accordingly I make that recommendation.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>QLD.2014.3265</th>
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<tbody>
<tr>
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<td>Law enforcement</td>
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<tr>
<td>Fatal facts edition</td>
<td>47 – cases closed between October and December 2015</td>
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</tbody>
</table>

Case summary

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

Multiple witnesses observed that they were struck from behind by a truck during morning peak-hour traffic.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the eyewitness statements and accounts diverged in how the young person came to be positioned in front of the truck prior to the accident.

Coronial recommendations

The coroner made the following recommendations related to this case:

- Electronic recording of the process whereby witness statements are made, should be routinely undertaken and saved. Privileges as attached to the substantive conversation should also attach to the recording.

- Further improvement could be considered by:
  - making the pedestrian crossing across [street] as wide as possible, and
  - marking a bicycle path on the right-hand side of the pedestrian crossing from the northern to the southern side of [street]. This would lead directly into the bicycle dedicated lane on the eastern side of [road].

- Consideration could be given to positioning CCTV [closed-circuit television] camera coverage focusing on the intersection from this corner. This could provide Council with information about compliance with the no parking change and whether enforcement action is necessary.

- Clearway cycling lanes on [road], which are currently being trialled by Council, should be extended so that the peak hour cycling lanes operate during both morning and evening peak times on both inbound and outbound bicycle lanes along [road].
Balancing the huge potential for harm to any other small vehicle, including motorcycles and cyclists, against the inconvenience to a truck driver required to maintain visual observation of all traffic ahead of the truck driver, focuses attention on physical safety versus optimal traffic flow. Physical safety must prevail. It is recommended:

- The Queensland Government should amend the *Transport Operations (Road User Management - Road Rules) Regulation 2009*, to require motor vehicles (including heavy vehicles) who stop as the first vehicle behind a bike box, to stop in a position which enables the driver to see the entire bike box.
- Coupled with this recommendation it is essential to release a targeted and frequent education program aimed to alert motorists, and other road users of the risk of placing themselves immediately in front of a heavy vehicle with impeded forward vision.
- Consideration could also be given to making such action by a driver/riding, an offence.

Noting in their final submissions that Council acknowledged the force of the submission for a technologically triggered bike box and head start light, it is recommended that this be seriously examined and considered, balancing safety of cyclists and not solely traffic flow considerations.

Conventional shaped heavy vehicles should be prohibited unless they are fitted with appropriate technologies to warn the driver of any obstacles or other road users within the forward blind spot of the truck.

Publically disseminated information for car drivers, motorcyclists and cyclists should aim to educate them about the extent of the blind spot in front of conventional shaped heavy vehicles. Eye level signage at the back of vehicles (similar to Keep Clear of Turning Vehicle) could assist in alerting other road users to the danger of positioning themselves directly in front of conventional shaped heavy vehicles.

It is recommended that [council] engage with bicycle representative groups to investigate, plan and develop more dedicated exclusive bikeways in [city]. Resources and planning should be prioritised to extend Council’s excellent existing dedicated bicycle only bikeways that provide physically exclusive bicycle paths.
Coronial recommendations: Fatal facts

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<tr>
<th>Case number</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Homicide and assault</td>
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<tr>
<td>Additional categories</td>
<td>Law enforcement</td>
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<td>Fatal facts edition</td>
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Case summary
An adult female died due to an assault perpetrated by their partner.

The adult’s family members heard the assault and contacted police. The police arrived some time later, but the adult was unable to be revived. The adult and their partner had a history of family violence.

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

The coroner found that there was a delay in the police responding to the incident, which may have contributed to the death. The coroner found that the call made by the family member was not categorised appropriately, and the responsible officer did not appropriately consider the clear threat to personal safety that was articulated in the job details.

The coroner referenced the following recommendation from the report titled Not Now, Not Ever: Putting an End to Domestic and Family Violence in Queensland:

- Recommendation 138 – a review of training packages available to police officers, with a view to assessing the appropriateness and frequency of compulsory professional development opportunities relevant to domestic and family violence.

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

- I recommend that the Queensland Police Service (QPS) extend the implementation of recommendation 138 to all officers within the QPS who are likely to have contact with domestic violence situations, irrespective of whether they are administrative or sworn officers.

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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<tr>
<th>Case number</th>
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<tr>
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<td>Child and infant death</td>
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<td>Additional categories</td>
<td>Adverse medical effects</td>
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<td>Fatal facts edition</td>
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Case summary

A female child died due to complications of ingesting a lithium button battery.

The child was taken to see their general practitioner due to a variety of symptoms a few weeks prior to their death. At the time, their condition was misdiagnosed.

The child was subsequently admitted and discharged twice from hospital with other misdiagnoses. Upon their third presentation to hospital, the child was identified as requiring urgent care and was transferred to a specialised hospital. The button battery was subsequently identified during an x-ray. The child’s condition deteriorated and despite attempts at resuscitation, they were unable to be revived.

Coronial findings

The coroner found that the death was unintentional.

The coroner was unable to determine the source of the battery, but found that it was likely swallowed by the child at least a few days prior to their death.

The coroner found that there were deficiencies in the record keeping, clinical diagnosis and treatment of the child by both the general practitioner and the treating doctor in the hospital.

The coroner found that such an extensive coronial investigation and inquest would not have been required had a more adequate investigation been conducted by the hospital earlier.

Coronial recommendations

The coroner made the following recommendations related to this case:

- Button battery manufacturers are urged to fund and develop without delay:
  - Safer button batteries that design out the hazard so that chemical reactions do not occur when ingested by children; and
  - Cheap battery disposal containers for storage in the household and transport to recycle centres.
Button battery manufacturers are called upon to urgently implement the ACCC’s [Australian Competition and Consumer Commission’s] suggested packaging and safety warning standards for all button batteries sold in Australia. This should be reflected in the development of an industry ‘best practice guideline’.

All manufacturers, distributors and retailers of products containing button batteries are called upon to:

- Place adequate warnings on their packaging, on the products themselves, and within User Manuals that identify the presence of a button battery and that the battery is a health hazard if ingested or inserted; and
- Ensure that button batteries are not supplied with their product in a way that is easy accessible to small children. This should be achieved by implementing an existing child resistant packaging standard for battery packaging and by implementing the existing toy standard to ensure that batteries are secured in a child resistant battery compartment within the product.

That the ACCC:

- Rapidly develop regulation for the federal government’s consideration, which mandates (through an Australian Standard [AS] or otherwise):
  - a horizontal standard, requiring all button battery compartments within products to be secured so that they are child resistant; and
  - a current child resistant packaging standard for non-pharmaceutical products (currently AS 5808-2009 for non-re-closable packaging or AS 1928-2007 for re-closable packaging) to all battery packaging

That the Commonwealth government implement, in conjunction with State governments, industry, and the Australian Battery Recycling Initiative:

- A national battery disposal/recycling system for all hand held batteries; and
- The provision of practical advice to the public about household storage and transport of hand held batteries to disposal centres.

That the Queensland Government collaborate with the button battery industry and product manufacturers, distributors and retailers to fund organisations such as the Office of Fair Trading and Kidsafe to:

- Conduct an ongoing active public awareness campaign to warn the public about the dangers of button batteries for children and practical ways to mitigate the risk.

That all State Health Departments:

- Co-ordinate with a view to developing a national reporting system for battery related exposures and injuries;
- Promote Poisons Information Centre services as a first point of information for families following a battery exposure;
- Develop retrieval and management protocols for button battery related injuries for their particular jurisdiction. This protocol should be shared with the Poisons Information Centre network; and
National Coronial Information System

- Re-design their 24 Hour Fluid Balance Charts and introduce protocols to ensure that it is clear where vomit and blood should be recorded, and to standardise the way in which loss of blood is described (in relation to volume, consistency and colour). The form should include the patient’s weight and a formula for calculating circulating volume. (This form re-design is a broader health issue, not just related to button battery ingestion).
- That all Paediatric Hospital sites:
  - Increase awareness of the identification of button battery ingestion amongst staff, patients, and patients’ families; and
  - Develop algorithms for foreign body related injury and upper gastrointestinal bleeding that highlight the potential involvement of disc batteries. Such algorithms should be accessible externally.
- The Royal Australian and New Zealand College of Radiologists and the Australian Institute of Radiographers are encouraged to:
  - develop an algorithm for early clinician notification where a button battery is present on X-ray.
- The Australasian College of Emergency Medicine; Royal Australasian College of Surgeons (general paediatric surgeons and ear nose and throat surgeons); and Royal Australasian College of Physicians (Paediatricians and Paediatric Gastroenterologists) are encouraged to:
  - adopt policy documents, which support prevention of button battery ingestions; and
  - identify management strategies.
- That AHPRA [Australian Health Practitioner Regulation Agency]:
  - Raise awareness amongst clinicians, pharmacists, and radiographers in relation to emerging product safety issues such as button battery ingestion by emailing a brief description of the issue and providing a link to the ACCC reporting site and the Poisons Information Centre.
- That [hospital] (and [health clinic]):
  - Review and revise the current process for reviews of hospital deaths, including unexpected deaths of patients who have presented at the Emergency Department to ensure that systemic issues are always considered and such processes are recorded and conducted impartially;
  - Introduce a medical record keeping system to ensure that all electronic entries are automatically date and time stamped and that clinicians are educated as to the need to record the date and time of their specific observations and activities;
  - Re-design their 24 Hour Fluid Balance Chart and protocols to ensure that it is clear where vomit and blood should be recorded, and to standardize the way in which blood is described (in relation to volume, consistency and colour). The form should include the patient’s weight and a formula for calculating circulating volume. (This form re-design is a broader health issue, not just related to button battery ingestion);
Implement a protocol for phone and telemedicine consultations where [Hospital] medical practitioners obtain primary support from other Hospitals (such as for paediatric support from the [Hospital]) to ensure that:

- structured information is provided in a standardised manner (eg. provision of raw number for vital signs). This should minimise the risk of assumptions being made on a false premise and minimise the risk of misdiagnosis and mismanagement; and
- the information conveyed and advice received is recorded.

That the [hospital]:

Implement a protocol to ensure that where the [Hospital] provides primary support to other hospitals (such as paediatric support to the [Hospital]):

- Information is sought and advice provided in a structured and standardized manner (to minimise the risk of misdiagnosis and mismanagement); and
- The advice is recorded by the medical practitioner providing the advice, regardless of whether the [Hospital] holds a patient file for the patient being discussed.

That the Queensland Ambulance Service:

Develop procedures and training to enable ambulance officers who attend a scene and have an opportunity to observe blood to more accurately record colour, consistency and volume (where clinical circumstances allow).

That [general practitioner]:

Focus on making more comprehensive medical notes in relation to his examination of patients in future. If this is not achievable due to his patient load, he should consider decreasing his patient load to achieve this;

Record in writing any additional notes or observations that he can recall in relation to consultations should a patient of his die or be involved in a serious incident in the future. Such information should be provided to the Coroner at the earliest opportunity, if the death is a ‘reportable death’; and

Consider initiating follow up appointments on a case-by-case basis for children who are unwell, wherever possible in future.
TASMANIA

The following cases summaries and recommendations relate to deaths reported to a coroner in Tasmania.
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: TAS.2012.511, TAS.2012.512</th>
</tr>
</thead>
<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>47 – cases closed between October and December 2015</td>
</tr>
</tbody>
</table>

Case summary

A middle aged female and an older male died due to an assault.

The pair were fatally assaulted by the middle aged person’s son, who had a long history of mental ill health, including paranoid schizophrenia. The son was living and being treated ad hoc in Western Australia. They returned to Tasmania a short time before the incident and were residing with the middle aged person and the older person.

Coronial findings

The coroner found that the deaths were due to assault.

The coroner noted that the son was found not guilty of the murders on the ground of insanity.

The coroner found that the failure to maintain a treatment regime for the son’s mental illness may have contributed to the deaths. The coroner found that the son did not have medical care or supervision in Tasmania, and was not using the medication that had proven to control their mental illness.

The coroner found that the son had a history of non-compliance with their medication. The coroner was unable to make a finding on what more could be done to ensure the son’s compliance with medication.

Coronial recommendations

The coroner made the following recommendations related to these cases:

- I am unaware as to the circumstances as to why a community treatment order was not in operation in 2012. If this was an oversight then the circumstances need to be addressed to minimise similar omissions in the future. If it was based upon a clinical assessment or the lack of legal justification in the circumstances at the time I take the matter no further
but recommend that responsible entities in Western Australia consider the circumstances and take any action thought appropriate.

- However, my investigation of this has highlighted that even if [the son] was the subject of a community treatment order in Western Australia in 2012, that would not have precluded him from coming to Tasmania and the order would not have been enforceable in Tasmania. I am unaware as to the prevalence of cases where the treatment of mental illness controlled by formal enforcement measures in our State is interrupted by the person moving to another State, but there is clearly a need to ensure that the interests of the patient and the public are properly protected by ensuring mandatory treatment regimes are maintained across borders. If in fact there is a recognised and objectively based concern as to such circumstances I would recommend consideration by the authorities within all States and the Commonwealth of establishing a national framework to address the issue.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>TAS.2013.310</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Homicide and assault</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Law enforcement</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>47 – cases closed between October and December 2015</td>
</tr>
</tbody>
</table>

Case summary

A middle aged male disappeared in suspicious circumstances and was subsequently presumed deceased.

The adult resided on a property with a married couple with whom they were friendly. They were involved in an affair with the wife of the couple for some time.

Coronial findings

The coroner found that the body was not recovered and was satisfied that the person was deceased. The coroner was satisfied that the death was due to assault.

The coroner found that the affair was discovered and the adult was attempting to move away from the property. They had made arrangements for a friend to pick them up, but they had disappeared by the time the friend arrived. The coroner was satisfied the adult was deceased by this time.

The coroner found that the married couple were untruthful in their evidence, and knew considerably more about the circumstances of the adult’s death than they revealed at inquest.

The coroner could not be satisfied as to who killed the adult. The coroner noted there was insufficient evidence to make a finding as to the precise cause and mechanism of death, or what became of the adult’s body.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the file remain open pending the coming to light of additional information.

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.2012.434</th>
</tr>
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<tbody>
<tr>
<td>Primary category</td>
<td>Mental illness and health</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Drugs and alcohol</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>47 – cases closed between October and December 2015</td>
</tr>
</tbody>
</table>

Case summary

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

The adult was being treated for mental ill health. In the lead up to their death, their marriage had deteriorated and their regular psychiatrist took extended leave. This resulted in a significant deterioration in their mental state. They visited a general practitioner and received a prescription for antidepressants.

The adult had a history of suicide attempts by drug overdose.

Coronial findings

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

The coroner found that in the context of their history of mental ill health and overdose, the prescription issued by the general practitioner was excessive.

Coronial recommendations

The coroner made the following recommendations related to this case:

- [The deceased] clearly suffered significant mental health issues which led to an addiction to prescribed medication. The loss of family contact, unsatisfactory accommodation arrangements, lack of community support and the loss of his established support from his treating psychiatrist all contributed to his death. I recommend that Statewide Mental Health Services review their involvement with [the deceased] in order to ensure appropriate engagement and care was provided and if additional steps or different decisions ought to have been taken then ensure processes are reviewed to ensure risks of similar outcomes in the future are minimised.

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>TAS.2013.427</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Drugs and alcohol</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Law enforcement</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>47 – cases closed between October and December 2015</td>
</tr>
</tbody>
</table>

Case summary
An adult female died as a result of intravenous drug use.
The adult and their partner had a known history of extensive illicit drug use.

Coronial findings
The coroner found that the death was unintentional.
The coroner found that the adult had been injecting medication in tablet form and noted the dangers inherent in injecting tablet medications.

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

- This is the second death relating to intravenous use of tablet form medication in which [the partner] was in a relationship with and participated in illicit drug use activity with the deceased person. I recommend that Tasmania Police and the Alcohol and Drug Service maintain an ongoing oversight of his drug taking activities.

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Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>TAS.2014.461</th>
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<td>Intentional self-harm</td>
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<td>Additional categories</td>
<td>Drugs and alcohol, Mental illness and health</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>47 – cases closed between October and December 2015</td>
</tr>
</tbody>
</table>

Case summary

An adult female took their own life by hanging.

The adult had a history of mental ill health and drug and alcohol abuse following the death of their father. They had been hospitalised multiple times for alcohol detoxification. Following a short period of abstinence after each discharge, the adult would lapse and continue drinking.

Coronial findings

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

The coroner found that the adult’s decision was clearly a consequence of their significant mental illness. The coroner found that they were unable to cease their alcohol consumption so as to be properly treated for their mental health issues.

The coroner found that the contributing factors leading to the adult’s death commenced with the death of their father.

Coronial recommendations

The coroner made the following recommendations related to this case:

- This case, unfortunately, highlights once again the apparent shortcomings in the services available within Tasmania for treatment of addiction to alcohol and other substances, both prescribed and illicit. It is of concern to note that on the occasions of her admission to [hospital], [the deceased] appeared to commence the process of addressing her addiction; however she would always fail at some stage after her discharge. One must question whether there was appropriate ongoing outpatient support and supervision available subsequent to discharge from hospital; if there was, why was this not instigated for [the deceased] and if there was not such a program, surely this would be of significant benefit to persons attempting to break the cycle of addiction. I am well aware of limited addiction medicine specialists within this State and recommend that if the resource cannot be found from medical practitioner specialists, then other options be
considered, for example multidiscipline support teams having the pharmacotherapy input from suitably qualified nurse practitioners.
Coronial recommendations: Fatal facts

<table>
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<th>Case number</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Adverse medical effects</td>
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<tr>
<td>Additional categories</td>
<td>Aged care, Drugs and alcohol, Older persons</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>47 – cases closed between October and December 2015</td>
</tr>
</tbody>
</table>

Case summary

An older adult male died due to multiple medical complications.

The adult experienced pain and mobility issues due to Parkinson’s disease and used a continuous positive airway pressure (CPAP) machine for sleep apnoea.

The adult had been admitted to a nursing home while their usual carer was unable to provide care. Their pain medication was changed whilst in the nursing home. The adult became unwell and was transported to hospital, where they were admitted to intensive care. The adult’s condition deteriorated and they subsequently passed away.

Coronial findings

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

The coroner found that older adults have increased pharmacodynamic sensitivity to morphine and that there were issues with the adult’s medication management and observation regime. The coroner noted that it may have been prudent to involve a pain management specialist in the adult’s care.

No blood samples were taken at the time of the adult’s admission to hospital. As a result, the coroner was unable to determine if opiate medication had contributed to the death.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That all hospitals in this State investigate and, if reasonably practical, adopt protocols to ensure the identification of those patients who present with a possible drug related illness and the retention of a sample of their blood, either until their discharge or, in the case of death, for provision to the State Forensic Pathologist or [their] assignee.

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.2014.537</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Falls</td>
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<tr>
<td>Additional categories</td>
<td>Aged care, Older persons, Fire related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>47 – cases closed between October and December 2015</td>
</tr>
</tbody>
</table>

Case summary
An older adult female died due to injuries sustained in a fall at the nursing home where they resided.

The adult and other residents were moved to a sitting area following the activation of a fire alarm at the nursing home. There was no visible fire. They were instructed by staff to remain in the sitting area, however no staff member stayed to supervise the residents.

The adult left the sitting area and was knocked to the ground when struck by a fire door opened by staff and fire officers. Observations were undertaken, however the adult’s condition deteriorated and they were found unresponsive. They were transferred to hospital where they later passed away.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that had the residents been supervised at the time the fire alarm was activated, they adult would not have left the sitting room and would not have sustained their fatal injuries.

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

• That in the event that any fire alarm is activated at that home, all residents are to be taken to a designated safe area as soon as possible where a staff member (or members) remain with those residents to ensure the residents do not leave the designated safe area until it is safe to do so.

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.2014.159</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Water related</td>
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<tr>
<td>Additional categories</td>
<td>Child and infant death</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>47 – cases closed between October and December 2015</td>
</tr>
</tbody>
</table>

Case summary
A male child died due to drowning in a swimming pool on their extended family’s property.

The child was playing outside unattended. The swimming pool was covered but was not fenced off. After some time, the family went looking for the child and they were subsequently found in the pool. The child had fallen through a tear in the pool cover. The child could not swim.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the swimming pool pre-dated regulatory requirements for fencing. The coroner found that while the pool covering acted as an impediment to a child entering the pool, it was not a safety device.

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

- The fact that there are no statutory or regulatory requirements to fence any pool constructed or installed before 2 November 1994 is not a position that should, in my view, be allowed to continue. As a consequence I recommend, pursuant to section 28 (2) of the Coroners Act 1995 that immediate steps be taken by the appropriate authorities to enact a regulatory regime to ensure all domestic pools, irrespective of when they were constructed or installed, comply with the applicable Australian Standard.

- I warn that a solar dome is not a substitute for a properly constructed safety fence.

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

A middle aged male died due to a farming incident.

The adult was fatally injured when they were ejected from a tractor and became caught under the tractor’s operating tyres.

The adult had been suffering from seizures in recent weeks.

Coronial findings

The coroner found that the death was unintentional.

The coroner was unable to determine how the adult came to be in a position where they were caught under the tractor tyres. The coroner found that it was possible that they suffered a seizure and fell from the tractor.

The coroner found that the tractor was an old model that did not have any safety features incorporated.

Coronial recommendations

The coroner made the following recommendations related to this case:

• Due to the age of the tractor being operated by [the deceased] it was not fitted with accepted safety mechanisms now common on such equipment. The existence of a cut-off switch that would stop the engine once weight was lifted from the driver’s seat could have avoided this tragic accident. I am unaware of the cost of retrofitting such a device to older style tractors, however it would be my recommendation that persons operating this type of equipment, especially in circumstances where there is an increased risk of falling from the tractor, consider fitting such a safety device.
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.2012.129</th>
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</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Homicide and assault</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>47 – cases closed between October and December 2015</td>
</tr>
</tbody>
</table>

Case summary

A middle aged female died due to an assault perpetrated by their spouse.

The relationship between the adult and their spouse occurred in the context of family violence. Intervention orders relating to the adult and their spouse had been sought and revoked, and the pair had attended couple’s counselling run by a community organisation.

The adult’s body was discovered at their home.

Coronial findings

The coroner found that the death was due to assault.

The coroner was unable to determine the cause of the adult’s death.

The coroner found it was regrettable that the counselling service’s processes for detecting, assessing and responding to the risk of family violence, both at intake and during the actual counselling sessions, were not more rigorous.

Coronial recommendations

The coroner made the following recommendations related to this case:

[Community organisation]

- Ensure that the organisation’s couple’s counselling intake form prompts screening questions to be asked which give effect to the requirement of the organisation’s Intake Procedure to “establish a risk or history of family violence”, and further ensure that potential participants have the opportunity to provide that information in a safe and confidential environment.
- Ensure that the organisation has clear and established referral policies and pathways to allow referral to culturally appropriate men’s behaviour change, or similar programs.
- Ensure that the organisation has clear and established referral pathways which allow for disclosures or identified risks of family violence to be referred to appropriately qualified agencies.
• Develop and publish a clear policy on whether or not couple's counselling can be provided where there is a history or risk of family violence, and to the extent that the organisation determines that couple's counselling may proceed in those circumstances, the additional safeguards and safety planning that are required.

• Ensure that [community organisation's] counsellors understand that, irrespective of the screening processes employed at intake and the characterisation of the presenting issue, family violence screening and risk assessment is their ongoing responsibility, and further ensure that their counsellors have the professional training and tools to be able to competently and consistently undertake this task and respond appropriately to any disclosures.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2012.3865</th>
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<td>Additional categories</td>
<td>Law enforcement</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>47 – cases closed between October and December 2015</td>
</tr>
</tbody>
</table>

Case summary

A young female died due to an assault perpetrated by their spouse. Both the young person and their spouse were from culturally and linguistically diverse (CALD) backgrounds.

The young person had separated from their spouse some months prior due to family violence. An intervention order was made against the spouse, and the young person moved to new accommodation. The spouse breached the intervention order a number of times. These breaches were reported to police.

The spouse discovered the young person’s location with the assistance of a private investigator. They attended the young person’s new address and assaulted. The spouse also died as a result of the subsequent fire, although it was unclear if they intended to take their own life.

Coronial findings

The coroner found that the death was due to assault.

The coroner found that the police response to the young person’s complaints about breaches of the intervention order and to the escalating seriousness of their predicament was inadequate.

The coroner found that the spouse was solely responsible for the young person’s death, and while the police response was inadequate, none of the inadequacies or flaws directly contributed or caused the death.

The coroner found that there was no formal intervention directed at attempting to educate the spouse in relation to what constitutes family violence in Australia.

The following recommendations were made by the joint Community Legal Centres (CLCs):

- That the Department of Immigration and Border Protection (DIBP) should seek the consent of women who report domestic and family violence to the Police so that the intersecting migration and family violence issues can be dealt with in an integrated way.
(Officers of any State Police force in Australia are defined pursuant to section 5 of the Migration Act 1958 to be officers under the Migration Act); and

- That any person who is a victim of family and domestic violence should be case managed by the DIBP family violence team who should be trained in the common risk assessment framework and operate in an integrated way with the police, courts and specialist family violence services who are engaged with the person.

Coronial recommendations

The coroner made the following recommendations related to this case:

Victoria Police:

- In line with my recommendations in [name] finding relating to the use of the L17, I recommend that the Chief Commissioner of Police amend the 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 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.

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.

- In line with my recommendation in [similar] finding, 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 Domestic Advocate position.
- Accepting [inquest expert]’s proposal, I recommend that the State of Victoria, working in conjunction with the family violence sector, give consideration to the development of education programs for culturally and linguistically diverse (CALD) men who are perpetrators of family violence and who currently have limited or no access to such programs.

Department of Immigration and Border Protection:

- I recommend that when the Department of Immigration and Border Protection has completed the development of policy in response to proposed recommendations put forward by the joint CLCs, those policies be provided to the Coroners Court of Victoria and made public.

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>
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<tr>
<td>Fatal facts edition</td>
<td>47 – cases closed between October and December 2015</td>
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</table>

Case summary

A middle aged female died due to an assault perpetrated by their spouse.

The couple resided in a regional town. The spouse visited the couple’s adult child some distance away, and left their child with money and possessions. The child became concerned for their mother, and called the local police station to request a welfare check. The station was closed and the call was diverted to the nearest open station. The child was told to call the local police station when it was open.

Police attended the couple’s address the following day and found them both deceased.

Coronial findings

The coroner found that the death was due to assault.

The coroner found there was a history of family violence perpetrated by the spouse.

The coroner noted that the spouse may have suffered from an undiagnosed mental illness, however found that this could not be attributed to any specific shortcoming in their medical care.

The coroner made recommendations only in relation to the adult’s death, and not in relation to the spouse’s death.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that Victoria Police members should be advised that where a person contacts a police station out of hours to express concern for the safety or welfare of another, and that call is diverted to a second, open station, Victoria Police should:
  - assess the call in the ordinary manner, including by obtaining information from the reporting person about the nature, reason and background for the report or request;
  - determine whether police attendance is warranted, including for the purpose of conducting a welfare check; and
o if it is assessed that police attendance is warranted, ensure that a job is created and allocated accordingly, without requiring the caller to phone around or phone back to coordinate a response.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2010.2020</th>
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<td>Additional categories</td>
<td>Mental illness and health, Law enforcement</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>47 – cases closed between October and December 2015</td>
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</table>

Case summary

An adult female died due to an assault perpetrated by their ex-partner.

The incident occurred in the aftermath of family law proceedings concerning the child of the adult and their ex-partner.

The ex-partner had a history of violence against the adult.

Coronial findings

The coroner found that the death was due to assault.

The coroner found that the ex-partner had been detained and taken to hospital under the Mental Health Act 1986 following a family court proceeding. Detailed clinical notes were taken by the emergency room doctor, which stated that the ex-partner expressed an intent harm to themselves and the adult. These expressions were not detailed to police, and police were not notified when the ex-partner was released from hospital.

Coronial recommendations

The coroner made the following recommendations related to this case:

Chief Commissioner of Police

- I recommend that the Chief Commissioner of Police amend the Code of Practice for the Investigation of Family Violence in order to provide more specific guidance about the manner in which family violence incidents might present to police. In particular, I recommend that consideration be given to specifying the following:
  - Family violence incidents may not be categorised as such by the person reporting them to police. This may be because the person making the report does not recognise the family violence element of the incident and/or does not want the reported incident to be characterised in that way.
An incident need not be exclusively characterized as "family violence", in order to enliven the Victoria Police Options Model set out on page 21 of the Code of Practice for the Investigation of Family Violence.

Police may attend an incident, whether reported as family violence or not, and assess, in respect of a person present, that it is necessary to exercise their powers of apprehension under the *Mental Health Act 2014*. This does not foreclose the incident also being characterised as a family violence incident, with the Code of Practice for the Investigation of Family Violence followed accordingly. This remains the case regardless of whether the incident involves the suspected commission of a criminal offence or some other form of family violence.

In order to determine whether an incident should be categorised as a family violence incident, although not reported as such, it may be necessary to obtain information in addition to that gathered from those present. Where evident family violence risk factors are noted, consideration should be given to conducting LEAP [Law Enforcement Assistance Program] checks to determine, amongst other things, whether any of the relevant parties has a history of family violence or whether there are any intervention orders in place.

The affected family member/family violence victim need not be present in order for a matter to qualify as a family violence incident. For example, threats to harm a family member who is not present should be considered as a family violence incident, notwithstanding that the family member faces no immediate safety risk and, being unaware of the threats, has no consequent fear for their safety or well being.

Department of Health and Human Service and the Chief Commissioner of Police

- I recommend that the Department of Health and Human Services and the Chief Commissioner of Police address in their shared Protocol for Mental Health the circumstances in which Victoria Police should be notified of the discharge of a person initially apprehended by Victoria Police under the *Mental Health Act 2014*. Consideration should be given to making such notification mandatory, rather than contingent on an assessment of future or current risk.
Coronial recommendations: Fatal facts

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<tr>
<th>Case number</th>
<th>VIC.2009.5867</th>
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<tr>
<td>Primary category</td>
<td>Law enforcement</td>
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<tr>
<td>Additional categories</td>
<td>Mental illness and health, Drugs and alcohol</td>
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<td>Fatal facts edition</td>
<td>47 – cases closed between October and December 2015</td>
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Case summary

A male adult died from unascertained causes on a background of agitated delirium.

The adult died whilst being transported to police cells after being subdued with capsicum spray and physical restraints.

They had a history of mental illness and drug use. Paramedics had cleared them for transportation following observations and physical examinations.

Coronial findings

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

The coroner found that the initial cause of death (Excited Delirium) is not appropriate or helpful as it is not recognised as a distinct medical entity or diagnosis by the Australasian College for Emergency Medicine, the Royal Australian and New Zealand College of Psychiatrists, the Australian Medical Association, the World Health Organisation or any college or organisation in Australia or New Zealand.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I commend Victoria Police for the introduction of the QSTT (Operational Safety & Tactics Training) training package that addresses the possible presenting signs and symptoms of 'Excited Delirium' however in line with the approach adopted by the Canadian Mounted Police following the Braidwood Commission, I recommend that Victoria Police remove from its' training materials/literature reference to "Excited Delirium" and/or "Excited Delirium Syndrome" until such time that it is recognised by Australian medical professional bodies as a discreet medical condition/entity. The interpretation of this recommendation by Victoria Police should not be so prescriptive so as to exclude the use of audio-visual materials obtained and already utilised from other jurisdictions such as the United States.
With the view to developing a collaborative and coordinated approach to the management of people presenting with delirium, agitation or acute behavioural disturbance by first responders, I recommend that Victoria Police and Ambulance Victoria convene a working group in consultation with the Australasian College for Emergency Medicine with the aim of developing a working protocol/clinical practice guidelines or operational work instructions between the organisations including but not limited to, exploring the development of a readily accessible reference tool such as, but not necessarily limited to, a pocket card such as developed by the NIJ's (National Institute of Justice) Technology Working Group on Less-Lethal Devices. The development of such a readily accessible reference tool (which could take the form of an application for telecommunication devices) should be consistent with Recommendation 1 and should instead adopt nomenclature for ‘delirium’ as it is referenced in the DSM-5 (Diagnostic & Statistical Manual of Mental Disorders-5).

With the view to developing a collaborative and coordinated approach to the management of people presenting with delirium, agitation or acute behavioural disturbance by first responders, I recommend that Victoria Police and Ambulance Victoria develop a joint training package including but not limited to, scenario based training which is focussed on the implementation of any newly developed joint protocol, and the use of the readily accessible reference tool.

In anticipation that it may take some time for recommendations 1 & 2 to be considered, commenced, completed and implemented and with a view to supporting first responders and in particular, paramedics with enhancing understanding and knowledge of the constellation of presenting symptoms of persons experiencing the range of manifestations of delirium, I recommend that Ambulance Victoria, if they have not already done so, not only review the Police training material as referred to in paragraph 49 of their written submissions but implement training and/or continuing professional development to its paramedics in this regard.
Coronial recommendations: Fatal facts

Case number: The coroner held a joint investigation into the following deaths which resulted from the same incident: VIC.2011.4485, VIC.2011.4486

Primary category: Water related

Additional categories: Transport and traffic related, Leisure activity, Weather related

Fatal facts edition: 47 – cases closed between October and December 2015

Case summary

Two adult males drowned while fishing in their modified sea kayaks.

The adults did not advise their partners where they were departing from, where they were going, or when they would return. There was a strong wind warning issued for later that day.

The adults were wearing personal floatation devices at the time of the incident, but were not carrying any other safety equipment.

Coronial findings

The coroner found that the deaths were unintentional.

The coroner found that both adults lacked boating experience, and one of them was not a good swimmer.

The coroner found that neither adult had knowledge or appreciation of the predicted weather on the day of the incident. The coroner found that there was a lack of preparation for the fishing expedition, including not telling anyone of their departure points and estimated return time.

The coroner found that the modifications made to the kayaks impacted their seaworthiness. Both kayaks had been registered as power boats, but neither adult was carrying the safety requirements for power boats at the time of the incident.

Coronial recommendations

The coroner made the following recommendations related to these cases:

- I recommend that the Department of Economic Development, Jobs, Transport and Resources and Transport Safety Victoria considers reviewing and increasing the current regulatory safety requirements for operators of canoes and kayaks travelling more than 500 m from shoreline in enclosed waters by requiring them to carry either flares and a
torch, or a marine radio, or a personal locating beacon (PLB) or an emergency position indicating radio beacon (EPIRB).

- I recommend that Transport Safety Victoria continues to explore potential models for a non-commercial vessel seaworthy inspection and certificate regime as a means of ensuring the seaworthiness of vessels at points of registration, transfer of ownership and after any modification.
Coronial recommendations: Fatal facts

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<tr>
<th>Case number</th>
<th>VIC.2014.6221</th>
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<tr>
<td>Primary category</td>
<td>Transport and traffic related</td>
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<tr>
<td>Fatal facts edition</td>
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Case summary

A middle aged female died from a head injury sustained in a vehicle incident in which they were a pedestrian.

The adult stepped onto the road from behind a light pole when it was unsafe to cross the road and was struck by a vehicle.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that pedestrian safety was reduced due to the location of the light pole.

Coronial recommendations

The coroner made the following recommendations related to this case:

- The [council] and VicRoads take a coordinated approach to improving pedestrian safety at the [street] exit from the roundabout by relocating the light pole on [street] so that it no longer obscures the view of pedestrians and/or by building a designated pedestrian crossing further away from the roundabout and installing a fence to force pedestrians to cross the road at that point.
Coronal recommendations: Fatal facts

Case number: VIC.2014.3481
Primary category: Transport and traffic related
Additional categories: Older persons, Physical health
Fatal facts edition: 47 – cases closed between October and December 2015

Case summary

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

The adult was driving in wet conditions with poor visibility when they veered out of their lane and collided with a tree. Emergency services attended, however the adult was deceased at the scene.

Coronal findings

The coroner found that the death was unintentional.

The adult’s driving skills were noted to have deteriorated in recent years, and multiple notices of suspension had been issued by VicRoads. On each occasion, the adult’s general practitioner provided the required medical assessment, and was satisfied that the adult met the national medical standards. The general practitioner was not aware of the adult’s previous driving incidents, and was unsure of the specific reason that the medical reports had been requested by VicRoads.

The coroner found that there would be value in a medical practitioner having a broad understanding of why a medical report had been requested by VicRoads.

Coronal recommendations

The coroner made the following recommendations related to this case:

- That VicRoads consider amending its medical report forms to highlight the ability of medical practitioners to contact VicRoads as to the reasons the assessment is required.

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

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<th>Case number</th>
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<td>Location, Law enforcement, Leisure activity</td>
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<td>Fatal facts edition</td>
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Case summary
An adult female died due to injuries sustained in a motor vehicle incident in which they were a pedestrian.

At the time of the incident, the adult was attending a music festival. They were sleeping in a tent when the tent was run over by a vehicle. The driver of the vehicle was under the influence of drugs and alcohol at the time.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that there were a number of areas for further investigation, including police responses to music festivals and entertainment events, local government consultation with police and review of the legislative and regulatory regime for music festivals.

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

- I recommend that the Planning Guide for Entertainment Events be reviewed and adopted by Victoria Police more broadly in order to improve the liaison between festival organisers and police, as well as other emergency service providers.
- I recommend that local councils be required to consult with Victoria Police upon receipt of a Place of Public Entertainment occupancy permit application.
- I recommend that the Victorian Department of Environment, Land, Water and Planning review the current legislative and regulatory regime in order to develop a framework that is a better fit for the regulation of music festivals and to consider whether there is scope for the introduction of a requirement for the separation of camping and parking areas at music festivals.

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

An adult male died due to complications associated with crush injuries.

The adult had been assisting a friend in moving a house boat when they were accidentally trapped between the boat and the riverbank. The adult was conveyed to hospital with multiple injuries and was managed in intensive care. They developed severe pneumonia requiring mechanical ventilation and subsequently underwent a tracheostomy.

There were issues with the adult’s ventilation and their condition declined until they passed away.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that there were no significant deficiencies in the adult’s clinical management and care and that a review of the hospital’s tracheostomy-related policies was being undertaken at the time of the adult’s death.

Coronial recommendations

The coroner made the following recommendations related to this case:

- Tracheostomy tube displacement is an uncommon but known complication of management of patients with a tracheostomy, with an increased risk in obese patients. I recommend that Victorian hospitals consider the indications for the use of longer tracheostomy tubes, their availability and the education of staff regarding their use.
Coronal recommendations: Fatal facts

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

An adult male died due to injuries sustained in a vehicle incident in which they were a passenger.

The adult worked as a truck driver. The adult was a passenger in a truck and being driven by a colleague at the time of the incident. It was the colleague’s first experience of driving the truck. The adult was fatally injured when the driver lost control of the vehicle and the truck collided with a power pole.

Coronal findings

The coroner found that the death was unintentional.

The coroner found that the truck was in an un-roadworthy condition. The adult had previously notified their employer of a fault with the truck’s seat, but there was no documented evidence that repairs had been made to the seat. The driver at the time of the incident stated that they had lost control of the vehicle due to the driver’s seat collapsing.

Coronal recommendations

The coroner made the following recommendations related to this case:

- [Company], [deceased’s] employer, undertake a periodic review of its system of work in relation to the reporting and rectification of vehicle faults, periodic and routine maintenance and servicing of its heavy vehicles, and the general safety of its vehicle fleet.
- [Company], [deceased’s] employer, undertake a periodic review of its system of work in relation to the induction of new employees and regular training of its workforce, including regularly employed subcontractors, in the procedures relating to the inspection and reporting of vehicle faults to management.
- Using [deceased’s] death as an example, VicRoads review its publications and information distribution to heavy vehicle operators to promote industry awareness of the importance of periodic and routine maintenance and servicing of heavy vehicles, the importance of having and regularly reviewing a safe system of work in relation to...
procedures relating to the inspection and reporting, and the repair/rectification, of vehicle faults, and the inherent dangers of the failure to do so.

- Using [deceased's] death as an example, WorkSafe review its publications and information distribution to heavy vehicle operators to promote industry awareness of the importance of periodic and routine maintenance and servicing of heavy vehicles, the importance of having and regularly reviewing a safe system of work in relation to procedures relating to the inspection and reporting, and the repair/rectification, of vehicle faults, and the inherent dangers of the failure to do so.

- Using [deceased's] death as an example, the National Heavy Vehicle Regulator review its publications and information distribution to heavy vehicle operators to promote industry awareness of the importance of periodic and routine maintenance and servicing of heavy vehicles, the importance of having and regularly reviewing a safe system of work in relation to procedures relating to the inspection and reporting, and the repair/rectification, of vehicle faults, and the inherent dangers of the failure to do so.

- Using [deceased's] death as an example, the Insurance Council of Australia review its Code of Practice, publications and information distribution to heavy vehicle operators to ensure that, in relation to insurance contracts, it encourages industry awareness of the importance of periodic and routine maintenance and servicing of heavy vehicles, the importance of having and regularly reviewing a safe system of work in relation to procedures relating to the inspection and reporting, and the repair/rectification, of vehicle faults, and the inherent dangers of the failure to do so.
Coronial recommendations: Fatal facts

Case number | VIC.2012.1220
Primary category | Work related
Fatal facts edition | 47 – cases closed between October and December 2015

Case summary
An older adult male died due to a workplace incident.

The adult was working on a construction site with a portable site office at the time of the incident. The office was secured by cyclone fencing and a sliding gate. The adult was fatally injured when the sliding gate became unsecured from its guidance runners and fell on the adult.

The adult was working alone on the site at the time of the incident.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that there was no Australian Standard specific to the style of gate involved in the incident.

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

- That Standards Australia address the need and if considered appropriate, implement an Australian Standard governing the safety, performance and reliability of sliding metal fence gates.
Coronial recommendations: Fatal facts

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<th>Case number</th>
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<td>Additional categories</td>
<td>Domestic incident</td>
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<td>Fatal facts edition</td>
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Case summary

A middle aged male died due to a fire that broke out in their home.

A neighbour noted that the property was alight and contacted emergency services. The adult was located deceased in their home by fire fighters.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the home did not meet safe building practices and regulations. The adult had built and extended the home over time without applying for building permits. This had not come to the attention of authorities. The local council had been collecting rates and conducting kerbside inspections of the property without become aware that the building was non-habitable.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the [council] conducts an audit on properties within the municipality that are assumed to be uninhabited, and considers how it can better use its authority under section 212 of the Building Act 1993 (Vic) and be alert to, investigate and deal with illegal building works within its district.
Coronial recommendations: Fatal facts

<table>
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<tr>
<th>Case number</th>
<th>The coroner held a joint investigation into the following deaths which resulted from the same incident: VIC.2013.589, VIC.2013.590</th>
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<tr>
<td>Primary category</td>
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Case summary

An adult male and a young female died as a result of a tree falling on the cabin of their work vehicle. They were both employed as fire fighters and were undertaking firefighting activities at the time of the incident.

They were amongst a number of firefighters and other personnel fighting a large bushfire over a number of weeks. On the day of the incident, controlled burns were being undertaken in the attempt to contain the fire. The weather suddenly changed, and all firefighters were ordered to withdraw. The adult male and young female were following another vehicle to withdraw, when a large tree fell onto the truck, fatally injuring them.

Coronial findings

The coroner found that the deaths were unintentional.

The coroner found that the tree was an alpine ash. These trees were known to create a particularly heightened risk to firefighters as they are heavy and have the potential to fall without warning. The coroner found that these risks were raised in daily safety briefings.

The coroner found that a risk assessment was undertaken of trees near the track, and that it was expected the specific tree would fall down the hill, rather than uphill as it did in the fatal incident. At inquest, the risk assessor noted that there was a significant wind blowing uphill at the time of the incident, which would have been a major contributing factor to the direction the tree fell.

At inquest, it was noted that some personnel considered the order to withdraw came too late, and that conditions amongst the alpine ashes were dangerous. The coroner found that the personnel in charge exercised reasonable judgement in their analysis of the situation, and was not critical of them having not reached a conclusion to withdraw earlier.

The coroner found that there was opportunity to withdraw earlier, but that no one person was in possession of all the information available. With multiple crews at different sites, the
systems in place failed to ensure all available information was collated and considered by individual ground and operational commanders.

Coronial recommendations

The coroner made the following recommendations related to these cases:

- In line with the submissions on behalf of the Department of Environment Land Water and Planning (DELWP) and their indication that they would be willing to accept a recommendation to this effect, I recommend that DELWP highlight the necessity for two way situation and weather reporting between the Incident Management Team (IMT) and those on the fire ground in its training and preseason briefings.

- In line with the submissions on behalf of DELWP and their indication that they would be willing to accept a recommendation to this effect, DELWP require, where possible, more information be provided at both morning and evening briefings on the strategy of fighting the fire at particular locations.

- In line with the submissions on behalf of DELWP and their indication that they would be willing to accept a recommendation to this effect, DELWP include information on the salmon card reporting process and how the information in a salmon card is used in its preseason briefings as well as providing specific feedback to each person who makes or is affected by a salmon card report.

- In line with the submissions on behalf of DELWP and their indication that they would be willing to accept a recommendation to this effect, DELWP (together with any other relevant agencies) utilise an Options Analysis template that specifically nominates and identifies safety to firefighters and human life as the number one priority.

- In line with the submissions on behalf of DELWP and their indication that they would be willing to accept a recommendation to this effect, DELWP participate in a national review of falling tree fatality, injury and near-miss incidents involving trees during fire response operations, and a literature review on the subject to bring in some international context as articulated in exhibit 52 (AFAC [National Council for Fire and Emergency Services] report) at page 8.

- In line with the submissions on behalf of DELWP and their indication that they would be willing to accept a recommendation to this effect, DELWP continue to implement its program of designing fire vehicles to withstand greater tree impacts.

- In line with the submissions on behalf of DELWP and their indication that they would be willing to accept a recommendation to this effect, DELWP re-emphasise the purpose of red flag warnings in its training and preseason briefings.

- DELWP liaise with any other relevant agency, to develop a training package designed for Operations Managers and Incident Controllers together with their support staff, which facilitates liaison with Fire Behaviour Analysts (FBANS), interpreting the data accessed by FBANS and in establishing protocols for the dissemination of weather forecasts relevant
to fire fighter safety to strike force leaders and sector commanders or via the open channel to all personnel.

- DELWP liaise with any other relevant agency to ensure that the Options Analysis specifically addresses the terrain, topography, type of trees and their individual dangers in the context of the work proposed, and further should incorporate reference to the mapped areas of fire burnt alpine ash.

- DELWP liaise with any other relevant agency to develop a protocol which best ensures that fire crews are not exposed to fire effected alpine ash forests unless absolutely necessary and only if all safety precautions, in particular removal of hazardous trees and regular monitoring of weather conditions are undertaken.

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 summary
A male child died due to a fire that broke out in their family home.

The family was awoken in the night by a fire in the home. The occupants evacuated the home but were unable to rescue the child. Emergency services attended and found the child deceased.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the fire originated in the child’s room and that the point of origin was in the immediate area of a multiple outlet power board. The coroner found that lack of education in the use of power boards rendered them being misused by the public.

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

- With the aim of minimising risks associated with power board misuse, I recommend that Energy Safe Victoria (ESV) and the Metropolitan Fire Brigade (MFB) jointly fund a public awareness campaign to inform the public about the importance of power board safety. I recommend that the public awareness campaign:
  - Informs the public that power boards are to be used for temporary use and not permanent installation;
  - Informs the public about what may constitute power board misuse, including but not limited to:
    - Overloading power boards;
    - Cocooning power boards;
    - Piggy-backing power boards;
    - Contamination of power boards;
− Using power boards designed for indoor use outdoors (and informing the public what symbol to look for on packaging to determine if the power board can be used outdoors);
− Do-it-yourself repair of faulty power boards;
− Using power boards manufactured before 1 January 1984 (and informing the public how to determine the manufacture date of a power board); and
− Using power boards that have been subjected to wear and tear for a number of years;
  o Informs the public about the possible risks associated with power board misuse; and
  o Informs the public how to identify when a power board should be discarded (for example, signs of wear and tear such as discolouration of plastics and discarding power boards manufactured a certain number of years ago).
• That ESV in consultation and collaboration with the MFB undertake testing of a range of used and old power boards (the range mutually agreed upon by ESV and the MFB) to determine if cocooning, contamination, general wear and tear (such as continuous plugging and unplugging of appliances into the power board while it is on), overloading, piggy-backing and age of a power board does cause electrical degradation or safety issues.
• That the results of the testing referred to in recommendation two should be compared against the most recent AS/NZS [Australian Standard/New Zealand Standard] 3105 Standard and if there is evidence that there is electrical degradation or safety issues that may increase the risk of a fire occurring, I recommend that Standards Australia be notified and review AS/NZS 3105 in light of the new information provided to them by ESV.
Coronial recommendations: Fatal facts

Case number: VIC.2009.5127
Primary category: Child and infant death
Additional categories: Water related
Fatal facts edition: 47 – cases closed between October and December 2015

Case summary
A male child died due to drowning in a river.

The child was diagnosed with autism. They had a fascination with water and the tendency to abscond.

The child and their family were staying on a property that backed onto a river. The child left the property via an unsecured window while their family was sleeping. An extensive search was undertaken to locate the child. They were later found in the nearby river.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the property was not the family’s usual residence, and was therefore not equipped with measures to prevent the child from absconding. The external fencing of the property was not secure and the gates were in a state of disrepair.

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

- That [Amaze Autism Victoria] and the Department of Education and Early Childhood Development agree which agency is the most appropriate to develop and publish a home audit information sheet to assist parents and carers with a ready reference risk assessment tool identifying risks that need to be assessed by them around the home (or temporary accommodation) for a child with absconding/elopement tendencies. This should include control measures such as the availability and effectiveness of cost-effective window and door locking devices
- That the Department of Health and Human Services finalise its Draft Paper authored by [names] (in submission) on the use of Global Positioning System (GPS) devices for elopement of people with an Autism Spectrum Disorder and publish its findings/conclusions. Such publication should include a clear statement as to the Department’s position on:
Whether the use of GPS tracking devices for children, who are shown to have a history of eloping together with a future potential to elope, is compatible with the 
Charter of Human Rights and Responsibilities Act 2006;

The circumstances, if any exist, it would fund the use of GPS devices

That the Department of Education and Early Childhood Development and the Department of Health and Human Services review its respective publications to ensure they contain clear, unambiguous and up to date information for families with children with Autism Spectrum Disorders as to how they can access services and funding to seek assistance.
Coronial recommendations: Fatal facts

Case summary
An adult female died due to complications associated with a caesarean section.

The adult was known to be experiencing placenta praevia during their pregnancy, and had been advised about the risk of placenta accreta.

The adult underwent a planned caesarean section. The infant was delivered, and the adult was subsequently found to be suffering a morbidly, partially adhered placenta with ongoing heavy bleeding. A hysterectomy was performed, however the adult's condition deteriorated and they passed away.

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

The coroner found that:

- the consultant obstetric surgeon was only made aware of the adult’s clinical situation the day prior to surgery
- there was a delay in calling for a second senior surgeon
- there was an absence of a massive haemorrhage procedural guideline.

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

- That the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) Women’s Health Committee considers highlighting the following, in its ‘Placenta Accreta’ guideline:
  - that because of the difficulty in diagnosing placenta accreta prior to birth, high risk pregnancies should be managed on the assumption that placenta accreta exists. This means the patient, the surgeon and the anaesthetist should all be prepared for immediate hysterectomy with possible massive blood transfusion; and
that the surgeon should be prepared for rapid referral to an additional senior surgeon for decision on the need for and implementation of immediate hysterectomy.
Coronial recommendations: Fatal facts

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<td>Fatal facts edition</td>
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Case summary
An adult male died due to injuries sustained in a motor vehicle incident in which they were a pedestrian.

The adult had been diagnosed with schizophrenia, and their mental state was noted to have deteriorated leading up to their death. The adult had been transported to hospital by ambulance paramedics following conversations with police in which they revealed self-harm. They left hospital prior to receiving a suicide and self-harm risk assessment.

Later that day, the adult was fatally struck by a vehicle when they stepped onto the road.

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

The coroner found that the adult’s judgment was impaired immediately prior to the incident.

The coroner found that an improved flow of information in relation to the adult’s care would have optimised clinical decision-making and may have prevented their death.

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

- I recommend that the Royal Australian and New Zealand College of Psychiatrists develop specific practice advice or guidelines regarding patient “dropouts” or “disengagement” (including defining these terms) to assist private psychiatrists to make an appropriate decision regarding the need to follow-up of patients who unexpectedly disengage from treatment.

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

Case number | VIC.2012.378
Primary category | Adverse medical effects
Additional categories | Child and infant death, Drugs and alcohol
Fatal facts edition | 47 – cases closed between October and December 2015

Case summary
A male child died due to accidental drug toxicity following surgery.

The child had been prescribed with pain relief following their discharge from hospital that was specifically designed for use in adult patients only. The prescription had been filled at an independently owned retail pharmacy as opposed to the hospital pharmacy.

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

The coroner found that the oral medication, along with other formulations or the medication, were not approved by the Therapeutic Goods Administration for use in children under 12 years of age.

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

- The Therapeutic Goods Administration investigate the clinical need for Tramal Oral Drops in adults and paediatric patients above 12 years of age in order to determine whether it is appropriate to remove this medication from the Australian Register of Therapeutic Goods.
- Doctors prescribing Tramadol medication to their patients upon discharge from [hospital], advise family that it be dispensed at the hospital pharmacy, rather than a community pharmacy.

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

Case number | VIC.2013.2804
Primary category | Natural cause death
Additional categories | Physical health
Fatal facts edition | 47 – cases closed between October and December 2015

Case summary
An older adult male died due to a cardiac condition.
They had a history of ischaemic heart disease, atrial fibrillation and gastritis.
The adult was transported to hospital due to chest pains on the day of the incident. The hospital emergency department was experiencing a high volume of patients, and there was no cubicle available for the adult. They remained on an ambulance trolley in the care of paramedics for a couple of hours. Their vital signs were not recorded during this time, and the electrocardiogram (ECG) that had been ordered was not undertaken.
The adult’s condition deteriorated and they were transferred to another hospital for surgery. They suffered cardiac arrest on several occasions during the journey to hospital, and were unable to be resuscitated.

Coronial findings
The coroner found that the death was due to natural causes.
The coroner found that the care provided by the ambulance and hospital staff was appropriate, and that the hospital had implemented recommendations made by an independent expert. Nonetheless, the coroner found that there were areas for improvement in relation to handover and the timeliness of clinical responses.

Coronial recommendations
The coroner made the following recommendations related to this case:
- That Ambulance Victoria reinforces to its staff that responsibility for patient monitoring rests with them until handover to ED [emergency department] staff has occurred. Further that the importance of documentation of this monitoring (including vital signs as appropriate for clinical condition) be emphasised as well as prompt communication of perceived clinical deterioration to ED staff.
• That Ambulance Victoria and [health service] collaborate to develop processes to ensure that patients with chest pain who cannot be immediately off-loaded to an ED treatment space receive an ECG within 10 minutes of ED arrival.

• That [health service] extend its audit and review processes such that the Cardiology Service audits all acute inter-hospital transfers for urgent coronary intervention, looking specifically at the reason for transfer, timeliness of diagnosis and transfer, treatment provided at [health service] and clinical outcome. Any deaths should be included in [health service’s] established morbidity and mortality review process.
Case summary

An older adult male died in hospital following blood and iron transfusions.

The adult had a medical history that included iron deficiency anaemia. They were admitted to a hospital emergency department for a blood transfusion, and were also administered an iron transfusion. Following the iron transfusion, the adult’s condition deteriorated and they were administered other medications. They subsequently lost consciousness. Despite resuscitation attempts, they were unable to be revived.

Coronial findings

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

The coroner found that the adult suffered an anaphylactic response to the iron infusion. The coroner found that there were a number of deficiencies in the adult’s management, including a failure to move them to a resuscitation cubicle during their anaphylactic response.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That [healthcare provider] reviews their clinical practice guideline with an aim of developing a clinical practice guideline for iron infusion that includes pre-treatment investigation of anaemia, indications for an iron infusion, consent requirements and indicates the most appropriate locations within the hospital to deliver an iron infusion taking into account the need for close monitoring of patients in these circumstances.
WESTERN AUSTRALIA

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

The coroner held a joint investigation into the following deaths which resulted from similar incidents: WA.2011.452, WA.2012.410, WA.2011.332, WA.2012.442, WA.2011.1237

<table>
<thead>
<tr>
<th>Case number</th>
<th>The coroner held a joint investigation into the following deaths which resulted from similar incidents: WA.2011.452, WA.2012.410, WA.2011.332, WA.2012.442, WA.2011.1237</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Intentional self-harm</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Mental illness and health</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>47 – cases closed between October and December 2015</td>
</tr>
</tbody>
</table>

Case summary – WA.2011.452

A young female took their own life by hanging. They had a history of mental illness and self-harming behaviour.

In the weeks prior to their death, the young person experienced a relationship breakdown. Their parents became very concerned about their resultant unstable behaviour. The young person experienced another severe situational crisis and subsequently went missing. They were later found deceased in their home.

Coronial findings

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

The coroner found that the young person’s care was not well integrated, and was fragmented as a result of the structure of the mental health services available.

The coroner found that the mental health services lacked cohesion and continuity, leaving the young person responsible for following up on their own care in circumstances where they had been exhibiting behaviour and ideations capable of being interpreted as suicidal.

Case summary – WA.2012.410

An adult male took their own life in a deliberate fall from height. They had a history of drug and alcohol abuse and associated mental illness, for which they were treated with medication. They were considered to be at chronic risk of suicide.

The adult was experiencing a crisis in the week leading up to their death. They were admitted as an involuntary patient to a psychiatric ward. The adult was later discharged, and subsequently took their own life.

Coronial findings

The coroner found that the death was due to intentional self-harm.
The coroner found that the hospital did not have policies and procedures, of a sufficient standard or quality, to provide for the assertive follow-up of involuntary patients being discharged directly into the community.

**Case summary – WA.2011.332**

A young female took their own life by hanging. They had a long history of self-harming behaviour, suicidal ideation and prior suicide attempts.

The young person was experiencing an increase in suicidal thoughts, and was voluntarily admitted into psychiatric care. They made an attempt on their life a few days prior to their death. The young person was discharged a few days later and left the facility alone. They were subsequently found deceased in a park.

**Coronial findings**

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

The coroner found that there were no clear procedures and policies in place to support the facility’s staff in communicating with the young person’s family, and that there were no records of the family’s repeated attempts to contact the young person’s treating team, and that such records ought to have been made.

The coroner found that the doctor responsible for the young person’s care did not exercise sound clinical judgment when they formulated and approved the young person’s discharge and follow-up plans.

**Case summary – WA.2012.442**

A middle aged male died due to multiple injuries sustained in a vehicle incident in which they were a pedestrian. The adult intentionally stepped into the path of traffic.

The adult had an extensive history of mental health problems and drug and alcohol abuse. They had been admitted for psychiatric care on multiple occasions.

The adult absconded from the facility while on escorted ground access and died a short time later.

**Coronial findings**

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

The coroner found that the hospital did not have adequate security measures in place to contain an involuntary patient on escorted ground access in the court yard; and also did not have adequate measures in place to ensure an alert could be raised immediately if an involuntary patient went missing from the court yard.
Case summary – WA.2012.442

A middle aged male died took their own life by unascertained means.

The adult began to experience mental health issues after they became unemployed. They spent periods of time as a mental health inpatient and residing in supported accommodation. They were later discharged home.

Despite recent assessments made, the adult’s mental health deteriorated and they experienced another crisis and attempted suicide. The adult was again admitted into care. Following discharge, they went missing. Their remains were later found in scrubland.

Coronial findings

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

The coroner found that there were failings by the facility’s staff in referring the adult to services and undertaking appropriate consultation relating to the adult’s discharge.

Coronial recommendations

The coroner made the following recommendations related to these cases:

- I recommended that the Western Australian Department of Health develop policies and procedures for the implementation of Carer's Plans, and that such policies and procedures address matters of patient consent and risk issues, and that the following matters be explored for inclusion in Carer's Plans:
  - information concerning the diagnosed condition and medication regime;
  - information relevant to a relapse prevention plan;
  - information relevant to guidance as to when to proactively re-engage with the mental health services;
  - information relevant to the individual needs and concerns of the carers; and
  - information relevant to support services available to carers.
- I recommend that for the purposes of implementing improvements in the delivery of mental health services, the Western Australian government continues its efforts to provide the funding and resources required to progress the Stokes Review recommendations and the Chief Psychiatrist's standards from the planning stage to the implementation stage.

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**  
WA.2013.897

**Primary category**  
Water related

**Additional categories**  
Transport and traffic related, Leisure activity

**Fatal facts edition**  
47 – cases closed between October and December 2015

**Case summary**

A middle aged male died due to drowning following a boating incident.

The adult had been fishing on a private boat with friends. The boat sank while the group were some distance from shore. All members of the group were recovered from the water; however the adult was unable to be revived.

**Coronial findings**

The coroner found that the death was unintentional.

The coroner was unable to determine why the boat sank.

The coroner found that the life jacket worn by the adult was not done up properly, and was unsuitable for the conditions. The Department of Transport was undertaking a review of safety equipment requirements for recreational vessels at the time of the incident.

**Coronial recommendations**

The coroner made the following recommendations related to this case:

- I recommend that the Department of Transport give strong consideration in its review of recreational vessel safety requirements to mandating the wearing of lifejackets by persons over 12 months old on recreational vessels in Western Australia, when such a vessel is in unprotected waters.

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Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>WA.2013.1024</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Water related</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Leisure activity</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>47 – cases closed between October and December 2015</td>
</tr>
</tbody>
</table>

Case summary

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

The adult was fishing from a rock when they were swept into the ocean by a wave.

Coronial findings

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

The coroner found that the deceased was not proficient in English and may not have understood signage which indicated the dangers of fishing along portions of the coast due to unpredictable wave formations.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that, in addition to the warning sign located above the fishing spot referred to as “second grid”, there be a separate large pictorial depiction of a fisherman being swept from a cliff similar to the stylised diagram at the top of the current warning sign.
- In addition, in view of the number of overseas workers in the area, specific warnings in a number of languages would be helpful. Those suggested by the investigating police officer in this matter were Vietnamese, Japanese, Cantonese, French, German and Italian.
## 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>
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<td>----------------------------------</td>
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</tr>
<tr>
<td>Location</td>
<td>Cases where the location of either the incident or the discovery of the body is of significance, does not refer to geographic location.</td>
</tr>
<tr>
<td>Mental illness and health</td>
<td>Incidents where the existence of mental illness issues were involved in the circumstance on death, both diagnosed and anecdotal. Please note mental health is included as a contributing factor to death at the discretion of the coroner.</td>
</tr>
<tr>
<td>Misadventure</td>
<td>Risk taking behaviour such as train-surfing, unintentional drug overdose.</td>
</tr>
<tr>
<td>Natural cause death</td>
<td>Cases where the death is due to natural causes.</td>
</tr>
<tr>
<td>Older persons</td>
<td>Cases related to a specific demographic group or where the age of a person was a factor in the death.</td>
</tr>
<tr>
<td>Physical health</td>
<td>Cases where the existing physical health of the person contributed but were not necessarily cause the death.</td>
</tr>
<tr>
<td>Sports related</td>
<td>Cases where a sports incident significantly impacted the cause of death.</td>
</tr>
<tr>
<td>Transport and traffic related</td>
<td>Cases involving road, water and air vehicle incidents, motorised or naturally powered. Also includes cases where pedestrians are impacted by transport vehicles.</td>
</tr>
<tr>
<td>Water related</td>
<td>Includes swimming, scuba, snorkelling, boating, fishing and all water related activity in both a recreational or commercial context.</td>
</tr>
<tr>
<td>Weather related</td>
<td>Cases where the environmental conditions such as heatwave or storm conditions were significant to the cause of death.</td>
</tr>
<tr>
<td>Work related</td>
<td>Includes cases where work is related to the death and also where unemployment is significant.</td>
</tr>
<tr>
<td>Weapon</td>
<td>Cases where the involvement of a weapon is significant.</td>
</tr>
<tr>
<td>Youth</td>
<td>Cases related to a specific demographic group.</td>
</tr>
</tbody>
</table>