Coronial recommendations: Fatal facts

A summary of cases and recommendations made between January and March 2016

Edition 48
# CONTENTS

<table>
<thead>
<tr>
<th>Coroner's Recommendations</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian Capital Territory</td>
<td>5</td>
</tr>
<tr>
<td>New South Wales</td>
<td>7</td>
</tr>
<tr>
<td>Queensland</td>
<td>13</td>
</tr>
<tr>
<td>South Australia</td>
<td>15</td>
</tr>
<tr>
<td>Tasmania</td>
<td>26</td>
</tr>
<tr>
<td>Victoria</td>
<td>35</td>
</tr>
<tr>
<td>Western Australia</td>
<td>57</td>
</tr>
<tr>
<td>Appendix A: Fatal Facts Web Tool Category Tags</td>
<td>61</td>
</tr>
</tbody>
</table>
CORONERS’ RECOMMENDATIONS

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

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

*Coronial recommendations: Fatal facts* includes case summaries and recommendations for cases closed between January and March 2016.

AUSTRALIAN CAPITAL TERRITORY

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

**Case number**
ACT.2015.187

**Primary category**
Adverse medical effects

**Additional categories**
Law enforcement

**Fatal facts edition**
48 – cases closed between January and March 2016

**Case summary**
A middle aged female died whilst undergoing heart surgery.

**Coronial findings**
The coroner found that the death was due to complications of medical or surgical care.
The coroner found that the public resources utilised in the preparation for and holding of a hearing which is otherwise unnecessary could be better utilised elsewhere.

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

- In the inquest into the death of [name] of 2012, in which I delivered findings on 29 October 2013, I commented on a review conducted in 1935 of the equivalent of section 34A in the *Coroners Act 1887* of the United Kingdom and recommended that section 34A of the Territory’s *Coroners Act 1997* be similarly reviewed with a view to giving a Coroner a power to dispense with a hearing in cases such as this.
- I remain of the view that section 34A should be reviewed, and I reiterate my recommendation, first made in [case], for such a review. I note that a copy of the findings I made in [case], and a copy of the Wright Committee report referred to in those reasons, was forwarded to the Attorney-General as part of the findings and recommendation I made in the [case] inquest on 16 November 2015.

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

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>NSW.2013.710</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Homicide and assault</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Weapon, Law enforcement</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>48 – cases closed between January and March 2016</td>
</tr>
</tbody>
</table>

Case summary

An adult male died due to an assault perpetrated by an unknown assailant.

The adult died instantly from firearm-related injuries and was found hours after their death. The adult was known to police and was known to be engaged in illegal activities.

Coronial findings

The coroner found that the death was due to assault.

Coronial recommendations

The coroner made the following recommendations related to this case:

- The investigation into [the deceased's] death is ongoing and as yet, unsolved. I recommend that this case be referred to the Unsolved Homicide Team to be further investigated.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>NSW.2014.2448</th>
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</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>48 – cases closed between January and March 2016</td>
</tr>
</tbody>
</table>

Case summary

A middle aged male took their own life by hanging.

The adult had been discharged from a mental health ward a week prior to their death.

Coronial findings

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

At inquest, the coroner focused on practises regarding the discharging of patients from mental health facilities.

Coronial recommendations

The coroner made the following recommendations related to this case:

- A review be conducted of standard mental health admission and discharge forms and checklists to ensure that there is uniformity across all documentation and to ensure that hospital clinicians are provided with appropriate reminders of all mandatory requirements under the *Mental Health Act 2007* in relation to the notification of, and consultation with, primary carers concerning a patient's care and treatment.

- Appropriate training and education systems be implemented in order to ensure that medical officers in mental health facilities are aware of all mandatory requirements of the *Mental Health Act 2007* in relation to the notification of, and consultation with, primary carers concerning a patient's care and treatment, and that guidelines be implemented to clearly identify the authorised medical officer in all cases.

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Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>NSW.2013.2013</th>
</tr>
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<tbody>
<tr>
<td>Primary category</td>
<td>Child and infant death</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Adverse medical effects</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>48 – cases closed between January and March 2016</td>
</tr>
</tbody>
</table>

Case summary

A female infant died due to multiple factors shortly after birth.

The infant suffered from a lung abnormality caused by antenatal distress.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the death occurred following a difficult delivery in which the mother was attempting a vaginal birth after caesarean (VBAC).

Coronial recommendations

The coroner made the following recommendations related to this case:

- That consideration be given, in cases of unusual and unexpected deaths of newborn children in regional hospitals in New South Wales, to having autopsies conducted by specialist perinatal / paediatric pathologists or that deaths of such deceased newborn children be investigated medically by forensic pathologists and a specialist perinatal / paediatric pathologist together in whatever way is appropriate in all the circumstances to establish (if possible) the cause and manner of death.
- That the Local Health District consider introducing a protocol that if a newborn baby is unstable with low to intermediate Apgar scores at five minutes, a MET [Medical Emergency Team] team be placed on immediate alert to attend the birthing unit to assist.
- That the Local Health District consider developing from its current protocols a short checklist of matters that must be attended to in cases of instrumental deliveries with a clear delineation of responsibility for carrying out the listed tasks. One person, such as the Registered Nurse or Midwife responsible for maintaining observations, should be nominated as being responsible for ensuring that the checklist is followed.

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Coronial recommendations: Fatal facts

Case number | NSW.2014.1598
Primary category | Child and infant death
Additional categories | Natural cause death
Fatal facts edition | 48 – cases closed between January and March 2016

Case summary
A female child died due to natural causes.

The child was found unresponsive in their home and transported to hospital. Despite attempts to resuscitate the child, they were unable to be revived.

The child had suffered from asthma for majority of their life.

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

The coroner found that poor living conditions and neglect contributed to the child’s death.

The coroner found that there were opportunities for the Department of Family and Community Safety (FaCS) to provide support for children suffering neglect.

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

- That the Department of Family and Community Services (FaCS) lead the discussion at the JIRT Senior Management Group attended by senior representatives of FaCS, NSW [New South Wales] Health and NSW Police about the possibility of developing a joint Practice Review Training Package, focused upon the identification, assessment, and response to chronic neglect, including medical neglect. It is noted that this joint training package will reflect the de-identified Practice Review Learning Package, which has been prepared by the FaCS Serious Case Review Unit of the Office of the Senior Practitioner, following the review of [the deceased’s] tragic death.

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Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>NSW.2014.5062</th>
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<tbody>
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<td>Primary category</td>
<td>Child and infant death</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>48 – cases closed between January and March 2016</td>
</tr>
</tbody>
</table>

Case summary

A female infant was found deceased in a public place.

Coronial findings

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

The coroner was unable to determine the identity of the infant or the events that led to their death.

The coroner noted that the abandonment of children is a complex issue, and that initiatives could be implemented to protect babies and mothers at risk.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend to the Ministers for Health, Justice and Family & Community Services (whoever is most appropriate) that consideration be given to installing "baby boxes" of the type used in Germany, Canada, the Czech Republic and other jurisdictions, and the associated practices and procedures, in hospitals or other suitable locations, for the protection of babies and mothers at risk.

- I recommend to the Ministers for Health, Justice and Family & Community Services that consideration be given to introducing "safe haven" laws, together with the relevant practices and procedures, for the protection of babies and mothers at risk.

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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>QLD.2013.3649</th>
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</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Sports related</td>
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<tr>
<td>Additional categories</td>
<td>Transport and traffic related, Leisure activity</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>48 – cases closed between January and March 2016</td>
</tr>
</tbody>
</table>

Case summary

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

The adult was a professional race car driver and was coaching an amateur driver at the time of the incident. The car experienced a mechanical fault and collided with a barrier wall, fatally injuring the adult.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the death was results of risk taking leisure activities and that individuals need to have better education on the risk of these activities.

Coronial recommendations

The coroner made the following recommendations related to this case:

- Appropriate motor sports regulatory bodies including CAMS [Confederation of Australian Motorsport] and similar organisations should work together to develop guidelines for driver coaching and recreational activities conducted on race tracks in Queensland, such that individuals who provide venues for, organise and participate in these activities are appropriately informed about the risks involved and how to make these activities as safe as possible
- Information about this incident be provided to [manufacturer] (if this has not occurred already) so that the company can satisfy itself as to whether this was a one-off incident, or whether there may be any design or manufacturing faults with this particular vehicle.

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SOUTH AUSTRALIA

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>The coroner held a joint investigation into the following deaths which resulted from similar incidents: SA.2008.1555, SA.2009.541</th>
</tr>
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<tbody>
<tr>
<td>Primary category</td>
<td>Intentional self-harm</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Weapon, Location, Law enforcement</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>48 – cases closed between January and March 2016</td>
</tr>
</tbody>
</table>

Case summary – SA.2008.1555

A young female took their own life using a firearm at a firing range.

The young person suffered from multiple mental illnesses and had a history of suicide attempts. They had been discharged from hospital on the day of their death.

A few weeks prior to the young person’s death, their social worker had contacted police to inform them of the young person’s history of mental illness and self-harm, as they were aware that the young person was involved in rifle shooting through a club.

The young person was not a member of the shooting club, nor did they hold a relevant firearms licence or permit.

Coronial findings

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

Case summary – SA.2009.541

An adult male took their own life using a firearm at a firing range.

The adult did not have a history of mental health problems, but was experiencing personal issues around the time of their death.

The adult was not a member of the shooting club, nor did they hold a relevant firearms licence or permit.

Coronial findings

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

Coronial recommendations

The coroner made the following recommendations related to these cases:
• That the Attorney-General consider the amendment of the *Firearms Act* to require that commercial range operators, including firearms clubs, be obliged to install suitable tethering and/or bullet proof screening for use by persons who are not the holder of a firearms licence or member of a club. The requirement should be subject to such exceptions as may be prescribed, including the provision of training to security organisations where the trainees may not hold firearms licences. There may be other necessary exceptions.

• That the Attorney-General consider the material contained in this finding with a view to deciding whether it is necessary to amend the *Firearms Act* to make the situation clearer regarding the application of the prohibition order regime to mental health notifications.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>SA.2010.396</th>
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<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>48 – cases closed between January and March 2016</td>
</tr>
</tbody>
</table>

Case summary
A female adult died due to an assault perpetrated by their estranged spouse.

The adult had reported episodes of violence inflicted by their spouse to police prior to their death.

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

The coroner found that although the adult had lodged police incident reports, police failed to arrest, report or speak to the estranged spouse prior to the fatal incident.

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

Normally I would direct recommendations about the operations of SAPOL (South Australia Police) to the Commissioner of Police. However, given that this Inquest is about domestic violence, an issue which has recently been described by the Premier as a key priority of the Government, I have thought it appropriate to direct the recommendations to the Premier. The Premier will no doubt bring them to the attention of the Commissioner in due course, but it is my hope that the Premier will be able to maintain oversight of this key priority for Government.

- I recommend that all aspects of domestic violence policing be characterised by a sense of curiosity, questioning and listening. Risk assessment must be actually applied, not merely recited as a mantra.
- I recommend that the SAPOL Criminal Justice Section be staffed by legal practitioners so that domestic violence restraining orders can be properly presented before magistrates.
- I recommend that all domestic violence calls to the SAPOL call centre are handled by sworn police officers with particular training in domestic violence risk assessment.
• I recommend that the domestic violence training that cadets receive at the Police Academy from external domestic violence agencies occupy at least one day, rather than the half day that it has been reduced to.
• I recommend that all domestic violence safe houses be flagged with police communications in order to ensure consistency of approach when a response to an incident or report is made.
• I recommend that prosecutors appearing in domestic violence matters must, as a matter of course, seek out all available information about the longitudinal history of the domestic violence offending, particularly from Family Court documents if those exist.
• I recommend that prosecutors appearing in domestic violence matters must, as a matter of course, establish the outcome of the offence PIRs (Police Incident Reports) underlying the application.
• I recommend that police officers do not ask domestic violence complainants whether they still wish to proceed unless there is some communication from the complainant that justifies such an enquiry.
• I recommend that when a domestic violence victim makes a report at a police station, they are afforded an opportunity of privacy in an interview room.
• The evidence of Senior Constable [name] showed that the flow of taskings received by patrols meant that Priority A taskings that had been attended to but without result earlier in a shift, were unlikely to be returned to. This needs to be changed. Priority A taskings should remain higher in priority than later, lower priority taskings.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>SA.2010.999</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Law enforcement</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Mental illness and health, Geographic</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>48 – cases closed between January and March 2016</td>
</tr>
</tbody>
</table>

Case summary

A middle aged male died due to unascertained causes. The adult was being held in police custody subject to an inpatient treatment order pending transfer to a mental health facility.

Coronial findings

The coroner was unable to determine the circumstances of the death. The coroner found that the adult was not experiencing a medical emergency requiring immediate or earlier transfer to a mental health facility.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the Minister for Mental Health and Substance Abuse:

- The Court echoes the recommendation made by [independent expert] as follows:
  - There should be ongoing awareness by Rural and Remote Consultants of the need to assess carefully risk/safety factors and the limitations of rural hospitals in managing acutely psychotic and violent patients in rural SA (South Australia).
  - Reinforcement to transport and retrieval services to carefully risk manage/assess acutely psychotic patients in rural hospitals with a view to early transport where possible (I should also say that I am well aware that these recommendations form part of current policies of these organisations but that does not prevent me from stating them here).
- The Court also endorses [independent expert's] opinions as summarised [...] herein:
  - That in according priority to the transportation of mentally ill patients, that priority be given, wherever possible, to the transport of patients who are the subject of inpatient treatment orders under the Mental Health Act 2009 or who are the subject of other measures that have been invoked under that Act.

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Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>SA.2007.1244</th>
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<tr>
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<td>Natural cause death</td>
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<tr>
<td>Additional categories</td>
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</tr>
<tr>
<td>Fatal facts edition</td>
<td>48 – cases closed between January and March 2016</td>
</tr>
</tbody>
</table>

Case summary

An adult male died due to cardiac issues during a police arrest.

The adult suffered from schizophrenia and pre-existing heart disease.

The adult had absconded from a hospital mental health ward on the day of the incident. Police attended the adult’s home in order to escort them back to the hospital. The adult became aggressive towards police, and was forcefully restrained. During the restraint, the adult suffered cardiac and respiratory arrest and could not be revived.

Coronial findings

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

The coroner found that the death was caused by cardiac and repertory arrest due to existing heart disease easily triggered by physical and emotional stress.

The coroner noted the need for police to have detailed training in restraining persons with a mental illness.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Minister for Health consider ensuring that the outpatient mental health service of the [health service] (known as the [clinic]) and the Emergency Department of the [health service] are housed within the same building so as to eliminate or minimise the opportunity for patients detained at the [clinic] to abscond before they are examined within the Emergency Department of the [health service].

- That the signatories to the Mental Health Memorandum of Understanding together continue to develop practices and procedures that promote a collaborative culture in respect of the detention, apprehension and restraint of persons with a mental illness. I direct that recommendation to the Minister for Health, the Chief Executive Officer of the Department of Health, the Chief Executive Officer of the South Australian Ambulance...
Service, the Chief Executive Officer of the Royal Flying Doctor Service, the Minister for Police and the South Australian Police Commissioner.

- That the Minister for Health ensure that mental health services are, at short notice and at any time of the day or night, made available to assist police in the execution of their duties in respect of the apprehension of persons with a mental illness.
- That the Commissioner of Police take the necessary steps to ensure that officers are provided with specific and detailed training, orders and instructions regarding their duties and responsibilities when apprehending or restraining persons with a mental illness. Such training, orders and instructions should deal with the circumstances in which the services of the entities who are party to the Mental Health Memorandum of Understanding should be sought and utilised.
- That the Commissioner of Police takes the necessary steps to ensure that officers of the rank of Inspector or above are made aware of instances where junior officers are required to exercise their powers of apprehension and restraint pursuant to the Mental Health Act 2009 at the time that those instances occur.

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Coronial recommendations: Fatal facts

Case number | SA.2012.1365
---|---
Primary category | Natural cause death
Additional categories | Law enforcement
Fatal facts edition | 48 – cases closed between January and March 2016

**Case summary**

An older female adult died due to lung disease.

The adult was subject to a guardianship order at the time of their death due to their diminished mental capacity.

**Coronial findings**

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

The coroner found that the guardianship order had been enforced on only one occasion four months prior to the adult’s death.

The coroner found that the adult’s death was not a death in custody. The coroner found that the vast majority of mandatory inquests into deaths that occur in relating to persons detained pursuant to section 32 of the *Guardianship and Administration Act 1993* are unnecessary.

**Coronial recommendations**

The coroner made the following recommendations related to this case:

- An assessment as to whether the death of a person undergoing a guardianship regime imposed under section 32 of the *Guardianship and Administration Act 1993* was a death in custody depends upon whether or not the protected person had resided in such place as the guardian had thought fit and had been detained in that place. As seen here, it is not always the case that a guardian appointed pursuant to a section 32 order will have had any input into the decision as to where the protected person should reside.

- When these matters are reported to the State Coroner, as they must be by virtue of the underlying order that the person in question was a protected person, with or without orders as to residence and detention, it is not always easy to determine whether or not the matter may also be a death in custody requiring a mandatory Inquest and also, in practical terms, whether a detailed police investigation into the matter is needed to support that Inquest. This difficulty exists because any direction, determination or other...
decision that has been made or given by the guardian as to residence and detention may have been communicated informally and may not be in writing.

- It is therefore suggested that when an order is made pursuant to section 32 that includes orders that the protected person reside in such place as the guardian from time to time thinks fit, and an order that the protected person be detained in such place as the guardian shall from time to time determine, an order should also be made that such direction or determination of the guardian in that regard be reduced to writing.

- I direct this recommendation to the President of the South Australian Civil and Administrative Tribunal which entity now has responsibility in relation to the imposition of orders pursuant to the Guardianship and Administration Act 1993.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>SA.2010.238</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Adverse medical effects</td>
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<td>Additional categories</td>
<td>Older persons</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>48 – cases closed between January and March 2016</td>
</tr>
</tbody>
</table>

Case summary

An older female adult died from a brain bleed associated with their high blood pressure.

The adult had attended a radiology clinic for a scan. An abnormality was found, but the adult was not asked to remain on the premises to await the results of a second scan. The adult’s general practitioner was subsequently requested to conduct an urgent follow-up for further medical examinations, but failed to make contact with the adult prior to their death.

Coronial findings

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

The coroner found that the general practitioner did not appreciate the urgency of the medical follow-up that was required and did not take sufficient steps to ensure contact was made with the adult.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the Minister for Health negotiate with the Australian Medical Association, the Royal Australian College of General Practitioners, or another appropriate body representing general practitioners in South Australia, to ensure that when urgent, unexpected or sinister findings are reported following medical imaging, the general practitioner should ensure that if the patient concerned is not notified within 48 hours of the finding (or less if clinically indicated), the general practitioner must make contact with the South Australian Ambulance Service or South Australia Police to ensure that a welfare check is conducted and that the patient is advised to contact his or her general practitioner.

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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>TAS.2013.162</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Sports related</td>
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<tr>
<td>Additional categories</td>
<td>Transport and traffic related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>48 – cases closed between January and March 2016</td>
</tr>
</tbody>
</table>

Case summary

An older male adult died from injuries sustained in a motor vehicle incident in which they were a driver.

The adult was competing in an organised motorsport event at the time of the incident.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult’s inexperience in competing in motorsport events contributed to their driving too fast and losing control of the vehicle.

The coroner found that the CAMS (Confederation of Australian Motor Sport) Tarmac Rally Standing Regulations (TRSR) were not in force at the time of the event.

The coroner found that there was a generally poor approach to safety and there were no safety briefings to first-time competitors in the event.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the CAMS Tarmac Rally Standing Regulations (TRSR) apply to the running of any future events.
- That there be compulsory alcohol testing for all competitors before all stages, in all future events.
- That there be a formal, transparent system of review of course design and safety after each event, including the recording of the outcomes of the review.
- That consideration be given to the appointment of a safety assessor to assist the event course checker.
- That there be a separate beginners briefing for all first-time competitors in the event.
- That the use of HANS (head and neck support) devices be mandated for all competitors.
• That consideration be given to the accreditation of those who prepare pace notes for sale, including a system of uniformity of symbols and meanings.
• That the contractual prohibition on the use of chicanes (real and/or virtual) be dispensed with.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>TAS.2014.276</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Transport and traffic related</td>
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<tr>
<td>Additional categories</td>
<td>Youth</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>48 – cases closed between January and March 2016</td>
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</tbody>
</table>

Case summary

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

The young person was attempting to cross a road after alighting from a bus when they were struck by an oncoming vehicle.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the young person had walked onto the road without checking on the approach of any vehicles or at a time when their observation was obscured by the bus.

Coronial recommendations

The coroner made the following recommendations related to this case:

- Reference to recent fatal pedestrian crashes that have occurred in rural locations indicates that they have occurred because the pedestrian, a child, was crossing the road to a parent waiting on the other side of the road. It is apparent that if parents collect their children from the same side of the road that the bus stopped, the risks of such accidents would be minimised. I recommend that an education/awareness program encouraging parents who encounter this situation to collect children from the bus stop side as this will limit the risk of similar tragic outcomes in the future.

- I also recommend that consideration be given as to whether justification exists to extend the flashing light on school buses speed limitation to all buses operating on rural roads.

- The general public should also be made aware of the findings of a review of serious casualty pedestrian crashes which was presented in February 2012 by the Department of Infrastructure, Energy and Resources Tasmania where crashes between 2007 and 2011 were reviewed. This Paper looks at crash data statistics for serious and fatal pedestrian crashes within Tasmania. The police investigator who reviewed this Paper found that [the
deceased’s] fatal crash matched the highest risks category for a number of criteria, that being:
- Age group of 15 to 19 years is almost double any other age group;
- Friday has the highest number of crashes;
- July has the second highest number of crashes;
- Between 3 pm and 7 pm most crashes occur.

- It is recommended that an awareness program include these risk factors and also that further consideration be given to the reduction of urban speed limits, which is suggested to reduce the number of such vehicle/pedestrian accidents.
Coronial recommendations: Fatal facts

Case number | TAS.2014.290
Primary category | Intentional self-harm
Additional categories | Mental illness and health
Fatal facts edition | 48 – cases closed between January and March 2016

Case summary

A middle aged male took their own life in a fall from height.

The adult had recently been admitted to a mental health inpatient unit and was later discharged.

Upon follow-up from mental health services, the adult advised they did not require further medical assistance as they were going well and had adequate family support in place. Medical personnel closed the adult’s case based on their self-reported mental health status.

Coronial findings

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

The coroner found that the adult’s self-report to clinical personnel was not a true reflection of their actual mental health status.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I would recommend that confirmation of a patient’s self-reported mental health status be confirmed by a carer, family member or some other person able to independently comment upon and verify the description given by the patient.

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>
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</tr>
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<tr>
<td>Fatal facts edition</td>
<td>48 – cases closed between January and March 2016</td>
</tr>
</tbody>
</table>

Case summary

An adult male died due to drowning at a beach.

The adult had entered the water and been knocked over by a large wave. They were pulled into deeper water affected by a rip. The adult was recovered from the water but was unable to be revived.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult may have struck their head when knocked over by the wave which may have contributed to the difficulties they faced when pulled out into the deeper water.

The coroner found that this area of water was well known as being generally unsuitable for swimming as it is characterised by a steep beach and loose sand. The area was known to experience strong waves and very strong undercurrents during adverse weather conditions.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that appropriate signs be placed in prominent positions within the camping area and at access points to this beach warning of the potential danger to persons entering the water, especially at times of adverse wave conditions.

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>Older persons, Aged care</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>48 – cases closed between January and March 2016</td>
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**Case summary**

An older male died due to complications of a spinal fracture caused by falling chair.

The adult was a resident of an aged care facility in which the incident occurred. The adult was injured when the light weight plastic chair they were seated in fell back against a brick wall.

**Coronial findings**

The coroner found that the death was unintentional.

The coroner found that although the adult was determined to be at high risk of falls (and was therefore usually supervised when moving from chair to chair); the adult had moved the plastic chair themselves.

**Coronial recommendations**

The coroner made the following recommendations related to this case:

- It became apparent during this investigation that the use of light weight plastic chairs was not optimal, especially where used in outdoor areas that may not have been level. Since the incident in which [the deceased] was injured, all of the outside plastic chairs at the [aged care facility] have been replaced with metal chairs. This was an appropriate step to mitigate the risk of a future similar incident.
- I would also recommend, however, that appropriate steps be taken to ensure that residents using these chairs outdoors are confined to areas where the base upon which the chairs are placed is level and stable.
- I would also recommend that some formal procedure be in place to provide ongoing monitoring of residents in outdoor areas of aged care facilities. In this facility, as I assume others, there are call buttons or alarm buttons for residents to use in their rooms. However, there does not appear to have been any such system covering the outdoor areas, nor does there appear to have been a process whereby the monitoring of the activities and condition of residents in an outdoor area was checked on a regular basis.
• I would also recommend that the management of [aged care facility] carry out an assessment as to whether the most appropriate action was taken upon the initial movement of [the deceased] given the circumstances indicated the possibility that he had suffered a neck injury. Although there is no indication in this case that moving him from the chair to his bed caused any additional injury or increased the effects of the injury, the possibility must be considered in dealing with such circumstances.
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.2009.4208</th>
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<td>Mental illness and health</td>
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<tr>
<td>Fatal facts edition</td>
<td>48 – cases closed between January and March 2016</td>
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Case summary

A young female took their own life by hanging.

The young person was an inpatient at a hospital psychiatric unit at the time of death.

Coronial findings

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

The coroner found that hooks/housing installed behind modified bathroom doors at the hospital posed an unacceptable risk as a hanging or suspension point and were therefore inappropriate for use in a psychiatric inpatient facility.

The coroner found that a co-patient had previously disclosed a hanging attempt to hospital staff using the hooks/housing at the same inpatient unit. This information was recorded in this patient’s progress notes only, with no formal report being completed in the hospital’s incident management system (RiskMan).

Coronial recommendations

The coroner made the following recommendations related to this case:

- In furtherance of the Chief Psychiatrist’s responsibility for the safety of patients in the public mental health system, I recommend that the Chief Psychiatrist considers mandating the removal of the particular hook/housing used in the [hospital] inpatient unit, particularly from doors or any other placement where they can be utilised as a hanging or suspension point.
- I recommend that [the hospital] develop a procedure that addresses the need for scene preservation and/or recording, in circumstances where a serious suicide attempt has taken place in an inpatient facility, in anticipation of a foreseeable coronial investigation. Such a procedure could also assist the health service to undertake its own internal review or root cause analysis (whether mandated or otherwise) and to comply, more broadly, with their duty of care obligations.
I further recommend that such a procedure identify roles and responsibilities as clearly as possible, in particular as regards the completion of RiskMan report of the incident or any other tool or software being used from time to time in the health service to manage risk.
Coronial recommendations: Fatal facts

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<td>Fatal facts edition</td>
<td>48 – cases closed between January and March 2016</td>
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Case summary

A middle aged female took their own life by asphyxiation. The adult had recently been made an involuntary patient at a mental health unit. Following psychiatric review, they were transitioned to a low dependency unit and continued on regular observations. They were subsequently found deceased in the unit.

Coronial findings

The coroner found that the death was due to intentional self-harm. The adult had access to an item used as a ligature. The coroner noted the Chief Psychiatrist’s guidelines regarding dangerous and inappropriate items that may pose a risk of harm to patients or others.

The coroner noted the response made by another mental health service to a previous coronial recommendation:

“On [date] a memorandum... was issued to all [mental health service] staff outlining the removal of hazardous items in inpatient units which clearly addresses the need for staff to be vigilant regarding scarves and adhere to the Chief Psychiatrist Guideline on Criteria for searches to maintain safety in an in-patient unit for patients, visitors and staff.”

Coronial recommendations

The coroner made the following recommendations related to this case:

- I adopt [coroner’s] recommendation 1 in the Finding Without Inquest into the Death of [name] and urge [mental health service] to change its current policy that allows patients in the Low Dependency Unit to retain items that are capable of being used as a ligature.
- Further, to avoid confusion it is preferable for Acute In-patient Units to take a consistent approach on this point and I urge [mental health service] follows the position adopted by [other mental health service].

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Coronial recommendations: Fatal facts

Case number | VIC.2013.5732
---|---
Primary category | Intentional self-harm
Additional categories | Homicide and assault
Fatal facts edition | 48 – cases closed between January and March 2016

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

The adult had a history of alcohol abuse, and their relationship with their partner occurred in the context of family violence. The adult’s anger and abusive behaviour toward their partner escalated in the months prior to their death. The adult had previously taken part in a Men’s Behavioural Change Program.

The partner had left the family home to stay with relatives due to the adult’s aggressive behaviour. After being unable to contact the adult, police were engaged to conduct a welfare check. The adult was found deceased in their home.

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

The coroner found that the adult’s lack of engagement with health services made it difficult to appropriately address their suicide risk. The coroner noted that the death highlighted the difficulties of engaging male perpetrators of family violence with appropriate mental health and support services to address the underlying causes of their violent behaviour and suicide risk.

The coroner supported the recommendation of Victoria Police to the Royal Commission into Family Violence that conditions attached to family violence intervention orders should be tailored to meet individual circumstances. The coroner found that these conditions should include measures such as drug and alcohol treatment, and program completion should be monitored similar to a community corrections order.

Coronial recommendations
The coroner made the following recommendations related to this case:
• That No to Violence provide an updated minimum standards for Men's Behavioural Change Programs to incorporate a requirement for suicide risk assessment upon eligibility and throughout Men's Behavioural Change Programs.

• That the Victorian Government establish a state wide accreditation process for Men's Behavioural Change Programs in order to ensure that all programs meet an updated minimum standards as published by No to Violence.
Coronial recommendations: Fatal facts

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<th>Case number</th>
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<tr>
<td>Fatal facts edition</td>
<td>48 – cases closed between January and March 2016</td>
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Case summary

An older adult male took their own life using a firearm.

The adult had a history of mental illness and excess alcohol consumption. On the day of the incident, the adult contacted emergency services, informing the call taker that they intended to take their own life. Police attended the address and found the adult deceased.

Coronial findings

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

The adult held a current firearms licence at the time of the incident. On their most recent application, they did not admit to having a recent history of psychiatric or related problems, which was inconsistent with their previous applications. The coroner found that this discrepancy was either not detected or not investigated.

The coroner considered that a requirement that all applications for firearms licences or renewals be accompanied by a medical report would reduce under-reporting by applicants and alert health professionals to patients' holding of firearms licences.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Licensing and Regulation Division of Victoria Police implement a system whereby answers to relevant questions on firearms licence applications are compared to the same answers on previous applications.
- That the Licensing and Regulation Division of Victoria Police give further consideration to amending its firearm licence application process to require all applicants to submit a report from a treating health professional as to their fitness to hold a firearms licence.

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Coronial recommendations: Fatal facts

Case number
VIC.2012.1458

Primary category
Homicide and assault

Additional categories
Child and infant death

Fatal facts edition
48 – cases closed between January and March 2016

Case summary

A female infant died due to an assault perpetrated by their parent.

Coronial findings

The coroner found that the death was due to assault.

The coroner found that no health professional who worked with the parent prior to the infant’s death concluded that the parent posed a risk of harm to the infant. The parent had undergone numerous mental health screenings; however the screenings had been administered by different clinicians in separate medical facilities.

The coroner found that although the health professionals involved were aware of each other, they were unaware of the content and outcomes of the actions of each other due to information not being shared.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that relevant government departments (including the Department of Education and Training and the Department of Health and Human Services), in collaboration with the Municipal Association of Victoria and other stakeholders involved in delivering Maternal and Child Health services, examine the feasibility of the creation of a shared data base, being in effect a single health record, of the monitoring and treatment of infants and children passing through the Maternal and Child Health system in Victoria. The purpose of the database would be to enable those monitoring and treating the infant/child to inform themselves, in real time, of progress and/or changes in the health or development of that infant/child by accessing the full medical record to that point in time.

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Coronial recommendations: Fatal facts

Case number: VIC.2009.4951
Primary category: Drugs and alcohol
Additional categories: Adverse medical effects

Case summary

A middle aged female died due to complications of drug toxicity.

The adult had taken medication that had not been prescribed to them.

When the adult could not be roused, the adult’s medical practitioner (who was also a family friend) had been contacted for medical advice. However, the medical practitioner did not initiate the adult’s immediate transfer to hospital for medical assistance.

Coronial findings

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

The coroner found that the adult was denied the opportunity to receive potentially life-saving medical attention in a timely manner because the family and the medical practitioner did not adequately differentiate between the adult’s normal sleeping patterns and a medical emergency.

The coroner found that the medical practitioner’s failure to separate their professional standing from their personal relationship with the family denied the adult the most basic standard of care that the ordinary person in Victoria should be able to expect of a registered medical practitioner.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Royal Australian College of General Practitioners use the circumstances of [the deceased’s] death and in particular, how [medical practitioner’s] relationship with the [family] influenced his clinical decision making about [the deceased], as part of its ‘conflict of interest’ training to general practitioners.

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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<tr>
<td>Fatal facts edition</td>
<td>48 – cases closed between January and March 2016</td>
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Case summary

An adult male died due mixed drug toxicity associated with prescribed medications.

The adult had attended multiple medical facilities to obtain scripts from various medical practitioners; these scripts were then dispensed at different pharmacies.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that even though the adult was identified as a 'prescription shopper' for the purposes of Medicare's Prescription Shopping Program, there was a delay of at least two-and-a-half months in notifying the adult's prescribing practitioners accordingly.

The coroner found this delay undermined the ability of the various medical practitioners to respond optimally to the adult’s presentation and requests for further prescriptions, and access to excessive quantities of these drugs.

The coroner found that clinicians responded appropriately. They addressed the situation by counselling the adult about the dangers of misuse of prescription medication, warned that they would not continue to prescribe such medications, documented their concerns in clinical notes, alerted their colleagues to their concerns, and sought further information from the Prescription Shopping Information Service.

Coronial recommendations

The coroner made the following recommendations related to this case:

- In line with recent recommendations published by [coroner] in the Finding into the death of [name], I recommend that the Victorian Department of Health progress the implementation of a Victorian-based real-time prescription monitoring system as a matter of urgency to prevent ongoing harm and deaths associated with pharmaceutical drug misuse and inappropriate prescribing and dispensing of pharmaceutical drugs.
- While the Victorian Department of Health continues with its efforts to implement a real-time prescription monitoring program for Schedule 8 drug dispensing, I recommend that
it also identifies the legislative and regulatory barriers that might prevent drugs listed in other schedules (particularly Schedule 4) from being monitored within the scope of the program. And, if any such barriers are identified, I recommend that the department considered what reforms are necessary so that in due course its real-time prescription monitoring program can be expanded beyond Schedule 8 drugs.

- I note that the Department of Health and Human Services has responded to [the above recommendations] made in the [name] Finding [...], and to similar recommendations made by [coroner] in his Finding into the death of [name] and Finding into the death of [name]. The responses indicate that issues are under consideration and in the May 2015 Budget $300,000 was allocated to evaluate and plan for the implementation of a real-time prescription monitoring system but that no commitment to action has yet been made. Therefore, I reiterate the above-mentioned recommendations.

- That the Royal Australasian College of General Practitioners consider including and/or enhancing a section in its Standards for General Practices to inform and advise general practitioners about their legal obligations when prescribing medications, especially those arising from section 33 of the DPCS (Drugs, Poisons and Controlled Substance) Act and to provide opportunities for professional development relating to the safe prescription of ‘drugs of dependence’ to drug-dependent and non-drug-dependent patients.

- Pending implementation of a real-time prescription monitoring system, I recommend that the Royal Australasian College of General Practitioners reminds its members about the PSIS (Prescription Shopping Information Service) and encourages them to use it whenever they have concerns that a patient may be abusing prescription medications, as it provides the most up to date information current to up to 24 hours of any enquiry they make.
Coronial recommendations: Fatal facts

Case number: VIC.2012.4455
Primary category: Drugs and alcohol
Additional categories: Location

Case summary
A young male died due to combined drug toxicity in the setting of an inflammatory illness. The young person was found unresponsive in a research laboratory in which they studied.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the young person was able to access drugs through their studies at the research laboratory, and that audits conducted at the facility were insufficient to identify the redirection of opioids from the laboratory.

The coroner found that there were no guidance documents regarding the management of Schedule 8 poisons in the research and laboratory setting.

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

- The Victorian Department of Health and Human Services review the regulation of schedule 8 and 9 poisons used and produced in a research setting and consider the development of specific guidance documents, similar in nature to the guidance document, ‘Management of schedule 8 poisons in pharmacy’, for use in the research context. This should include guidance regarding weighing powders and managing synthesised poisons.

- The Victorian Department of Health and Human Services consider providing education to research facilities with permits pursuant to regulation 5 to use schedule 8 poisons, about their responsibilities to comply with the provisions of the Drugs, Poisons and Controlled Substances Act 1981 and Regulations, in relation to schedule 8 and 9 poisons used and created in experiments and otherwise.

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Coronial recommendations: Fatal facts

Case summary

An adult female died due to complications following a post-partum haemorrhage.

The adult had experienced a previous post-partum haemorrhage delivering their first child at a hospital, but opted for a home birth with their second child.

Coronial findings

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

The coroner found that the midwife’s failure to remove the deceased from the birthing pool to examine them immediately after delivery, coupled with the failure to maintain appropriate blood pressure and vital sign monitoring in the hour following the birth was wholly inappropriate and caused or substantially contributed to their death.

The coroner found that the management by the midwife for the home birth was inadequate and occurred in a setting where the midwife steadfastly maintained their commitment to home birth without outside intervention.

The coroner found that the midwife’s actions and omissions were undertaken without objective judgement and with little regard for the norms and protocols adhered to by their peers.

Coronial recommendations

The coroner made the following recommendations related to this case:

- The Department of Health and Human Services, in conjunction with the Australian Health Practitioner Regulation Agency, examines the adequacy of the regulatory system currently in place and develops a specific regulatory framework for privately contracted midwives, working in the setting of a home.
- The Nursing and Midwifery Board of Australia develops specific guidelines to define mandatory clinical competency and clinical experience standards, for privately contracted midwives, working in the setting of a home.
• The Nursing and Midwifery Board of Australia develops a system for monitoring mandatory clinical competency and clinical experience standards, for privately contracted midwives, working in the setting of a home.

• The Department of Health and Human Services provides ongoing training for registered midwives specifically engaged in providing home birth services. For the protection of all concerned, participation in such ongoing training should be mandatory.

• Additionally, I recommend that the Department of Health and Human Services undertakes a public campaign designed to provide education for women and for their partners who maybe considering home birth, to seek to inform as to how safe and otherwise reasonable decisions on this matter should be reached.

• I also recommend that the Department of Health and Human Services, in conjunction with the Australian Health Practitioner Regulation Agency, examines the question of whether there is a need to create a regulatory offence that would prohibit the receipt either directly or indirectly of a financial commission of any type for attending at a place of birth while being an unregistered midwife (or medical practitioner).

• Pursuant to Sections 49(1) and 69(2) of the Coroners Act 2008, I recommend that the Director of Public Prosecutions examines the evidence collected in this investigation and takes such action against [the midwife], as [they] may deem to be appropriate.
Coronial recommendations: Fatal facts

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<th>Case number</th>
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<tr>
<td>Additional categories</td>
<td>Work related</td>
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<tr>
<td>Fatal facts edition</td>
<td>48 – cases closed between January and March 2016</td>
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Case summary

A middle aged male died due to injuries sustained in a fall from a roof.

The adult was employed as a labourer. They were working on a roof without any fall protection measures in place at the time of the incident.

They were employed to work on a roof without any fall protection measures in place.

Coronial findings

The coroner found that the death was unintentional.

The coroner found the death occurred at a workplace in circumstances that were hazardous and largely preventable.

The coroner found that WorkSafe publications relevant to falls from height were voluminous, but had not been updated for some time.

Coronial recommendations

The coroner made the following recommendations related to this case:

- With the aim of enhancing workplace safety and minimising harms, I recommend that WorkSafe Victoria consider releasing an updated and comprehensive publication relating to both preventing and increasing awareness of the associated dangers of falls from height at the workplace.
Coronial recommendations: Fatal facts

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<td>Fatal facts edition</td>
<td>48 – cases closed between January and March 2016</td>
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Case summary
An older female died due to injuries sustained in an unwitnessed fall.

The older person was a resident in an aged care facility. The facility did not have a Division 1 Registered Nurse or medical practitioner on site at the time of the fall to assess any significant injuries. As a result, the adult was not conveyed to hospital for investigations until this was requested by visiting family members hours after the incident occurred.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the initial assessment of the adult’s injuries was inadequate and deficient.

The coroner found that a thorough examination and assessment of the adult’s injuries should have been undertaken by at least a Division 1 Registered Nurse or medical practitioner.

The coroner found that no formal post-incident review was conducted by the aged care facility to determine if their practices and protocols were being adhered to by their employees.

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

- If they have not done so already, I recommend [aged care facility] formalise and implement a comprehensive, robust internal review process.

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.2013.2982
Primary category | Adverse medical effects
Additional categories | Physical health
Fatal facts edition | 48 – cases closed between January and March 2016

Case summary
An adult male died due to complications of deep vein thrombosis following ankle surgery.

The adult presented to a hospital emergency department on two occasions following surgery. Their vital signs were not recorded during one of the presentations due to the streaming model of care (fast-track area) at the hospital.

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

The coroner found that the adult’s obesity was a contributing factor.

The coroner found that the fast-track area did not have nursing staffing available after 2:00am. Having medical staff review patients in a fast-track area without any nursing input after 2.00am appeared to have the potential to put patients at risk.

The coroner found that recording of vital signs is a core function of emergency departments; its omission in this case may have represented a missed prevention opportunity.

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

- I recommend that [hospital] reconsiders the practice of not having a registered nurse available for the ED (Emergency Department) fast-track area after 2.00am. If allocation of a registered nurse after 2.00am is not possible, an alternative option would be the closure of the fast track area after this time.

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Coronial recommendations: Fatal facts

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<tr>
<td>Fatal facts edition</td>
<td>48 – cases closed between January and March 2016</td>
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Case summary

A middle aged female died due to complications of a melanoma following a fall. The adult had a history of basal cell carcinoma and a family history of non-melanoma skin cancer.

A few years prior to their death, the adult was referred to a dermatologist, who diagnosed a skin lesion as benign. The lesion continued to grow, and the adult was later diagnosed with a malignant melanoma, though the primary site of the melanoma was unable to be determined.

The adult’s condition deteriorated and they were admitted to hospital on multiple occasions. While in hospital, the adult experienced a fall and sustained a fracture. They underwent surgery to treat the fracture. Following the surgery, the adult suffered a seizure and their condition worsened. 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 consideration should have been given to sending the skin lesion to pathology to confirm the diagnosis that the lesion was benign.

The coroner found that had the general practitioner’s clinical notes been more detailed, this would have assisted determination regarding the adult’s presentation with the lesion.

The coroner found that a sensor alarm would have provided an additional layer of protection against falls for the adult.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Royal Australian College of General Practitioners consider circulating educational material to its members regarding best practice as to management of skin lesions, including after excision.
• That the Royal Australian College of General Practitioners consider the need to establish guidelines as to best practice when a skin lesion has been excised, even after it has been clinically diagnosed as benign.
• That the Royal Australian College of General Practitioners continue to educate its members as to the importance of comprehensive contemporaneous clinical notes.
• That Alfred Health amends its policies to require the use of Proximate or similar sensor alert devices in conjunction with visual observations by a Constant Patient Observer or other nursing staff when a patient is assessed as a very high falls risk.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2014.473</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Adverse medical effects</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Physical health</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>48 – cases closed between January and March 2016</td>
</tr>
</tbody>
</table>

Case summary

An adult male died due to diabetic ketoacidosis.

The adult presented to their doctor the day before their death. They were noted to be febrile with high temperature and blood pressure. The doctor formed the opinion that the adult was suffering from a urinary tract infection, and prescribed antibiotics. The adult presented for a pathology consultation and provided a urine sample the next day. A subsequent report indicated the presence of ketones and glucose in the urine. The adult was found deceased by family members later that day.

Coronial findings

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

The coroner found that earlier detection of the adult's elevated blood glucose level may have led to the earlier identification of the adult's evolving ketoacidosis and their management in a hospital setting.

Coronial recommendations

The coroner made the following recommendations related to this case:

- The Royal Australian College of General Practitioners provides a clinical update to GPs [general practitioners] to highlight the importance of recognising hyperglycaemia and ketosis in adult diabetic patients, as an uncommon but potentially serious complication of type 2 diabetes, or indication of newly recognised adult-onset type 1 diabetes.
- The Royal Australian College of General Practitioners advise GPs that although uncommon in adults and clinically subtle in its earliest states, evolving diabetic ketoacidosis may produce a dangerous metabolic decompensation and require escalation of care to a hospital setting for further assessment and management.

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Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2015.1575</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Aged care</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Older persons, Falls</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>48 – cases closed between January and March 2016</td>
</tr>
</tbody>
</table>

Case summary
An older adult male died due to head injuries sustained in a fall.

The adult was a resident at an aged care facility. The adult experienced multiple falls in the days leading up to their death. Following the second fall, the adult was transferred to hospital.

The adult underwent an urgent computed tomography (CT) scan, and was found to have sustained a serious head injury. They were palliated and subsequently passed away.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the notes made by the aged care facility staff were suboptimal.

The coroner was unable to determine whether earlier medical intervention would have prevented the adult’s death.

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

- I recommend that [aged care facility] conduct training to ensure their staff understand the importance of clear and consistent documentation in client and medical records.
Coronial recommendations: Fatal facts

Case number | VIC.2014.3411
Primary category | Transport and traffic related
Fatal facts edition | 48 – cases closed between January and March 2016

Case summary
A young male died due to a motor vehicle incident in which they were a motorcyclist.

The young person sustained fatal injuries when their motorcycle collided with a section of fencing. The young person was under the influence of illicit drugs at the time of the collision.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the area had ambiguous or unhelpful signage for persons unfamiliar to the area.

The coroner found that the adult’s relative inexperience as a motorcyclist, excessive speed and the effects of multiple illicit drugs contributed to the death.

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

- While I find that there were a number of factors that caused or contributed to this death, signage that indicates how to access the freeway, between the [petrol station] where [the deceased] re-fuelled, and the collision scene some 600 metres away, is unhelpful and/or ambiguous and could be improved in the interests of other road users, particularly those unfamiliar with the area. I therefore recommend that VicRoads, [council] and [tollway company] review the area and consider how signs pointing the way to the freeway could be improved.

- I further recommend that the [council], in consultation with VicRoads and [tollway company] as necessary, consider repositioning and/or increasing the number of chevrons displayed so as to adequately warn eastbound [street] road users of the sharp left-hand bend into [street].

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WESTERN AUSTRALIA

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>The coroner held a joint investigation into the following deaths which resulted from similar incidents: WA.2010.1033, WA.2011.343, WA.2012.1821</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Drugs and alcohol</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>48 – cases closed between January and March 2016</td>
</tr>
</tbody>
</table>

Case summary – WA.2010.1033

An adult male died due to multiple drug toxicity.

The adult had a history of anabolic steroid and analgesic abuse and developed benzodiazepine and opioid dependencies following an injury. They were a registered drug addict, but obtained multiple prescriptions from different doctors.

The adult was prescribed opioid medication for pain relief following a procedure. A few days later, adult was found unresponsive in their room having ingested a large quantity of the medication. Emergency services attended but the adult was unable to be revived.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult’s doctors would have been better able to prescribe in the adult’s interests had they had real time access to information about the prescription medication dispensed the adult. The coroner found that communication of the adult’s drug-seeking behaviours would have prevented their death.

Case summary – WA.2011.343

A young male died due to multiple drug toxicity.

The young person had a history of illicit and prescription drug abuse, and obtained medication prescriptions from different doctors.

The young person was prescribed methadone, which they took in combination with other medications. They were found unresponsive in their room and emergency services were contacted. The young person was conveyed to hospital where they passed away.

Coronial findings

The coroner found that the death was unintentional.
The coroner found that the adult manipulated doctors into prescribing large doses of medication.

Case summary – WA.2012.1821

An adult male died due to multiple drug toxicity.

The adult had a history of mental illness and drug abuse, including heroin addiction. They also abused prescription medication and were a registered drug addict.

The adult obtained multiple prescriptions for oxycodone on the day prior to their death. The next day, the adult went to sleep and their partner was unable to wake them. Emergency services attended, but were unable to revive the adult.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that information relating to the adult’s prescription misuse was not drawn to the attention of prescribing doctors in a timely manner, and was not readily accessible to the doctors that later treated the adult.

The coroner found that the combination of excessive prescription oxycodone and other sedating medication led to the adult’s death.

Coronial recommendations

The coroner made the following recommendations related to these cases:

Secure Database

- WA [Western Australia] prioritise the real time collection of dispensing data from all pharmacies for all Schedule 8 and reportable Schedule 4 poisons.
- All WA real time dispensed medicine data be held in a secure regulated database held by the WA government regulator.
- WA regulate to ensure the supply or dispensation of all Schedule 8 and reportable Schedule 4 poisons are recorded in the secure regulated database held by the WA Government regulator.
- WA regulate to provide both prescribers, registered pharmacists and authorised suppliers access to that secure data via secure software links to facilitate real time decision making around both prescribing, supplying and dispensing of Schedule 8 and reportable Schedule 4 poisons.
- The current Schedule 8 (controlled drug) dependency register be part of that secure database and provide that information along with real time information about medicines dispensed on enquiry by a prescriber, registered pharmacist or authorised supplier.
• The information from any register regulated (e.g. reportable Schedule 4 poisons) as part of the secure database, be similarly available on enquiry for dispensed medicines.

• Once real time WA dispensing data is available for use there be a regulated time period to allow commercial practice case management software to be developed to facilitate real time access. Once that period is over it be regulated that prescribers access the available data prior to completing any prescription or supply for Schedule 8 or reportable Schedule 4 poisons. The intention is to ensure those with drug seeking behaviour understand prescribers must comply with regulation to enable a prescription to be written.

**Benzodiazepines**

• All benzodiazepines be included as reportable Schedule 4 poisons.
• There be a method implemented to assist prescribers and dispensers with decision making around benzodiazepine dependency, and restrictions imposed on recognised unsafe prescribing or supply. How that is achieved is up to the regulator. Again the concern is not with policing but providing prescribers with a mechanism with which to decline to prescribe in the face of undue pressure from drug seekers.

**CPOP [Community Program for Opioid Pharmacotherapy]**

• CPOP prescribers be given information about a patient’s prior CPOP programs and prescribers when seeking authorisation to commence a new program.
• CPOP prescribers to provide advice when seeking authorisation as to other medications to be prescribed in conjunction with the authorised program medicine. This is to include reportable Schedule 4 poisons and amounts with intended reduction regime, if that is applicable.

**Australia Wide Dispensing Information**

• The ultimate aim for the secure regulated database held by the WA Government regulator be for all prescription medicines to be captured. If medication warrants a prescription, it warrants monitoring.
• The ultimate aim for real time ERRCD [electronic recording and reporting of controlled drugs] data should be for Australia wide access to dispensing data for medical practitioners, registered pharmacists and authorised suppliers.

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## APPENDIX A: FATAL FACTS WEB TOOL CATEGORY TAGS

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