Coronial recommendations: Fatal facts

A summary of cases and recommendations made between April and June 2016

Edition 49
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APPENDIX A: FATAL FACTS WEB TOOL CATEGORY TAGS 95
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 April and June 2016.

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.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>ACT.2009.15</th>
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</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Work related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>49 – cases closed between April and June 2016</td>
</tr>
</tbody>
</table>

Case summary
A middle aged male died when they were crushed by a component of the vehicle mounted loading crane they were operating at the time.

Coronial findings
The coroner found that the death was unintentional. The coroner found that the adult had no experience or training in the operation of a vehicle mounted loading crane. The companies employing the adult failed to properly train and supervise them in the operation of the crane, and while there were industry standards regarding training, no licence was required to operate a vehicle mounted loading crane with less than 10 tonne lifting capacity.

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

- I am aware that a great deal of work has been undertaken by Worksafe ACT in relation to the level of training that should be required before a person is permitted to operate a [vehicle mounted loading] crane such as the one that caused [the deceased]’s death, particularly in light of the fact that prior to his death an operator of a [vehicle mounted loading crane] with a lifting capacity of less than 10 tonnes was not required to hold an operator’s licence issued by an appropriate licensing authority. In view of the fact that the training provided to [the deceased] was clearly inadequate, it is my view, given the dangers posed to life and limb through the operation of [vehicle mounted loading cranes], that the assessment of an employee’s competency should not be left to employers but, instead, be assessed by an independent and qualified person.
- Accordingly I recommend that formal training and licensing be required for any operator of a [vehicle mounted loading crane] with a lifting capacity of less than 10 tonnes. I note that formal training and licensing is required for operators of such cranes with a lifting capacity above 10 tonnes.

This Fatal facts summary has been produced by the National Coronial Information System and is released with the approval of the relevant State or Chief Coroner.
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<thead>
<tr>
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<tr>
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</tr>
<tr>
<td>Fatal facts edition</td>
<td>49 – cases closed between April and June 2016</td>
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</tbody>
</table>

Case summary
An older male died while under anaesthetic for day surgery.

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

The coroner made the following comment:

No matter of public safety arises in relation to [the deceased]'s death. This inquest is one where a hearing was not necessary to determine the manner and cause or death or for any other purpose. Ordinarily I would have dispensed with a hearing. I was unable to do so in this case because the express terms of section 34A(2)(b) of the Coroners Act 1997 prevent me from doing so when a person dies under or as a result of the administration of an anaesthetic administered in the course of a medical, surgical or dental operation. At the time of [their] death [the deceased] was under anaesthetics for day surgery.

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

- As I have noted in a number of recent inquests the public resources utilised in the preparation for and holding of a hearing which is otherwise unnecessary could be better utilised elsewhere.
- I remain of the view that section 34A should be reviewed, and I reiterate my recommendation for such a review.

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<thead>
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<th>Case number</th>
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<tr>
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<tr>
<td>Additional categories</td>
<td>Drugs and alcohol, Older persons</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>49 – cases closed between April and June 2016</td>
</tr>
</tbody>
</table>

Case summary

An older male died as a result of airway obstruction associated with a high blood alcohol level.

The older person was a resident in a nursing home.

Coronial findings

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

The coroner was unable to determine how the older person acquired the blood alcohol level which ultimately caused their death.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That CCTV [closed-circuit television] or other methods be put in place in nursing homes so that residents can be continuously monitored for their safety.

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Coronial recommendations: Fatal facts

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<td>Additional categories</td>
<td>Older persons</td>
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<tr>
<td>Fatal facts edition</td>
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</table>

Case summary

An older female died during surgery to remove their teeth.

The older person suffered from throat cancer and could not undergo radiation therapy until their teeth were removed. They had undergone surgery the previous day, but the surgery was stopped due to complications.

Coronial findings

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

The coroner found that an anaesthetist was not present during the multi-disciplinary meeting prior to surgery, and there was little consultation with anaesthetists prior to the second surgery commencing. The coroner found that better consultation with an anaesthetist would have allowed for more careful consideration of the complications that may have arisen in relation to the dental extraction.

The coroner found that the adult was a medically vulnerable patient and was unable to determine whether they would have survived if a different surgical approach was taken.

Coronial recommendations

The coroner made the following recommendations related to this case:

- Firstly, I recommend that the [hospital] consider the need for earlier involvement of anaesthetic specialists in complicated cases so that a proper assessment of anaesthetic risk and appropriate anaesthetic procedure can be made.
- Secondly, by way of formalising this approach, consideration should be given as to the need for a separate anaesthetic consent form in complicated matters. This is likely to encourage a treating team to consider the implications of anaesthetic problems in relation to other treatment being considered. It would also allow patients to give proper regard to risks associated with anaesthesia.
• Thirdly, an appropriate system for the storage of records related to monitoring during anaesthetic processes would allow practitioners to assess a situation after the event in order to properly understand what has occurred with a view to reducing future risk.
• Finally, [the deceased’s family member] raised an issue in relation to the operation of quality assurance committees created pursuant to the Health Act 1993 (“the Health Act”). The creation and operation of such committees is a matter for government. Whilst, generally speaking, there has been a significant cooperation between such committees and the Coroner, I do note that a tension arises in the sense that quality assurance committees make findings which could be of value to the Coroner and which the Territory, in their submissions, assert are not required to be disclosed. I note that section 43 of the Health Act states that:
  o “A quality assurance committee may give protected information to the Coroner’s Court if the committee is satisfied that giving the information would be likely to facilitate the improvement of health services provided in the ACT”.
I note that protected information as defined includes sensitive information. I note that the way the section is drafted it appears, on the face of it, to be entirely at the discretion of the committee.
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>The coroner held a joint investigation into the following deaths which resulted from related incidents: NSW.2012.5394, NSW.2013.3536</th>
</tr>
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<tbody>
<tr>
<td>Primary category</td>
<td>Mental illness and health</td>
</tr>
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<td>Fatal facts edition</td>
<td>49 – cases closed between April and June 2016</td>
</tr>
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</table>

Case summary – NSW.2012.5394

An adult female died after being assaulted by their spouse.

Coronial findings

The coroner found that the death was due to assault.

The coroner found that there was no clear explanation for why the spouse acted in the manner that resulted in the death. The coroner found that there was no evidence of premeditation.

Case summary – NSW.2013.3536

An adult male took their own life by hanging while in prison.

They were in prison for fatally assaulting their spouse some weeks earlier. The adult had attempted suicide at the time of the fatal assault.

The adult was placed in the disability cell as it was the only available cell. They were not placed on suicide watch and were therefore not placed in a protection cell with eliminated hanging points. The closed circuit television (CCTV) footage of the cell was unavailable, as the recording disk had failed.

Coronial findings

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

The coroner found that once the adult was assessed as not being at immediate risk, their placement in the disability cell was reasonable in the circumstances.

The coroner was unable to determine why the CCTV recording disk had failed, but noted that it was of considerable concern that the failure went undetected.
Coronial recommendations

The coroner made the following recommendations related to these cases:

- I make the following recommendations to the Minister for Corrective Services and Minister for Health:
  - A review of the Mental Health Screening Unit be conducted to identify and, if reasonably practicable, remove hanging points and any other identifiable hazards to both staff and inmates.
  - An audit be carried out all CCTV equipment within the Mental Health Screening Unit area and a system of daily back-up of CCTV footage be installed.

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Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
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<tr>
<td>Primary category</td>
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</tr>
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<td>Fatal facts edition</td>
<td>49 – cases closed between April and June 2016</td>
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</table>

Case summary
A male person’s remains were recovered from the ocean.

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

The coroner was unable to determine the identity of the male, or the precise manner of the death.

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

- I recommend that the death of the unknown male person found in the water off [location] on [date] be referred to the Unsolved Homicide Unit of the NSW [New South Wales] Homicide Squad for further investigation in accordance with the protocols and procedures of the Unit.

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Coronial recommendations: Fatal facts

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<tr>
<th>Case number</th>
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<td>Fatal facts edition</td>
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</table>

Case summary

A middle aged male was discovered deceased on the banks of a river.

Coronial findings

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

The coroner found that the medical officer who conducted the autopsy was not suitably qualified. The coroner found that the autopsy and the related reports were seriously inadequate and gave limited information on which to provide an opinion.

At inquest, a forensic expert noted that the level of decomposition of the body required it to be referred to a forensic unit, which was not done. The forensic expert found that the condition of the body indicated that the adult had died some days before they were found. The forensic expert could not determine a cause of death.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that consideration be given to [medical officer] not being accredited as a Coronal Medical Officer to undertake any Post Mortem Examinations of any kind.

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Coronial recommendations: Fatal facts

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<tr>
<th>Case number</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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</table>

Case summary

An adult male died in a vehicle incident in which they were a driver. Their vehicle collided with a trailer being towed by a truck travelling in the opposite direction.

The truck was travelling around a sweeping bend when the trailer swung into the path of oncoming traffic and collided with the adult’s vehicle.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that there was no evidence that either the adult or the driver of the truck was driving recklessly, carelessly, or at an excessive speed at the time of the incident.

The driver of the truck was a probationary licence holder but was familiar with the road and had legal qualifications for driving the truck.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the Minister for Roads, Maritime and Freight

- In light of the findings in this inquest that inexperienced Medium Rigid licence holders may not have the capacity, training or experience to load trailers attached to their vehicles correctly and safely, I recommend that Transport for New South Wales refer to the Transport Logistics Industry Skills Council, in consultation with the Austroads Registration and Licensing Task Force, for review and consideration the following:
  - Whether the content of the competency-based training and assessment regime for MR licences is adequate; and
  - Whether competence in loading and towing trailers should be included in the training and assessment regime.
- I also recommend that Transport for New South Wales consider whether P2 Medium Rigid licence holders ought be permitted to tow trailers behind Medium Rigid heavy vehicles.
If this recommendation raises issues of national consistency, I further recommend that Transport for New South Wales raise this question (with reference to the coronial findings of fact in this inquest) with Austroads Registration and Licensing Taskforce for its consideration.
Coronial recommendations: Fatal facts

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<tr>
<th>Case number</th>
<th>NSW.2014.1131</th>
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<tbody>
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<td>Fatal facts edition</td>
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Case summary
An adult male drowned in a storm drain in the course of their employment.

The adult was attempting to clear the drain of debris during a flash flood in waist deep water. They were sucked into the drain and were unable to be freed due to the rising water levels.

Coronial findings
The coroner found that the death was unintentional.

The coroner noted that the adult’s company had policies in place for employees not to enter water deeper than ‘gumboot height’, and that employees should take shelter during severe storms (Code brown). The coroner found that the adult did not comply with either of these policies.

The coroner found that there was also a policy in place to prevent the water running off green waste (leachate) produced at the site from overflowing, which on the day of the incident conflicted with the other policies. The coroner found that the adult chose the policy with the greatest benefit to the company.

The coroner found that whether the risk of these conflicting policies was theoretically foreseeable or not, it was not foreseen and not guarded against.

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

I make the following recommendations to [company]:

- That [company] engage an independent expert in fluid dynamics to inspect and assess its organic waste recycling facilities, and any other sites from which it large volumes of water may need to be drained, to report on any serious potential or latent risks of the type that developed at the [site] on [date] during severe storm conditions.
• That [company] develop with all reasonable speed a specific plan for dealing with the problem of the rapid build-up of leachate fluids in extreme storms if the drainage system becomes blocked or overwhelmed by the volumes of stormwater, bearing in mind the well-reported scientific evidence and opinions that climate change is real and will, over time, lead to increasing frequency and severity of storms.
• That [company] review all Environmental Quality and Safety (EQS) policies to eliminate latent conflicts between policies that apply in severe weather conditions.
• That [company] EQS management consider how collective mindfulness of serious risk (as described by [industrial psychologist] in the reasons for decision above) can be promoted and encouraged within its corporate safety culture and workplace safety training programs and procedures. In particular, I recommend that [company] consider instituting a water safety risk mindfulness training program including the showing of appropriate videos or other visual demonstrations of such risks for EQS staff and workers potentially exposed to water safety risk.
• That [company] clarify the Emergency Response Plan to ensure that there is always a person on each [company] site delegated the authority to call a ‘Code Brown’ in relevant circumstances.

I request that [company] provide its response to these recommendations within six months of the date of these findings and recommendations.
Coronial recommendations: Fatal facts

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

A middle aged female died during cardiac surgery when a surgical wire became stuck in their mechanical heart valve.

The adult had a long history of heart problems and had the mechanical heart valve inserted many years prior to their death. The surgery was being conducted to identify the cause of their heart problems. The surgical wire became stuck in the mechanical valve, causing it to close. Surgeons were unable to remove the wire and the adult suffered a cardiac arrest.

Coronial findings

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

The coroner found that the overall procedure was appropriate and necessary to identify the cause of the adult’s heart problems.

The coroner found that the procedure of passing the surgical wire past the mechanical heart valve was not necessary, as it was not a life-threatening situation and alternatives were available.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the Director, Medical Services, [hospital]:

- I recommend that consideration be given to having an appropriately qualified medical practitioner prepare a summary of, or article about, [the deceased]’s case for submission to an appropriate medical journal and/or circulation to other cardiology departments in NSW [New South Wales] hospitals, contingent upon [the deceased]’s name not being published.

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NORTHERN TERRITORY

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

**Case number**  
NT.2014.122

**Primary category**  
Intentional self-harm

**Additional categories**  
Mental illness and health, Youth

**Fatal facts edition**  
49 – cases closed between April and June 2016

**Case summary**

A young female took their own life by hanging. They were under the care of the Department of Children and Families (DCF) at the time of their death.

The young person had a significant history of mental ill health and suicide attempts. They were frequently non-compliant with psychological treatment, schooling and employment opportunities facilitated by DCF.

**Coronial findings**

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

The coroner found that there were several errors on behalf of DCF in relation to the young person’s management, but despite this, the errors did not necessarily cause or contribute to the death.

The coroner found that while many individuals were attempting to provide for the young person’s needs, there were no regular meetings or sharing of information between them to ensure that the knowledge they each possessed was known to all.

The coroner made the following comments:

_I note too that the Department of Health (DOH) has undertaken its own review with the assistance of [psychiatrist]’s analysis and are considering the eight (8) recommendations that have been made by [psychiatrist] as a result of [the deceased]’s death. I note the evidence given by [Director of Psychiatry], [location] Mental Health Service that a Draft Action Plan is presently being refined by [location] Mental Health Service for approval by the Chief Operating Officer of [location] Mental Health Service. I recommend the DOH to consider the recommendations that have been made by [psychiatrist] with a view to their implementation as soon as possible in accordance with any Action Plan finalised by [location] Mental Health Service. I annex a copy of [psychiatrist]’s recommendations in this regard._
It is also important that the Draft Action Plan referred to by [psychiatrist] be finalised as quickly as possible and submitted for approval as soon as possible in order to begin the process to effect the recommended changes. Although I do not intend to make a formal recommendation to this effect, I would strongly encourage the Minister for Health to ensure that the DOH is sufficiently resourced to implement such recommendations should they be deemed appropriate by [location] Mental Health Service within any finalised Action Plan. I consider that [location] Mental Health Service are the most appropriate service to determine whether such recommendations by [psychiatrist] are appropriate in the context of the mental health system within which they operate.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Minister for Children and Families direct all case managers provide formal written confirmation of any and all information exchanged between case managers at the time of handover of any case relating to a child in the care of the Chief Executive Officer pursuant to any order under the Care and Protection of Children Act.
- That the Minister of Health favourably consider the outcomes described in paragraphs [above].
Coronial recommendations: Fatal facts

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<tr>
<th>Case number</th>
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Case summary

A young male was electrocuted in the course of their employment.

The young person worked on a fishing trawler and was angle grinding while out at sea. They were not wearing appropriate personal protective equipment. A large wave washed over the deck and the young person, causing them to be electrocuted.

The vessel was many hours from the nearest port and did not have a defibrillator or an EpiPen on board. The crew were unable to resuscitate the young person with manual cardiopulmonary resuscitation.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the general purpose socket on the deck that the grinder was plugged into was not protected by a safety switch.

The coroner found that the company that owned the trawler did not follow their own Safety Management System in relation to the use of angle grinders on board. The coroner found that they also failed to use the risk controls identified in legislation.

The coroner noted that a death had occurred some years prior in similar circumstances. The coroner found that the death of the young person would have been prevented had the recommendations regarding the similar death been followed.

The coroner found that it was likely that personal protective equipment was not routinely worn while working and that the young person was not appropriately trained in the use of electrical equipment on board and was not appropriately supervised at the time of the incident.

Overall, the coroner found that the trawler failed to provide a safe workplace and that there was a failure of the regulators to ensure compliance with the legislation.
Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that both Marine Safety authorities and the Work Health and Safety authorities revisit the recommendations of the Western Australian Coroner with a view to ensuring that persons conducting a business or undertaking on Domestic Commercial Vessels well understand the law and their duties to their employees and others.
- I recommend that those same authorities conduct inspections of Domestic Commercial Vessels (and require certificates from electricians where necessary) to ensure compliance with the requirements of Work Health and Safety duties and legislation.
- I have no doubt that unless that is done, there will be more needless and preventable deaths of young men and women on Domestic Commercial Vessels.
- I recommend that the Australian Maritime Safety Authority (AMSA) take the lead in ensuring that the legal requirements and duties of the workplace are communicated through the mechanisms of marine safety and in particular the message that Domestic Commercial Vessels are workplaces and require all general purpose outlets to be protected by residual current devices.
- I understand that AMSA have employed an Electrical Engineer and are looking to ways to communicate with the industry and improve industry compliance.
- I believe that offences may have been committed in connection with the death of [the deceased] and in accordance with section 35(3) I report my belief to the Commissioner of Police and the Director of Public Prosecutions.
- I also refer the matter to NT [Northern Territory] WorkSafe for their further and better consideration.
Coronial recommendations: Fatal facts

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<th>Case number</th>
<th>NT.2014.129</th>
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Case summary

A middle aged male was fatally struck by a falling tree branch on a golf course. The golf course leased the land off the council, and responsibility for tree maintenance was unclear.

Coronial findings

The coroner found that the death was unintentional. Both the golf course and the council were aware of the dangers posed by the species of tree, and as a result the maintenance arrangements for the trees were inadequate.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That there be compulsory inspection of all trees on property owned by [council] at least every six (6) months.
- That such compulsory inspection is conducted by qualified arborists.
- That [council] conduct an audit of all current leases and ensure inclusion within their terms for:
  - the compulsory inspection of all trees on such property/ies at least every six (6) months;
  - such compulsory inspections to be conducted by a qualified arborist;
  - specific provision as to who bears responsibility for the costs of such inspections and/or any works recommended to be carried out as a result of the same.
- That [council] ensure all future leases include within their terms:
  - the compulsory inspection of all trees on such property/ies at least every six (6) months;
  - such compulsory inspections to be conducted by a qualified arborist;
  - specific provision as to who bears responsibility for the costs of such inspections and/or any works recommended to be carried out as a result of the same.

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QUEENSLAND

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

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<th>Case number</th>
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<td>Intentional self-harm</td>
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<td>Additional categories</td>
<td>Older persons, Fire related, Aged care</td>
</tr>
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Case summary

An older male died as a result of burns.

The adult was a resident in a nursing home. They were taken to the facility's smoking room to have a cigarette and were discovered alight a short time later. They were taken to hospital and died that night.

The adult had a recent medical history of cancer and their overall health and wellbeing had deteriorated significantly following surgical interventions.

Coronial findings

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

The coroner found that the care provided by the nursing home was appropriate. The coroner noted that the nursing home had made changes since the adult’s death surrounding risk assessments of residents who smoke.

Coronial recommendations

The coroner made the following recommendations related to this case:

- In light of the research referred to in relation to physical diseases as predictors of suicide in older adults, and the evidence of [the deceased’s oncologist] that this is a real psychosocial issue which needs resources to address the issue, I recommend that the Queensland Department of Health, in partnership with the aged care sector and the general practitioner sector, implement routine screening and assessment for elderly persons diagnosed with and/or undergoing treatment for significant physical conditions, together with screening for depression (given the correlation between the two).
- I further recommend that the Queensland Police Service [QPS], Queensland Fire and Emergency Service and Workplace Health and Safety Queensland collaboratively review their involvement in this matter and identify the most practical and efficient means for ensuring that, in future, when the agencies are concurrently investigating a death or serious injury involving a fire, that the roles and responsibilities of each agency to inform
each other’s recommendations and to properly advise and put all relevant evidence before the investigating coroner, are clearly defined and appropriately carried out. This may include entering into a Memorandum of Understanding and/or implementing current initiatives being the Reducing Unlawful Fires (Including Arson) Investment Proposal and QPS Reducing Unlawful Fires Initiative Proposal.
Coronial recommendations: Fatal facts

Case number
QLD.2013.2617

Primary category
Work related

Additional categories
Water related

Fatal facts edition
49 – cases closed between April and June 2016

Case summary
An adult male drowned in the ocean in the course of their employment.

The adult was employed in the fishing industry. They were fishing alone from a small satellite boat. The boat capsized and the adult was discovered drowned shortly afterwards.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that it was likely the adult’s boat capsized due to a stuck anchor, and the application of power the adult used to free the boat. The coroner found that it was likely the adult struggled in the water in wet weather gear and became entangled in fishing line, and they were unable to stay afloat.

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

- Australian Marine Safety Authority (AMSA) formally review the need to mandate the wearing of Personal Floatation Devices, particularly in operations of this nature where dory operators are working alone in offshore conditions (a copy of the review to be provided to Coroners Court of Qld).
- AMSA consider using the circumstances of this tragic incident in Safety Management System workshops with this industry to develop safe working procedures through the application of the risk management process. The developed procedures to be shared with other operators and owners as examples of what might be appropriate for implementation within their operation.
- AMSA continue with the development and implementation of the new restricted Class C fishing vessel standard to cover fishing operations like live coral trout fishing from dorries;
- AMSA require vessels formerly grandfathered to standards applicable at the start of the National Law and to which this new standard would otherwise apply, to comply at the end of a transition period no greater than 2 years.
AMSA establish a standard for an effective safety management system, audit a sufficient sample of the fishing sector to establish a base level for the number of compliant operations, establish a realistic target for improvement to be achieved by a specified date, the means by which it is to be achieved, periodic reviews to assess progress and a final review on the due date.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>QLD.2015.798</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Water related</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Child and infant death, Law enforcement</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>49 – cases closed between April and June 2016</td>
</tr>
</tbody>
</table>

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

The child was at a neighbouring property when they gained access to the swimming pool area unnoticed. The entrance gate to the pool had been propped open in order to allow the children easy access to the pool whilst they were being supervised. The gate was not secured when the children had finished swimming.

The child was unable to swim independently and required supervision at all times.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the neighbours had previously been informed of the child’s inability to swim.

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

- It is recommended that the issue of creating a new offence where serious injury or death occurs in circumstances where there have been intentional or negligent breaches of pool safety laws be reconsidered by the responsible State Government Minister in the context of the facts arising from these cases as well as the support for the implementation of such additional offences by other coronial jurisdictions.
- Queensland Police Service review their Operational Procedures Manual Chapter 8.5.11 regarding the investigation of swimming pool deaths to ensure all possible aspects of swimming pool compliance and safety are included in the investigation.

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.
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.2012.481</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Homicide and assault</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Child and infant death, Law enforcement</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>49 – cases closed between April and June 2016</td>
</tr>
</tbody>
</table>

Case summary

A male infant died due to head injuries inflicted by their parent.

The infant’s parents both had dealings with child protection services from a very young age.

Coronial findings

The coroner found that the death was due to assault.

The coroner found that the infant had been subjected to abuse for most probably the entirety of their life by one or more of the caregivers living in the family home. During the infant’s life, they and their parents were seen by child protection services workers, child health and parenting service nurses, extended care midwives, integrated family support workers and a general practitioner.

The coroner found that failure to protect the infant fell mainly on child protection services, where they had the power to remove the infant from the parents at birth after reports during antenatal care from nurses described drug use. The coroner found that deficiencies on behalf of the community-based intake service and police also failed to protect the infant.

Coronial recommendations

The coroner made the following recommendations related to this case:

*Child Protection Services, [community-based intake service] and [support service]*

- That Child Protection Services (CPS) implement a comprehensive training regime for all its workers in the application of the Tasmanian Risk Framework (TRF), CPS Practice Manual and Specialist Guides, and that the training be regularly updated to maintain the integrity of the risk assessment process and current learning in the field.
- That CPS implement a comprehensive independent review of the functionality and usage of Child Protection Information System (CPIS) including but not limited to: the capacity of CPIS to aid CPS in meeting its statutory and organisational responsibilities; barriers to CPIS usage-including workplace culture and worker confidence in using the system, the
adequacy of staff knowledge and training in CPIS, and; the quality of CPIS cases notes, recording of decision-making processes, and use of CPIS for related searches.

- That CPS implement an audit and quality assurance system to determine whether the TRF is being routinely and correctly used, that CPIS searches are being routinely and correctly conducted and that risk assessments based upon the TRF accord with the statutory responsibilities of CPS and the CPS Practice Manual.

- That CPS implement an audit system in respect of unborn baby notifications for the state to determine whether such notifications are being investigated and actioned properly and in a timely manner and consistent with the Act and CPS Practice Manual.

- That CPS, with the support of Department of Health and Human Services (DHHS), develop child protection liaison officer positions in the [areas] of the state, the key duties of the roles to include but not limited to:
  o Provision of consultation and assistance to hospital staff in relation to the full range of child protection matters across antenatal, neonatal and paediatric services.
  o Facilitation of positive and effective working relationships between the relevant hospitals, CPS, [community-based intake service], [support service] and government agencies in respect of child protection issues.
  o Management of the unborn baby alert process across the hospitals and CPS, including the coordination of multidisciplinary case conferencing involving social work staff across the maternity and neonatal and paediatric intensive care units.

- That in respect of infants under six months of age where the subject of a notification involves bruising, CPS arranges an examination of the infant and review of the circumstances by a paediatrician or other suitably qualified medical practitioner as soon as practicable for the purpose of assisting in the determination of whether the bruising is non-accidental in origin.

- That CPS provide all notifiers with an electronic receipt for all notifications, including email and telephone notifications.

- That CPS continuously reviews the working and constitution of the Three and Under Panel to ensure that it remains effective in its role.

- That where a notification has been referred by CPS to [community-based intake service], CPS ensures that [community-based intake service] is provided with a copy of the completed TRF relating to the notification, and that [community-based intake service], in turn, provides that document to any [support service] organisations tasked to work with the families.

- That, as a matter of priority, DHHS implement a formal review of the functions and working of the CBIS system, with focus upon;
  o The capacity of a Community Based Intake Service (CBIS) to effectively manage referrals from CPS in accordance with the Act;
  o The statutory, procedural, organisational and cultural environment in which referrals from CPS take place; and
The timeframe for appropriate risk assessments; the adequacy, enhancement and access to the Common Assessment (CAF) Framework tool as a risk assessment tool; the standard of completion of the CAF tool required from CPS; implementation of home visits and personal meetings with the family in nominated higher risk cases; the optimal procedures for comprehensive provision, sharing and disclosure of documents between organisations; intake, case management and case closure procedures; and ongoing quality assurance.

- That CPS, [community-based intake service] and [support service] implement regular training for their workers as appropriate to the functions of their organisation in the following:
  - The rarity and significance of bruising on an infant not yet mobile, and associated reporting requirements;
  - The risk factors for family violence, the detection of family violence and the impact of a family violence history upon the ability to be protective towards a child;
  - The possible risk factors posed to a child by the use of cannabis, and the need for a thorough investigation into the extent and effect of that use; and
  - Effective, robust questioning of parents or those with whom a child is living in order to properly assess critical factual matters regarding risk to a child.

- That CPS, [community-based intake service] and [support service] implement joint training for its workers in risk assessment in respect of children, including but not limited to the operation of the Child Protection Manual and TRF as appropriate, the CAF (or any replacement) and the matters referred to in the previous recommendation so as to ensure consistency in knowledge and approach to risk assessment between organisations.

- That the government considers amendments to the Children, Young Persons and Their Families Act 1997 to provide for increased powers of the Secretary where the Secretary knows or suspects on reasonable grounds that a child is at risk as a result of drug abuse by a parent, guardian or other person, and the cause of the child being at risk is not being adequately addressed; such powers including orders to ensure that the parent, guardian or other person undergoes appropriate treatment for drug abuse; and to ensure that the parent, guardian or other person submits to periodic testing for drug abuse.

- That the CPS Redesign Reference Group and those responsible for developing the Vulnerable Infant Strategy incorporate these recommendations, where appropriate, into the respective strategies with a view to their implementation in a staged and monitored setting.

- That the government consider strengthening protocols between agencies, utilising the Safe Families Coordination Unit if appropriate, to identify at an early stage high risk perpetrators of family violence who may also perpetrate child abuse.
Tasmania Police

- That Tasmania Police identify whether there is a need across all police officers, or any group of police officers, to provide training and education regarding reports of child abuse or neglect, including:
  - The making of electronic referrals to CPS from the IDM [information data management] system or other system used by police officers;
  - The requirements for reporting to CPS under the Police Manual and/or Memorandum Of Understanding (MOU);
  - The requirements for mandatory reporting under the *Children, Young Persons and Their Families Act 1997*; and
  - The prioritising of the investigation of such reports by an allocated investigating officer.

- That, if such need is identified, Tasmania Police implement training and education programs as required in those areas identified, and maintain training and education programs upon a sufficiently regular basis to ensure that police officers are able to respond efficiently and effectively to reports of child abuse or neglect.

- That Tasmania Police review the role of the Crime Management Unit (CMU) in vetting information reports regarding child abuse and neglect and the creation of electronic CFS referrals, with a view to enhancing and standardising their role across the state; and, if necessary, create guidelines for CMUs in respect of their role and the processes to be followed.
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.2014.54, TAS.2015.301</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Transport and traffic related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>49 – cases closed between April and June 2016</td>
</tr>
</tbody>
</table>

Case summary

An adult male and an adult female died as a result of a single vehicle crash. The male died at the scene. The female was taken to hospital with severe head injuries, remained in a clinically vegetative state and died some months later.

The male was driving at the time of the crash and the female was a passenger.

Coronial findings

The coroner found that the deaths were unintentional.

The coroner found that it was likely the driver had fallen asleep at the wheel.

Coronial recommendations

The coroner made the following recommendations related to these cases:

- I recommend that the Department of State Growth consider the feasibility and merits of implementing further strategies into the driver licence testing system with the aim of educating new drivers as to the major causes of fatalities and serious crashes, and their prevention.

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

<table>
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<tr>
<th>Case number</th>
<th>The coroner held a joint investigation into the following deaths which resulted from the same incident: TAS.2014.284, TAS.2014.285</th>
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<td>Transport and traffic related</td>
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<tr>
<td>Fatal facts edition</td>
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</table>

Case summary

A middle aged male and an older female died in a vehicle incident.

The driver was distracted by their mobile phone at the time of the collision. They veered off the road, and lost control of the vehicle while attempting to correct their path. The vehicle slid into oncoming traffic and collided with an oncoming truck.

The male was the driver of the vehicle and the female was a passenger.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the vehicle veering off the road was most likely due to the driver being distracted by an incoming call.

The coroner found that the driver of the truck was driving in an appropriate manner and did everything possible to avoid the collision.

Coronial recommendations

The coroner made the following recommendations related to these cases:

- I recommend the Road Safety Advisory Council and Tasmania Police maintain their public awareness campaign as to the risks associated with mobile phone use, that ongoing attention be given to detecting those who infringe and that if necessary consideration be given to the level of penalty applicable to such offences.

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 middle aged female died due to mixed drug toxicity.

The adult suffered from a back injury that resulted physical limitations, chronic pain and multiple surgeries. The adult’s family observed that they were suffering from increasing depressive symptoms and alcohol and prescription drug misuse. The adult had also been admitted to numerous substance abuse programs.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult was known by medical practitioners to abuse prescribed medications, taking more than the prescribed amount, requesting specific medications and requesting medications at increased quantities.

The coroner found that the adult’s doctor was ill-equipped to manage the numerous conditions that their patient had. The doctor failed to comply with the mandatory conditions of prescribing. In addition, the coroner found that the doctor had failed to conduct a risk evaluation and take steps to mitigate risks, knowing that the adult had a substance abuse problem.

Coronial recommendations

The coroner made the following recommendations related to this case:

• That Government and medical professional bodies ensure that prescribers are aware that the current scientific knowledge indicates:
  o There are significant risks of adverse events with chronic opioid therapy, and where opioids are used in combination with other drugs. Those risks include but are not limited to sedation, serotonin syndrome, cardiac arrhythmia and death;
  o Opioids have a limited role in treating chronic non-cancer pain (CNCP) with little evidence of long term benefit. Tolerance to opioids and opioid induced hyperalgesia further complicate the use of opioids in CNCP;
Central sensitisation and tolerance can occur within 4 weeks;
Different pain types/mechanisms exist (nociceptive, neuropathic, neuroplastic, central sensitisation) requiring assessment and management tailored to the individual patient’s circumstances and specific diagnosis;
The risk of chemical coping and abuse, misuse and addiction is significant;
Comorbid conditions e.g. anxiety and depression, complicate patient management with the use of opioid medication;
The known risks of opioid use and limited benefits provided in CNCP mandates a risk-benefit approach to prescribing opioids in CNCP.

- Primary prescribers be provided with available support options when treating patients with CNCP including:
  - A coordinated and integrated pain management system providing formal and informal pain management options, advice and support from pain management and addiction medicine specialists;
  - The availability of multi-discipline support to deal with the multi-dimensional aspects of chronic pain: e.g. psychologists, physiotherapists, nurses, occupational therapists;
  - Allowing within the Medicare costing structure of a general practitioner visit, appropriate recognition of the extra time needed to deal with a complaint of CNCP, which allows the treater to deal with the complete picture rather than focussing upon the symptom of pain as a number alone;
  - Consideration of a funding model (similar to community mental health plans) to provide multi-discipline support for CNCP;
  - Professional development in regard to developing skills to deal with demanding, aggressive and chemical coping patients. Also a process to allow referral of such patients to a prescriber or specialists who has those skills if required.

- Prescribers and patients are informed that opioid pharmacotherapy cannot be considered to be the core component of the management of CNCP and the passive receipt of opioid therapy is a distraction from the need to address the multi-factorial concept of chronic pain.

- In implementing the White Paper recommendations for State-wide pain management services an early determination is made as to the required qualification, experience and competence required of a medical practitioner to satisfy the criteria of “specialist medical practitioner with sub speciality training in pain management”.

- Any co-ordinated model for pain management developed during the White Paper implementation ensures that the Alcohol and Drugs Service is structured so as to be able to provide clinical guidance and assistance in respect to addiction issues to hospitals, Persistent Pain Service (PPS), primary prescribers and the Pharmaceutical Services Branch (PSB).

- That there be a continuation of the required funding for the employment of pain management and addiction specialists and that consideration be given to providing the
required clinical support by use of suitably qualified medical or nurse practitioners to fill the current and projected need.

• Government assist medical professional bodies in efforts to educate the general community as to the current state of scientific knowledge highlighting the limited role and benefits of opioid medication in cases of CNCP and the concurrent risks of long term use of opioid medication for CNCP. That such community awareness also highlights the benefits of a multi-disciplinary approach to CNCP.

• Medical professional bodies highlight to their members the dangers associated with poly-pharmacy. In particular prescribers must ensure that medication is prescribed appropriately, both individually and in the context of the patient’s total medication exposure so as to protect against drug interactions. Action by way of regular review of a patient’s medication regime is required to ensure prescribing is appropriate and it remains appropriate and safe.

• The PSB 2009 Protocol for Opioid Prescribing be revised in light of and in order to reflect the current state of scientific knowledge concerning the prescribing of opioid medication in general and in particular with respect to CNCP.

• In order to address the continued inappropriate prescribing of opioid medication in respect of CNCP, consideration be given to:
  o Limiting (after a specified period) such prescribing only to those patients who have engaged with a form of multi-disciplinary pain management program where pharmacotherapy is but a component of that process;
  o Limiting such prescribing to prescribers who have access to and use Drugs and Poisons Information System Online Remote Access (DORA) in those circumstances and that dispensers use DAPIS [Drugs and Poisons Information System] and DORA;
  o Removing the prescribing rights of opioid medication from those prescribers shown to have prescribed other than in accordance with accepted scientifically based clinical practice or alternatively limit the authority to prescribe, in those circumstances, to those who have endorsed that recommended clinical practice and undertake to comply with it;
  o Provide additional resources for increased staff at PSB so as to allow oversight of the prescribing of opioid and other targeted medication so as to identify prescribing that is not in conformity with safe medical practice;
  o Develop a protocol that allows assessment of those incidents of prescribing apparently not in conformity with safe medical practice and to allow intervention in such cases either informally or formally by way of prescribing right restrictions or professional disciplinary action. Such protocol would need to be developed in association with the Ombudsman in order that issues as to patients’ rights could be addressed.

• That the Government work with the appropriate medical and allied health specialists to implement the recommendations outlined at pages 82 -106 in the National Drug and
That future coronial investigations relating to “combined drug toxicity” not be limited to a consideration of whether the ingestion of those drugs (in particular prescriptions drugs) was done with intent to self-harm; with the alternative that any overdose was accidental. Focusing upon the overdose itself does not permit a clear determination of the underlying issues and identification of direct, contributory or systemic causes of the death. The coronial investigation should consider:

- Whether the prescribing of the medication was appropriate and safe;
- Whether proper consideration was given to the adverse effects of individual drugs, any possible cumulative effect from multi-drug use, or the adverse effects due to medication/medication interactions;
- Whether the fatal outcome, given the history of the patient, the nature and effects of the medication upon the patient, the physical and psychological condition of the patient, was in fact likely and avoidable if that medication regime had been objectively assessed against likely risk versus the efficacy of the poly-pharmacy.

Government and medical professional bodies objectively assess the efficacy of Quetiapine when used “off label” rather than for its formal approved use with Schizophrenia and Bipolar Disorder (and associated mania/depressive episodes). Limited evidence exists as to its effectiveness when used “off label” and there has been a startling increase in its involvement in fatal overdoses and illicit use. The social benefits of widespread use of this drug need to be assessed against the increased rates of misuse and illicit use. Noting the resourcing issue that this creates it is further recommended that in the interim Quetiapine and benzodiazepines, “z drugs” and “gaba drugs” such as gabapentin be made reportable drugs that require authority under section 59E for prescribing in circumstances where the patient has been reported or diagnosed as drug dependant or drug seeking/coping.

The application for authority to prescribe opioid medication (Poisons Act 1971) which is currently under revision needs to be completed and introduced for use without delay. Any required resources for that task must be provided as this process has the potential to modify the prescribing habits of primary prescribers and to increase the understanding and appreciation upon this topic by the patient.

Consideration is given as to standardisation of the various terms and phrases used in relation to reporting the misuse of prescribed medication. I am advised there is evidence of inconsistency in definitions related to substance use over time between countries, medical organisations, clinicians, legislation and lawyers. Many terms such as addiction, substance abuse, substance dependence and dependence are often used interchangeably. This uncertainty and lack of precision may not only confuse health professionals and lead to an imprecise clinical picture on a patient but it also hinders the collection, correlation and analysis of data on this topic which negatively impacts upon research findings.
In order to achieve a consistent safe and effective clinical use of opioids the key challenge is to translate current, very clear scientific knowledge and recommendations into clinical practice. I encourage the continuation and expansion of endeavours to date in order that the approach incorporates:

- Education and knowledge needs of all prescribers in particular addressing the knowledge/practice gap;
- Reinforcing to all prescribers the need to adhere to recognised Uniform Precautions in prescribing (Gourlay et al, Universal Precautions in Pain Management, Pain Med 2005;6(2):113);
- Adherence to the guidance on opioid prescribing provided in the Review of Opioid Prescribing in Tasmania: A Blueprint for the Future 2012 at p58 and following;
- Support mechanisms available to prescribers who require such assistance, e.g. expert advice and support from specialists in pain medicine and addiction medicine;
- State-wide equity of access to multi-disciplinary care for the clinical needs of patients; and
- The creation of an environment that encourages and supports, and where necessary mandates and enforces, safe and effective clinical practice through regulatory or legislative means.

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>
<th>TAS.2014.8</th>
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<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>49 – cases closed between April and June 2016</td>
</tr>
</tbody>
</table>

Case summary
An older adult female died due to cardiac issues.
The adult had previously been diagnosed with moderate aortic stenosis.

Coronial findings
The coroner found that the death was due to complications of medical or surgical care.
The coroner found that the seriousness of the adult’s condition was not recognised and acted upon at the time of diagnosis or at other points of care with medical practitioners who reviewed previous clinical notes regarding the condition.

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

- That the State’s health authority gives consideration to adopting a practice whereby all patients diagnosed with moderate to severe aortic stenosis are referred to the cardiology unit at the [hospital] for an annual review of their condition.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>TAS.2014.286</th>
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<td>Adverse medical effects</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>49 – cases closed between April and June 2016</td>
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</table>

Case summary

An older adult male died due to a stroke.

The adult had been admitted to hospital and was fitted with a central venous catheter. Following a surgery, the catheter was removed, and the adult suffered an air embolism. The adult did not regain consciousness and later passed away.

Coronial findings

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

The coroner found that the nurse removing the catheter did not apply an appropriate dressing after the removal. The dressing applied was not air occlusive which resulted in air being able to enter the wound, causing the embolus.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the [hospital] ensure that at all times air occlusive dressings are used following the removal of central venous access devices.

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Coronial recommendations: Fatal facts

<table>
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<tr>
<th>Case number</th>
<th>TAS.2014.287</th>
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<tr>
<td>Primary category</td>
<td>Drugs and alcohol</td>
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<tr>
<td>Fatal facts edition</td>
<td>49 – cases closed between April and June 2016</td>
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</table>

Case summary
An adult female died due to alcohol and mixed drug toxicity.

The adult suffered from depression, anxiety and alcohol addiction. They had been prescribed several anti-anxiety and anti-depressive medications by their general practitioner.

Coronial findings
The coroner found that the death was unintentional.

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

- That medical practitioners prescribing such medication ensure that the dangers of mixing alcohol, especially alcohol taken in excess with such medication are fully explained and emphasised to the patient.

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

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<tr>
<th>Case number</th>
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<tr>
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<td>Water related</td>
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<td>Additional categories</td>
<td>Leisure activity</td>
</tr>
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<td>Fatal facts edition</td>
<td>49 – cases closed between April and June 2016</td>
</tr>
</tbody>
</table>

Case summary

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

The adult was fishing when the boat they were in capsized due to being struck by consecutive waves.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult was an experienced boater and was wearing a personal flotation device (PFD) at the time of the incident. However, the life jacket was in disrepair, had not been serviced. As a result, the life jacket failed to right the wearer and to keep the wearer’s head out of the water when they were forward facing in the water. Due to the life jacket’s age, it no longer complied with Australian standards.

Coronial recommendations

The coroner made the following recommendations related to this case:

- No person should wear a Personal Floatation Device (PFD) that does not comply with AS [Australian Standard] 4758.1.
- All inflatable PFDs must be serviced in accordance with manufacturer’s recommendations.

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

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

Case number | VIC.2008.4523
Primary category | Work related
Fatal facts edition | 49 – cases closed between April and June 2016

Case summary
A middle aged male died due to crush injuries sustained in a workplace incident.
The adult was using a crane to unload a semi trailer at a work site when the crane truck tipped over, causing the adult’s fatal injuries.

Coronial findings
The coroner found that the death was unintentional.
The coroner found that the adult had not fully extended one of the safety legs of the crane as per the manufacturer’s instructions.
In addition, the coroner found that the use of the crane to unload the semi trailer was inappropriate, that there was no appropriately trained spotter present to assist the adult, and that the adult was not appropriately trained or licenced to be operating the crane truck.

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

• That [company] implement a policy that two employees be assigned for work where the use of the crane truck is anticipated, or alternatively that a suitably trained 'spotter' always be available to assist on site.
• That [manufacturer] include in the Use and Maintenance manual 170A.22 a recommendation that a spotter should always be available to the operator of the crane.
• That WorkSafe issue Safety Alerts on a regular and periodic basis, and not only in response to a fatality; on the dangers of operating hydraulic cranes, including recommendations that a spotter always be available.
• That the Minister for Finance, who is also responsible for WorkSafe, [name], consider the need for the Parliament of Victoria to expressly incorporate the requirement of appropriate staffing, or availability of a spotter, to section 27 of the Occupational Health and Safety Act 2004, which requires that 'a person who designs plant who knows ... that the plant... is to be used at a workplace must' inter alia 'give adequate information to each person to whom the designer gives the design... concerning... any conditions
necessary to ensure the plant... is safe and without risks to health if it is used for a purpose for which it was designed.'

- That the Minister for Finance, who is also responsible for WorkSafe, [name], consider the need for the Parliament of Victoria to expressly incorporate the requirement of appropriate staffing, or availability of a spotter, to section 29 of the *Occupational Health and Safety Act 2004*, which requires that 'a person who manufactures plant who knows... that the plant... is to be used at a workplace must' inter alia 'give adequate information to each person to whom the manufacturer provides the plant... concerning... any conditions necessary to ensure the plant... is safe and without risks to health if it is used for a purpose for which it was manufactured.'

- That the Minister for Finance, who is also responsible for WorkSafe, [name], consider the need for the Parliament of Victoria to expressly incorporate the requirement of appropriate staffing, or availability of a spotter, to section 30 of the *Occupational Health and Safety Act 2004*, which requires that 'a person who supplies plant who knows... that the plant... is to be used at a workplace... must' inter alia 'give adequate information to each person to whom the supplier supplies the plant... concerning... any conditions necessary to ensure the plant... is safe and without risks to health if it is used for a purpose for which it was designed, manufactured or supplied.'

- That the Minister for Finance, who is also responsible for WorkSafe, [name], consider the need for the Parliament of Victoria to expressly incorporate the requirement of considering appropriate staffing, or availability of a spotter into Part 3.5 of the *Occupational Health and Safety Regulations 2007*, relating to Plant, or Part 3.6 relating to High Risk Work.

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

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

A middle aged male died due to head injuries sustained in a work place incident.

The adult was struck by a hydraulic concrete placing boom when the truck the boom was attached to tipped.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that several factors contributed to the death:

- there was no spotter within proximity to the concrete pumping truck.
- the ground conditions on which the loaded concrete truck was stationed were untested and unknown.
- there were inadequate packing or engineered bog mats for the outrigger/stabiliser pads.
- there was no exclusion zone around the boom, which allowed the adult to be working directly underneath it.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Minister for Finance, who is also responsible for WorkSafe, [name], consider the need for the Parliament of Victoria to expressly incorporate the requirement of appropriate staffing, or availability of a spotter, to section 27 of the Occupational Health and Safety Act 2004, which requires that ‘a person who designs plant who knows... that the plant... is to be used at a workplace must' inter alia 'give adequate information to each person to whom the designer gives the design... concerning... any conditions necessary to ensure the plant... is safe and without risks to health if it is used for a purpose for which it was designed. ' 
- That the Minister for Finance, who is also responsible for WorkSafe, [name], consider the need for the Parliament of Victoria to expressly incorporate the requirement of appropriate staffing, or availability of a spotter, to section 29 of the Occupational Health and Safety Act 2004, which requires that ‘a person who manufactures plant who knows...
that the plant... is to be used at a workplace must' inter alia 'give adequate information to each person to whom the manufacturer provides the plant... concerning... any conditions necessary to ensure the plant... is safe and without risks to health if it is used for a purpose for which it was manufactured. ' 

- That the Minister for Finance, who is also responsible for WorkSafe, [name], consider the need for the Parliament of Victoria to expressly incorporate the requirement of appropriate staffing, or availability of a spotter, to section 30 of the Occupational Health and Safety Act 2004, which requires that 'a person who supplies plant who knows... that the plant... is to be used at a workplace... must' inter alia ' give adequate information to each person to whom the supplier supplies the plant... concerning... any conditions necessary to ensure the plant... is safe and without risks to health if it is used for a purpose for which it was designed, manufactured or supplied.'

- That WorkSafe issue Safety Alerts on a regular and periodic basis, and not only in response to a fatality; on the dangers of operating concrete pumping trucks, including recommendations that a spotter always be available.

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Coronial recommendations: Fatal facts

**Case summary**

An adult male died of carbon monoxide poisoning when they fell asleep in their vehicle with the engine running.

The adult worked as a taxi driver.

**Coronial findings**

The coroner found that the death was unintentional.

The coroner found that the taxi’s exhaust pipe was broken, and a gap in the back seat allowed carbon monoxide to enter the cabin of the vehicle. The coroner found that there were shortfalls in the maintenance and checking of the taxi.

**Coronial recommendations**

The coroner made the following recommendations related to this case:

- I acknowledge the reasons provided by the Taxi Services Commission for declining to instigate a policy of widespread installation of carbon monoxide alarms in taxis. With this in mind, and with the aim of preventing like deaths, I instead recommend that the Taxi Services Commission consider the introduction of mandatory carbon monoxide monitoring for taxi vehicles that is periodic or at the time of service.

- With the aim of preventing like deaths, I recommend that the Taxi Services Commission provide education to drivers on the dangers of carbon monoxide poisoning in connection to ‘power napping’ while the car engine is running, and also proceed with incorporating the planned amendments to the ‘Fatigue Management Guidelines’ to explicitly advise drivers to turn their engines off while resting and discourage any existing accepted practices in this regard.

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Coronial recommendations: Fatal facts

Case number
VIC.2011.1080

Primary category
Adverse medical effects

Additional categories
Work related, Physical health

Fatal facts edition
49 – cases closed between April and June 2016

Case summary
A middle aged female died from respiratory failure due to failure of their ventilator.

The adult had been diagnosed with motor neurone disease and was dependent on a home non-invasive ventilator (NIV). They were under the care of an in-home carer. The carer had been supplied by a company and trained by the adult’s family on how to care for the adult with respect to medication, moving them and use of the ventilator.

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

The coroner found that the carer was not appropriately experienced or qualified to provide care for patients with non-invasive ventilation dependence. The coroner found that the company supplying the carer should have supplied a disability support worker who was adequately trained for the task.

The exact manner in which the ventilator and its back-up malfunctioned was unable to be established.

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

- That the Department of Health and Human Services and/or other regulatory bodies review or establish guidelines regarding the expected qualifications and/or experience of disability support workers employed to care for clients who require chronic domiciliary non-invasive ventilation.
- That the Department of Health and Human Services secure funding for the establishment of an education course regarding caring for clients with chronic domiciliary non-invasive ventilation, such as the ‘Course in Personal Care Training Using Non-Invasive Ventilation’ developed by the Victorian Respiratory Support Service (VRSS) outreach nursing service. This would establish an avenue for under skilled disability support workers (as well as family members and primary carers of clients, if desired) to receive appropriate and
structured teaching of the skills and knowledge required to care for clients who are dependent on chronic domiciliary non-invasive ventilation. The course should cover practical training of patient transfer for non-invasive ventilator (NIV)-dependent patients, as well as simulation of an emergency response to ventilator failure.

- That the Department of Health and Human Services review the requirements for clinical governance of non-Department of Health and Human Services registered disability service providers, and consider excluding such organisations from providing disability support workers to care for clients who require chronic domiciliary non-invasive ventilation.

- That the VRSS be provided with information of the circumstances of [the deceased] death to enable an informed internal review of their policies and procedures. Focus points for the VRSS review should include:
  - The risks and benefits of providing clients with main and back-up NIVs of identical versus alternative brands.
  - Consideration for the provision of an anchoring device (such as a wheel-based vertical pole) to clients, to reduce the risk of NIVs tipping or being damaged. This would be of greatest benefit for clients with separate NIV and humidifier devices, such as the ones supplied to [the deceased].
  - The feasibility of including a manual airway resuscitation device as a further safety measure for the main and back-up NIVs, such as a bag-valve-mask kit or resuscitation mask.

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Coronial recommendations: Fatal facts

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Case summary

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

The young person suffered from paranoia which had worsened in the month leading up to their death. They had been admitted as a voluntary patient to a mental health facility inpatient unit the day before their death.

Coronial findings

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

The coroner found that, upon admission, the young person’s patient notes indicated that they would require frequent engagement, however this did not occur.

Medical staff checked upon the young person on several occasions during the night. As they were noted to be sleeping, staff did not engage with the young person.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That [health service] provide specific periodic training on the use of the Clinical Risk and Management (CRAAM) guidelines, including but not limited to the expectations of night staff to engage with patients in circumstances such as [the deceased], where there is likely to be a significant delay between admission and assessment by a consultant psychiatrist.
- That the Chief Psychiatrist review whether there are or whether there should be guidelines issued by the Office of the Chief Psychiatrist, which provide guidance to clinicians on the appropriate engagement with clients in multifactorial situations, such as [the deceased], and in particular, but not limited to, on night shifts.

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Coronial recommendations: Fatal facts

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Case summary

An adult male took their own life by drug toxicity while on overnight leave from their psychiatric facility.

The adult had a history of illicit drug use and suicide attempts. They were a voluntary patient at the psychiatric facility at the time of their death.

Coronial findings

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

The coroner found that the adult’s family were unaware that overnight leave had been granted.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the [hospital] Prevention and Recovery Care Service (PARCS) Leave Procedure be amended to include a requirement that in the first overnight or leave event in circumstances where the resident will be alone, PARCS staff encourage the resident to notify family and/or friend/s of the leave, or staff gain consent to notify family and/or friend/s of the leave, or if this fails PARCS staff make telephone contact with the resident while they are on leave for the purpose of support and as an indicator of the resident’s safety.

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Coronial recommendations: Fatal facts

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Case summary
An adult male took their own life with a firearm issued through their work as a police officer.

The adult had made allegations that they were the subject of workplace bullying prior to their death. Their family member raised concerns that the adult’s rostered shifts contributed to their state of mind prior to their death.

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

The coroner found that the adult was rostered on for an unusually high number of weekends, and the rostering was outside the accepted standards in the Enterprise Bargaining Agreement (EBA).

The coroner found that there was confusion surrounding the role of WorkSafe, and the incident was not investigated by police as there was a mistaken belief that WorkSafe was investigating the matter.

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

- I am of the view the principles of equity and fairness should be taken into account when preparing rosters regarding the allocation of shifts at police stations to ensure the burden of shifts is borne fairly. Regular review and oversight of rosters is required to ensure this occurs. I recommend that the Victoria Police implement, as a matter of priority, a system to ensure that all rosters are consistent with its current Enterprise Bargaining Agreement (EBA). Where a police officer’s roster is not consistent with the EBA, this should be identified by management and subject to a reasonable explanation requirement.

- I recommend Victoria Police and Work Safe Victoria implement a written joint protocol that clearly documents the notification and investigative process of each agency when a
serving police officer appears to have taken their own life and should include a process to investigate any existing or posthumous allegations of workplace bullying. Such a protocol should address the intersection of the *Occupational Health and Safety Act (2004)* and section 21A of the *Crimes Act (1958)*. To ensure transparency, such protocol should be published by both agencies.
Coronial recommendations: Fatal facts

Case number
VIC.2010.4719

Primary category
Drugs and alcohol

Additional categories
Adverse medical effects, Water related

Fatal facts edition
49 – cases closed between April and June 2016

Case summary
An adult male died due to mixed drug toxicity and subsequent drowning.

The adult had a documented history of illicit drug use, opiate dependence, depression and anxiety. They were being treated for opiate dependence and had been prescribed multiple benzodiazepine medications to manage other health conditions.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the adult was doctor shopping and attending multiple pharmacies, which resulted in over-prescription and over-supply of prescription-only medications. The lack of real time prescription monitoring allowed the adult’s behaviour to continue.

The coroner found that the doctors that prescribed the medication did not verify the adult’s previous medical history and prescribed large amounts of benzodiazepines for an ongoing period. The coroner found that the use of the prescribed benzodiazepines should have been only for a short period.

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

- That the Department of Health and Human Services’ Real Time Prescription Monitoring Taskforce [RTPM] consider the inclusion of diazepam and other Schedule 4 drugs within the RTPM scheme.
- That the Royal Australasian College of General Practitioners [RACGP] develop guidelines or otherwise inform its members as to minimum standards for ensuring effective transfer of care between general medical practitioners or practices. In particular, the RACGP include guidance as to what should be included in a patient’s medical records to ensure accurate, comprehensive and current information accompanies a patient to a subsequent general practitioner upon a transfer of care.
That the Australian Health Practitioner Regulation Authority considers the circumstances in which [the deceased] died, and takes whatever action it deems appropriate in relation to [doctor] and [doctor].
Coronial recommendations: Fatal facts

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<th>Case number</th>
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Case summary
An adult male died due to mixed drug toxicity.
The adult had a history of mental ill health and prescription and illicit drug abuse.

Coronial findings
The coroner found that the death was unintentional.
The coroner found that the adult prescription-shopped and stockpiled prescription medication which they used in conjunction with illicit substances.
The coroner noted the dangers of benzodiazepine consumption in combination with illicit drugs, and the dangers associated with the ease of access to benzodiazepine prescriptions.

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

- That the Department of Health and Human Services' Real-Time Prescription Monitoring (RTPM) Taskforce consider the inclusion of diazepam and other schedule 4 drugs within the RTPM scheme.

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Coronial recommendations: Fatal facts

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Case summary

A middle aged male died due to bronchopneumonia contributed to by their use of methadone and benzodiazepines.

The adult had been previously diagnosed with asthma and bipolar disorder, and had a history of illicit drug abuse. They had been suffering from a chest infection for which they had been prescribed antibiotics at the time of their death. They were also prescribed and actively taking methadone and diazepam.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the prescription of methadone and diazepam may have exacerbated the adult’s decline in health in relation to their ongoing respiratory issues.

The coroner found that the adult was ‘doctor shopping’ to support their benzodiazepine dependence. The prescribing doctors did not call upon the adult’s previous medical records nor did they make reports to Drugs and Poisons Regulation in line with relevant legislation.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Victorian Department of Health and Human Services review the Policy for Maintenance Pharmacotherapy for Opioid Dependence (2013) to ensure it provides adequate and explicit guidance to clinicians on how to manage maintenance pharmacotherapy in patients with asthma or other respiratory conditions.
- That the Commonwealth Department of Health review the National Guidelines for Medication-Assisted Treatment of Opioid Dependence (2014) to ensure they provide adequate and explicit guidance to clinicians on how to manage maintenance pharmacotherapy in patients with asthma or other respiratory conditions.
- That the Victorian Department of Health and Human Services direct Drugs and Poisons Regulation to review the [healthcare provider] clinicians’ diazepam and methadone
prescribing to [the deceased], and determine whether the clinicians require any further training in maintenance pharmacotherapy, prescribing to drug-dependent patients, or the obligations of prescribers under the *Drugs Poisons and Controlled Substances Act 1981 (Vic)*.

- That the Australian Health Practitioner Regulation Agency review the treatment provided (and particularly drugs prescribed) to [the deceased] at [healthcare clinic] and consider whether this treatment raises any issues relating to the conduct of the practitioners involved.
- That the Victorian Department of Health and Human Services immediately proceed with implementing a real time prescription monitoring system in Victoria to tackle the ever increasing toll of pharmaceutical drug related deaths in the state.
Coronial recommendations: Fatal facts

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Case summary

A middle aged male died following a reaction to protamine during cardiac surgery. The adult had undergone cardiac surgery some days prior, during which blood thinning agents were used. At the conclusion of the surgery, protamine was administered to reverse the effects of the blood thinning agents. The adult’s blood pressure dropped significantly. Their reaction was documented in the operation report, but not on the anaesthetic chart.

The adult underwent a further cardiac surgery some days later. Their reaction to protamine was not mentioned in the handover. Protamine was once again administered during surgery, and their blood pressure again dropped significantly. It was discovered they had suffered a brain injury as a result. They were palliated and died some days later.

Coronial findings

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

The coroner found that there were no notes made in the intensive care unit admission following the first surgery outlining the intraoperative issues. The coroner found that the Surgical Safety Checklist for the first procedure recorded ‘no’ to the question “Does the patient have a known allergy?”, and a Surgical Safety Checklist was not completed at all for the second and ultimately fatal procedure. The coroner found that the allergy/reaction section of the anaesthetic chart for both procedures was left blank.

The coroner found that there were a number of stages at which the adult’s care could have been improved, including better documentation and better preparation and handover.

The coroner noted that given the complexities involved and the seriousness of the adult’s medical condition, that different treatment may not have been utilised, and may not have resulted in a different outcome.

Coronial recommendations

The coroner made the following recommendations related to this case:
• That [hospital] develop a general guideline for the use of protamine, outlining indications, high-risk patients, potential complications and management options for high risk situations.
• That [hospital] educate anaesthetists as to the need to document any significant intraoperative event and the medications administered.
• That [hospital] amend its Surgical Safety Checklist document to include adverse drug reactions as well as known allergies.

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Coronial recommendations: Fatal facts

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</table>

Case summary

An adult female died due to mixed drug toxicity.

The adult was known to suffer from heroin and benzodiazepine addiction and alcohol abuse.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that there was no real time prescription monitoring system in place to identify persons engaged in ‘doctor shopping’.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Victorian Department of Health and Human Services take the national lead in immediately implementing a Real Time Prescription Monitoring system in Victoria to tackle the ever-increasing toll of pharmaceutical drug related deaths in the state.
- That within 12 months the Therapeutic Goods Administration move all benzodiazepines into Schedule 8 of the Standard for the Uniform Scheduling of Medicines and Poisons.
- The Royal Australian College of General Practitioners (RACGP) consider revision of their standards and guidelines to provide best practice guidance on coordination of care in general practice between general practitioners at different clinics.

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Coronial recommendations: Fatal facts

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Case summary

An adult female died due to complications associated with an elective surgical procedure. The adult suffered from extensive bleeding during the surgery, following which they were conveyed to another hospital where 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 adult’s fatal injury was sustained during laparoscopic surgery, however the exact cause of the injury was unknown. The injury that caused bleeding was not identified at the time of the surgery.

The coroner found that the hospital where the surgery was performed was ill-equipped to deal with the repercussions of the incident. The coroner found that there was confusion or a misunderstanding at Adult Retrieval Victoria as to the nature of the principal problem confronting the adult. This led to a miscommunication to the receiving hospital. As a result, the adult was taken to the intensive care unit rather than being immediately taken to the operating theatre.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Royal Australasian College of Surgeons institute guidelines addressing the need for communication between the operating surgeon from the sending hospital and a surgeon at the receiving hospital in circumstances such as this, notwithstanding the presence of the Adult Retrieval Australia.
- That the Royal Australasian College of Surgeons consider mandatory and regular continuing professional development with theoretical and practical components, for surgeons performing laparoscopic procedures.

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Coronial recommendations: Fatal facts

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Case summary

An adult female died due to cardiac arrest following the administration of anaesthesia.

Coronial findings

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

The coroner found that there was a failure to detect the adult’s oxygen saturation levels and baseline pulse oximetry. As a result, the adult’s hypoxic state was not detected during the procedure. The coroner found that this was in direct violation of the treating centre’s functional procedures as well as being a gross departure from the accepted clinical practice standards expected of a reasonable medical practitioner practising in the area of anaesthesia.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Joint Consultative Committee on Anaesthesia (JCCA), a tripartite committee with representatives from the Australian and New Zealand College of Anaesthetists (ANZCA), the Royal Australian College of General Practitioners (RACGP) (RACGP Rural) and the Australian College of Rural and Remote Medicine (ACRRM), review the training required by general medical practitioners necessary for attaining accreditation from the JCCA to practice as a GP [general practitioner] Anaesthetist.
- That the JCCA implement a compulsory continuing professional development (CPD) scheme for GP Anaesthetists.
- That the JCCA link the provision of ongoing or triennium accreditation to practice as a GP Anaesthetist only on the completion of compulsory CPD points as determined within the stated period.
- That the JCCA investigate and examine the feasibility of introducing a formal but accessible mentoring program for GP Anaesthetists.

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Coronial recommendations: Fatal facts

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**Case summary**

A young male died due to injuries sustained in a vehicle incident in which they were a motorcyclist. The incident occurred during an organised racing event.

The young person had considerable experience with riding motorcycles, including at a competitive level. They had a licence which allowed them to ride in competitive events across Australia.

**Coronial findings**

The coroner found that the death was unintentional.

The coroner found that there were no barriers, permanent or semi-permanent, to stop a rider from re-entering the racetrack after having travelled off the race track into the infield.

**Coronial recommendations**

The coroner made the following recommendations related to this case:

- That Motorcycling Australia Limited, [racecourse operator] and the Federation Internationale de Motorcyclisme ensure that a conspicuous visual (non-retarding) barrier is installed at the [race circuit] in a position to dissuade riders who have left the track from attempting to cross the infield to re-join the track.

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Coronial recommendations: Fatal facts

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

Case summary
A young male died due to complications of anaphylaxis after ingesting a food containing nuts to which they were allergic.

The young person was attending a sports camp on the day of the incident. The young person always carried an Epipen; however, they had never needed to use it. The young person also suffered from severe asthma.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the family of the young person, though educated on their child’s allergies and action plan, still had deficiencies in knowledge especially regarding their child’s asthma versus anaphylaxis or the relationship of the two issues and delayed onset of symptoms after exposure.

The coroner found deficiencies in the sporting camp’s action toward the young person and their medical needs. Upon registration for the camp, allergies and medical details were required to be completed; however, no action plan towards the young person’s allergies was sought by the camp facilitators prior to or during the camp. All food was provided by the camp. On the day of the incident, the camp provided food from a fast food outlet. There were no ingredients listed for the food items or details about the food provided other than distinction between vegetarian and non-vegetarian items.

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

- That the Royal College of General Practitioners and Royal College of Physicians work collaboratively and in consultation with the Australian Society of Clinical Immunology and Allergy (ASCIA) for the purposes of producing an information specific brochure which also provides guidance on how parents should respond. Such a brochure should be in addition to and not as a substitute for education/information sessions provided to
such patients in the medical rooms/premises and similarly, should be in addition to and not as a substitute for specifically constructed Action Plans.

- That the Royal College of General Practitioners and Royal College of Physicians work collaboratively and in consultation with the Australian Society of Clinical Immunology and Allergy (ASCIA) for the purposes of producing an information specific brochure and/or education module and/or electronic device application directed at the identified high risk group of adolescents aimed at but not limited to, assisting them to minimise risk through understanding and managing their own food allergy(ies) during the transition from childhood dependence on others through to adulthood and independence. Such a brochure/module/application should be in addition to and not as a substitute for education/information sessions provided to such patients in the medical rooms/premises and similarly, should be in addition to and not as a substitute for specifically constructed Action Plans.

- That the Australian Society of Clinical Immunology and Allergy (ASCIA) if they have not already done so, review the content of the Action Plan for Anaphylaxis to include guidance on the management in the case of suspected allergic reaction or suspected asthma attack wording along the lines of but not restricted or limited to: "In the event of sudden breathing difficulties in someone that has both food allergy and asthma, administer EpiPen®/auto-injector, and then give Ventolin."

- That [fast food chain] provide a copy of the Allergen Guide with each catering order/pack such that the customer has readily available a reference guide for the consumers.

- That [fast food chain] implement a mandatory labelling policy for its catering orders/packs such that a label identifying potential allergens such as nuts, can be placed with the platter by the customer when it is laid out for the consumers.

- That [fast food outlet] mandate the display in the public area of the Allergen Guide in each [fast food company] restaurant outlet.

- That the Victorian Minister for Sport, in consultation with the Minister for Health, consider whether the provision of grants under the 'Community Sports Infrastructure Fund' to sporting clubs, be conditional upon them having policies and practices in place that require all staff, volunteers and employees to complete allergy and anaphylaxis training, through, but not limited to, first aid training or online training provided by the Australian Society of Clinical Immunology and Allergy (ASCIA).

- The Victorian Karting Association do not hold any further Junior Development Camps until such time as it has completed a legitimate and meaningful independent review of its policies and procedures on how to safely conduct camps for children, including, but not limited to, assessing the training required of its volunteers on allergy and anaphylaxis management and the safe provision of food to the children with identified allergies.

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

<table>
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<tr>
<th>Case number</th>
<th>VIC.2012.4459</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>
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<td>Fatal facts edition</td>
<td>49 – cases closed between April and June 2016</td>
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</tbody>
</table>

Case summary
A young female died due to an assault.
The young person had been at the perpetrator’s home when an argument occurred and they were fatally assaulted.

Coronial findings
The coroner found that the death was due to assault.
The coroner found that the perpetrator of the crime against the young person was previously incarcerated for violent crimes and that programs and interventions within prison and after parole had failed to identify the risk they posed to the community.

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

- That that the Victorian Government consider the establishment of a statutory scheme applicable to serious violent offenders (SVOs) analogous to the scheme that applies to serious sexual offenders (SSOs) under the *Serious Sex Offenders (Detention and Supervision) Act 2009*.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2013.248</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Mental illness and health</td>
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<tr>
<td>Additional categories</td>
<td>Weather related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>49 – cases closed between April and June 2016</td>
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</table>

Case summary

A middle aged male died of unascertained causes while on day leave from their psychiatric facility. There was a heatwave on the day of their death.

The adult was an involuntary patient in the psychiatric facility. They were taking medications for their mental illnesses and for heart problems.

Coronial findings

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

The coroner found that the adult had several known risk factors in heatwave conditions, including mental illness, high body mass index and prescribed medications. The coroner found that there was no evidence of awareness raising or education within the psychiatric facility around the risk factors of heat on patients.

The coroner found that the granting of leave on a day of extreme heat failed to provide a holistic approach to the adult’s care.

The coroner found that the adult’s spouse was not informed about the day leave and that there were no specific rules imposed on the adult regarding their leave.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I acknowledge the recommendation made by [coroner] following the investigation into [similar deaths], and I reiterate their recommendation that the Chief Psychiatrist issue a directive requiring all public mental health services to develop and introduce an appropriate guideline that identifies, among other things, the clinical responsibilities for case managed and at-risk clients at times of extreme weather conditions.
- It is still not apparent on the basis of the material provided to me that environmental factors have been formally incorporated into risk assessments for approving the day leave of psychiatric inpatients at [the hospital]. With the aim of preventing like deaths, I
recommend that [the hospital] incorporate environmental and climate conditions into their policy 'Mental Health - Leave from inpatient units', that was last reviewed on [date].
Coronial recommendations: Fatal facts

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<tr>
<th>Case number</th>
<th>VIC.2013.2139</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>Transport and traffic related, Leisure activity</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>49 – cases closed between April and June 2016</td>
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</table>

Case summary

An adult male drowned in a lake after falling from their small fishing vessel.

The adult was fishing alone on the lake. When they did not return home at the planned time, their family contacted police. The adult’s vessel was found unattended, and the adult’s body was located shortly afterwards.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that it was likely the adult slipped and fell into the water. The coroner found that the adult was not wearing a life jacket at the time of the incident, as all the lifejackets were located in storage on the vessel.

The coroner found that the vessel’s engine’s kill switch was in the run position but was not connected to the adult by a lanyard. This resulted in the engine continuing to run when the adult fell overboard. The coroner found that had the kill switch been operating appropriately, the engine would have immediately stopped upon the adult falling into the water, and they may have been able to reboard the vessel.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that Transport Safety Victoria continues to explore potential models for 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 of the vessel.
Coronial recommendations: Fatal facts

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<tr>
<th>Case number</th>
<th>VIC.2014.5059</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>Older persons</td>
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<tr>
<td>Fatal facts edition</td>
<td>49 – cases closed between April and June 2016</td>
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</table>

Case summary
An older male died as a result of a vehicle incident in which they were a pedestrian.

The adult was crossing a road, passing in front of stationary traffic at a red light. As they walked past a truck, the lights changed to green and the truck began moving forwards. The truck struck the adult and they were dragged for a short distance before the driver was alerted to the situation.

The adult was conveyed to hospital where they were palliated and died some time later.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the truck driver would have been unable to see the adult in front of the truck as they took off due to the height of the cabin and the short stature of the adult.

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

- That the Transport Industry Safety Group considers the particular challenges to pedestrian safety - especially those older and more vulnerable pedestrians - posed by trucks and heavy vehicles with limited forward visibility and considers developing a strategy to highlight this road safety issue to the public at large, and to truck and heavy vehicle operators and drivers in particular.

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>
<th>VIC.2015.3115</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>Location</td>
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<tr>
<td>Fatal facts edition</td>
<td>49 – cases closed between April and June 2016</td>
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</tbody>
</table>

Case summary
A middle aged male died due to injuries sustained in a vehicle incident in which they were a cyclist.

The adult was fatally injured when they were struck by a truck at a crossing point.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the design of the left turn lane and pedestrian/bicycle crossing may have contributed to the collision.

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

- I recommend that VicRoads examine the circumstances of this collision and take remedial action to improve pedestrian and cyclist safety at the [slip road] intersection with [road].

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>
<th>VIC.2015.4273</th>
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<td>Transport and traffic related</td>
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<tr>
<td>Fatal facts edition</td>
<td>49 – cases closed between April and June 2016</td>
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</table>

Case summary

A young male died due to injuries sustained when they were struck by a train.

The young person was witnessed walking alongside train tracks by a train driver. The driver notified the rail control centre. All drivers on the railway line were notified of a trespasser and provided with the location given by the reporting train driver.

Shortly afterward, the young person was struck by a passing train shortly afterward.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the young person was under the influence of an illicit drug at the time of their death.

The coroner noted that there was some inaccuracy in the reporting of the young person’s location on the railway line.

Coronial recommendations

The coroner made the following recommendations related to this case:

- The evidence suggests that the availability of a Global Positioning System (GPS) would have enabled the provision of more accurate information about [the deceased’s] location on [date], which may have in turn altered the outcome. With a view to avoiding like deaths, supporting train drivers and providing precise location coordinates at any one time, I recommend that Public Transport Victoria both accept, and provide the requested funding for, the [metropolitan train service] GPS proposal.

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Coronial recommendations: Fatal facts

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<tr>
<th>Case number</th>
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<tr>
<td>Primary category</td>
<td>Transport and traffic related</td>
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<td>Additional categories</td>
<td>Location</td>
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<tr>
<td>Fatal facts edition</td>
<td>49 – cases closed between April and June 2016</td>
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</table>

Case summary

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

The adult stepped onto the road and was struck by an oncoming vehicle. They were conveyed to hospital where they passed away.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the driver of the vehicle was not driving in a dangerous manner.

The coroner found that the road bottle necked near the intersection where the incident occurred, making the road potentially dangerous. The coroner noted that there was no signage to inform road users who must give way at that point.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the [council] undertake a feasibility assessment at the intersection of [road] and [road] in [suburb], to determine whether it requires safety enhancements in addition to the pre-existing ‘bottleneck’ structure, such as increased signage to warn motorists to give way to pedestrian traffic, and/or whether a delineated pedestrian crossing would improve pedestrian safety.

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>
<th>VIC.2013.2477</th>
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<tr>
<td>Primary category</td>
<td>Physical health</td>
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<td>Additional categories</td>
<td>Older persons</td>
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<tr>
<td>Fatal facts edition</td>
<td>49 – cases closed between April and June 2016</td>
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</table>

Case summary

An older male was found deceased in their home. They had insulin-dependent Type 1 diabetes and wore an insulin pump.

The adult had mild cognitive impairment and had a history of hypoglycaemia unawareness. They had recently attended hospital where it was discovered they were not accurately estimating their carbohydrate intake.

Coronial findings

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

The coroner found that the hospital should have considered a dietary review necessary at the adult’s recent attendance to rectify their inaccurate carbohydrate recordings.

The coroner found that the insulin pump was out of battery for an extended period in the lead up to the adult’s death. The parent company was unable to provide data for that time. As such, the coroner was unclear on whether the older person’s history of hypoglycaemia unawareness contributed to their death.

Coronial recommendations

The coroner made the following recommendations related to this case:

- With the aim of improving the provision of treatment to diabetic patients at [hospital], I recommend that all patients admitted to [hospital] for commencement of an insulin pump are more thoroughly screened, possibly through referral to a dietician’s assessment, for their ability to appropriately perform the tasks of carbohydrate counting and insulin calculating, both vital skills for the effective ongoing management of such a device.

- With the aim of maintaining important data records, I recommend that [company], in consultation with its parent company, install additional data retention technology to its [type] insulin pump, or implement a policy whereby the historic data contained in any
insulin pump devices under review is salvaged as a matter of priority, to prevent the possibility of it becoming corrupted.
Coronial recommendations: Fatal facts

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<tr>
<th>Case number</th>
<th>VIC.2015.1687</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>Older persons, Physical health</td>
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<tr>
<td>Fatal facts edition</td>
<td>49 – cases closed between April and June 2016</td>
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Case summary
An older adult male died due to cardiac issues alongside multiple comorbidities.

The adult had a significant medical history including strokes, cardiac illness and diabetes. The adult was medicated for their stroke risk. The adult died in hospital after suffering a stroke. At the time of their death, the adult had not been administered their anticoagulant medication for 48 hours.

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

The coroner noted several recommendations that arose from an internal review conducted by the hospital:

- the commencement of the inpatient medication chart in the ED [emergency department];
- a system for checking that the necessary documentation is completed prior to transfer from the ED;
- the checking of the inpatient medication chart by the admitting team upon arrival in the ward;
- a system of clinical handover between pharmacists to discuss medication stock availability and ordering;
- pharmacy review of staff resources on public holidays;
- [hospital] staff education on the role of newer, or unfamiliar, anticoagulant medications;
- [hospital] staff education of inpatient medication chart abbreviation denoting unavailable medication documentation in the inpatient medication chart;
- Inpatient medication review incorporated in the standard clinical handover process;
- [hospital] staff education on how to access information and medications.

Coronial recommendations
The coroner made the following recommendations related to this case:
On the material available to me, I am satisfied that [hospital] has undertaken an extensive review of the circumstances surrounding [the deceased’s] death. The review identified relevant recommendations to address gaps in the medication management system to ensure the correct medications are prescribed, dispensed and administered in a timely manner. I endorse these recommendations.
Coronial recommendations: Fatal facts

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<tr>
<th>Case number</th>
<th>VIC.2013.2851</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>
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<td>Fatal facts edition</td>
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Case summary

An older male died as a result of a small bowel obstruction.

The adult presented at a regional hospital during the night. They underwent a pathology test that provided immediate results, and had additional samples taken and sent for testing when normal working hours resumed. They were diagnosed with gastroenteritis and discharged with pain relief.

The adult re-presented at the hospital the following evening and collapsed while being triaged. They were unable to be resuscitated.

Coronial findings

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

The coroner found that given the adult’s symptoms, the diagnosis of gastroenteritis was not unreasonable.

The coroner found that there was a failure to recognise or act upon the abnormal results shown from the pathology test during the first admission and that recognition of the abnormal results may have led to more appropriate management and treatment of the adult’s condition.

Despite this, the coroner found that the adult may still have suffered a fatal incident even if they had been admitted. The coroner found that the hospital’s staffing and available services did not contribute to the death.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend the [hospital] implement a system in the Emergency Department allowing for a more timely review of pathology or X-ray tests ordered, be they during out of hours or throughout the normal working day. The practice in existence at the time was too
unstructured as to when results may reasonably be expected to be reviewed and by whom.

- I recommend the [hospital] implement a system where if a patient is found to have abnormal pathology results this fact should be discussed with a senior clinician prior to discharge and such discussions to be documented.
Coronial recommendations: Fatal facts

Case number  VIC.2014.4458
Primary category  Child and infant death
Additional categories  Natural cause death
Fatal facts edition  49 – cases closed between April and June 2016

Case summary
A male infant died as a result of Kawasaki disease.

The parents took the infant to hospital when they became unwell with a fever. The hospital considered a diagnosis of Kawasaki disease, but this was not diagnosed. The infant was discharged after some days and referred to their general practitioner (GP). They were reviewed by the GP, but the GP did not have access to the paperwork from the hospital, and a second review was scheduled.

The infant’s condition declined that evening, and they passed away on arrival at the hospital.

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

The coroner noted that there are diagnostic challenges faced by clinicians in diagnosing Kawasaki disease. The coroner found that the available evidence did not support a finding that there was any want of clinical management or care by staff at the hospital or the GP clinic that caused or contributed to the infant’s death.

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

- That the Victorian Department of Health Director Quality, Safety and Patient Experience consider mandating a formal requirement that when a patient is discharged from hospital with a plan for follow-up within 48 hours by another medical service, a member of the discharging team should personally contact the receiving medical service to effect patient hand-over.
Coronial recommendations: Fatal facts

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<tr>
<th>Case number</th>
<th>VIC.2014.5182</th>
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<tr>
<td>Primary category</td>
<td>Location</td>
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<td>Fatal facts edition</td>
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Case summary

A middle aged female died after choking on food. They had an intellectual disability and lived in supported accommodation at the time of their death.

The staff at the accommodation had served dinner to the adult and other residents in their unit and moved to a second unit to serve dinner to the remaining residents. A resident from the first unit approached staff to inform them the adult was choking. The adult was conveyed to hospital via ambulance, but their prognosis was poor. They were palliated and died soon afterwards.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult’s record noted that they required no supervision at meal times and were able to eat independently.

The coroner was unable to determine whether the outcome would have been different had the staff members been present at the time of the incident.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that [supported accommodation company] install an alarm in the kitchen in each unit located at [address] facility, to ensure that residents can readily alert the disability workers to an adverse or dangerous event.

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Coronial recommendations: Fatal facts

Case number: VIC.2014.6279

Primary category: Natural cause death

Additional categories: Child and infant death

Fatal facts edition: 49 – cases closed between April and June 2016

Case summary

A female infant died due to cardiac issues.

The infant was taken to hospital in the days prior to their death. They were reviewed by multiple medical professionals in hospital over the following days. The infant’s condition deteriorated, and resuscitation was commenced. They were conveyed to another hospital where they were found to have suffered a severe brain injury and later passed away.

Coronial findings

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

The coroner found that the infant had a rare and fatal condition, which was misdiagnosed. The coroner found that the care and management provided by the hospital was sub-optimal, and that junior staff treating the infant were not adequately trained and supervised.

Coronial recommendations

The coroner made the following recommendations related to this case:

- This case has highlighted a broader issue of training junior medical staff. In light of the Royal Australasian College of Physicians confirmation of [health service’s] accreditation as a secondment site for Basic Paediatric Training in Victoria, I recommend that [health service] use this case as a training example for junior medical staff to highlight the importance of differential diagnoses, particularly when a patient’s clinical condition does not improve, conducting thorough assessments and examinations, listening to nursing staff and parent’s concerns, escalating to senior staff and familiarisation and understanding of the hospital’s policies and procedures, particularly Medical Emergency Team protocols.

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>Primary category</td>
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<td>Additional categories</td>
<td>Leisure activity</td>
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<td>Fatal facts edition</td>
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Case summary
An adult male died due to drowning in a rock fishing incident.

The adult was rock fishing with a friend when they were swept off the rocks by a wave. The friend contacted emergency services. An extensive search was conducted over the following days, during which the adult was found deceased. The adult was not wearing a life jacket.

Coronial findings
The coroner found that the death was unintentional.

The coroner noted the frequency of rock fishing incident deaths, and that the use of personal floatation devices was a sound strategy to prevent such deaths.

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

- With the aim of preventing like deaths and encouraging a consistent national legislative framework, I recommend that the Victorian Minister for Sport consider implementing laws in Victoria that mandate the use of Personal Floatation Devices while rock fishing.

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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

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<th>Case number</th>
<th>WA.2012.307</th>
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<tr>
<td>Primary category</td>
<td>Transport and traffic related</td>
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<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 male died due to a motor vehicle incident in which they were a motorcyclist.
The motorcycle was the subject of a police pursuit and collided with another vehicle after speeding away from police.

Coronial findings
The coroner found that the death was unintentional.
The coroner noted that the police pursuit was brief, and that the inquest highlighted how quickly events escalated from the time that the adult was detected speeding up until their death.

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

- I recommend that Western Australia Police include, in their approved Emergency Driving Policy and Guidelines, a specific reference that addresses the increased risks in pursuing motorcycles.
- I recommend that in all of its training courses dealing with emergency driving, the Western Australia Police place particular emphasis on the increased inherent risks of intercepting and pursuing motorcycles.
Coronial recommendations: Fatal facts

<table>
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<th>Case number</th>
<th>WA.2010.1303</th>
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<tr>
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<td>Natural cause death</td>
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<td>Additional categories</td>
<td>Child and infant death</td>
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<td>Fatal facts edition</td>
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Case summary

A male child died due to pneumonia in association with an infection.

The child became unwell over a period of a few days. They were taken to hospital on multiple occasions. When the child’s condition did not improve, they returned to hospital and were admitted. The child suffered a cardiorespiratory arrest and resuscitation was attempted. They were unable to be revived.

Coronial findings

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

The coroner found that a series of missed opportunities and errors in the child’s care resulted in their initially minor illness turning into a serious condition. The condition remained undiagnosed until the day prior to the child’s death.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the Department of Health determine whether doctors in the public health system should employ the strategy of delayed prescriptions of antibiotics, and provide guidance accordingly.
- I recommend that the [health service] consider and, if practicable, implement a procedure to ensure that, where appropriate, radiologists’ reports of X-rays of children with potentially serious illnesses are provided to requesting clinicians with the least possible delay.

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.
## 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 id</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>