Coronial recommendations: Fatal facts

A summary of cases and recommendations made between July and September 2016

Edition 50
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CORONERS’ RECOMMENDATIONS

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

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

Coronial recommendations: Fatal facts includes case summaries and recommendations for cases closed between July and September 2016.

Previous summaries and recommendations are available at:
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.2012.20</th>
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<tbody>
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<td>Homicide and assault</td>
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<tr>
<td>Additional categories</td>
<td>Aged care, Older persons</td>
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<tr>
<td>Fatal facts edition</td>
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Case summary

An older male died in their nursing home following an assault by a fellow resident. They had been residing at the nursing home for one day. The fellow resident had behaved violently towards other residents on the day of the incident, and staff intervened. The adult’s welfare was not checked at this time; they were found deceased a short time later.

Coronial findings

The coroner found that the death was due to assault.

The coroner found that the nursing home’s training and protocols regarding such situations were inadequate. The fellow resident was known to be violent and was not appropriately supervised following reports of their behaviour. Observation of the adult during the incident was inadequate, especially as they were a new resident.

Coronial recommendations

The coroner made the following recommendations related to this case:

- The policy recommended by [investigating police officer] in relation to suspicious deaths and matters to be referred to the Coroner [...] be adopted and implemented by [nursing home] and all other aged care facilities in the Australian Capital Territory;
- Staffing requirements of aged care facilities be reviewed and a minimum staffing requirement be set for dementia specific units of aged care facilities such as [ward] at [nursing home]. I note that a Transitional Behavioural Assessment and Intervention Service (T – BASIS) unit has a maximum of 16 residents at any one time, each housed in individual rooms. There is a registered nurse on duty at all times, with an additional three staff until 9pm, and then an additional staff member until the commencement of day shift. In addition, a nurse manager is rostered on during the day. This should be the minimum staffing requirement for residents who suffer from dementia.
- Compulsory mandatory minimum training be implemented for staff employed in aged care facilities who are required to care for and deal with residents who have been diagnosed with dementia;
To ensure the safety of both residents and staff of [nursing home], and all other aged care facilities with dementia specific units, with the assistance of an eternal provider with expertise in aged care, undertake a review and/or implementation of policies and procedures including but not limited to:

- behavioural management strategies for staff for the management of residents with dementia and specifically with those who have a tendency to be aggressive;
- mandatory reporting, and recording, of all incidents of violence of any level between residents, between a resident and a staff member or between staff members;
- procedures for dealing with deceased residents; and
- development and implementation of an efficient record keeping system, preferably electronic;

To ensure the safety of both residents and staff, [nursing home] and all other aged care facilities undertake, with the assistance of an eternal expert provider in aged care, training or updating in Compliance with Elder Abuse reporting and maintenance of a register in accordance with the requirements of the Aged Care Act 1997 (Cth.).

[Nursing home] undertake a review of the staff structure within the facility so as to ensure that management fulfil their requirement to supervise and monitor staff and ensure task compliance.

That the discretion reposing in the management of aged care facilities to determine whether an assault is a “reportable assault” under the Aged Care Act 1997 (Cth.), where a resident has a cognitive impairment, be removed and that there be a requirement for mandatory reporting of all assaults in aged care facilities.

That all aged care facilities with a dementia unit be required to disclose to families of prospective residents of the unit, prior to their admission, the following:

- the level of risk of violence for potential residents (taking into account their particular circumstances); and
- the established protocols for protecting residents from witnessing and/or experiencing regular violent events; and
- the protocol for advising relatives of violent incidents as they occur, such that the relatives are able to reassess circumstances from time to time.

In making these recommendations, I share the view of Counsel Assisting that all aged care facilities have an obligation to ensure the safety of residents. All residents are entitled to be treated with dignity and respect, which no doubt they have earned as being past contributing members of a community, financially and practically and at one time loving and respectful parents, relatives and/or friends.
NEW SOUTH WALES

The following cases summaries and recommendations relate to deaths reported to a coroner in New South Wales.
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<th>Case number</th>
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<td>Homicide and assault</td>
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<td>Fatal facts edition</td>
<td>50 – cases closed between July and September 2016</td>
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</table>

Case summary

An adult male died as a result of gunshot wounds.

Coronial findings

The coroner found that the death was due to assault.

The coroner was unable to determine the person or persons responsible for the adult’s death.

Coronial recommendations

The coroner made the following recommendations related to this case:

- Refer to Homicide Squad for ongoing investigation.

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Coronial recommendations: Fatal facts

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<th>NSW.2013.5210</th>
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<td>Law enforcement</td>
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<tr>
<td>Fatal facts edition</td>
<td>50 – cases closed between July and September 2016</td>
</tr>
</tbody>
</table>

Case summary

An adult female went missing and was subsequently presumed deceased.

The adult was known to experience domestic violence perpetrated by their partner.

Coronial findings

The coroner found that the death was due to assault.

The coroner was unable to determine the cause or location of the adult’s death, but on the balance of probabilities, the coroner determined that the death was due to assault.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that this case be referred to the Unsolved Homicide Squad.

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Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
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<tbody>
<tr>
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<td>Additional categories</td>
<td>Transport and traffic related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
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</tr>
</tbody>
</table>

Case summary

An adult male died in the course of being restrained by transport staff.

The adult had been travelling on a train, and their behaviour had become increasingly erratic during the journey. They had been asked to leave the train. When they refused, several staff physically removed them. The adult fell unconscious and was transported to hospital, where they were declared deceased.

The train staff had requested the presence of police to assist with the adult’s removal, however the police did not attend.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult was intoxicated by methylamphetamine and was experiencing excited delirium during the train journey. This made them more susceptible to positional and restraint asphyxia.

The coroner found that the train staff had no authority to remove the adult but noted that a decision had been made by the police not to attend to appropriately remove the adult. The train staff considered the situation to be urgent and the adult to be a threat to other passengers.

The coroner found that the police demonstrated poor judgement in failing to respond to the call for assistance by the train driver.

The coroner found that the train staff behaved in an inappropriate manner given the limits of their authority, and their restraint demonstrated a failure to appreciate the risks of their actions. The coroner noted their lack of training and the lack of clarity surrounding the potential of similar situations arising in the future.
Coronial recommendations

The coroner made the following recommendations related to this case:

- To the Minister for Police:
  - That consideration be given to the review of the "[location] Local Area Command Recall Procedures" to provide for officers to be recalled where assistance is requested in relation to passengers on [company] trains.

- To the Minister for Transport:
  - That NSW [New South Wales] Trains continue to develop protocols to assist staff to manage passengers in a way consistent with passenger and staff safety, from the time a decision has been made to request police assistance until police are in attendance.
Coronial recommendations: Fatal facts

<table>
<thead>
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<th>Case number</th>
<th>NSW.2015.770</th>
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<td>Fatal facts edition</td>
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</table>

**Case summary**

A male infant died during a planned home birth.

The parents had a prior successful home birth and decided that there were to be no medical professionals present during the birth, despite receiving strong professional advice against their birth plan. The family home was a considerable distance from the nearest hospital.

Towards the end of the pregnancy, the infant was noted to be in a transverse position, and the parents were warned of the risks and dangers associated with a home breech birth by the local medical centre. The parents did not share this information with the friends involved in the birth and did not return to the doctor for further antenatal care.

The infant was born in a breech position after being stuck for several minutes. They were conveyed to hospital and found to have suffered a severe brain injury. The infant passed away in hospital the following day.

**Coronial findings**

The coroner found that the death was unintentional.

The coroner found that the parents had been adequately informed of the dangers of a home breech birth, but that their pre-existing views about the hospital system made them wilfully blind to the level of risk involved.

The coroner found that while there was no valid criticism of the medical centre, there needed to be a final attempt to contact the parents to alert them that the potential risks were catastrophic.

The coroner found that the local community services did not act in a timely fashion following a report regarding the impending birth as the community services did not have adequate resources to assign a caseworker.
Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Royal Australian College of General Practitioners consider developing policy guidelines to assist and support its members in advising patients in relation to requests for non-hospital births. Consideration could be given to the “National Midwifery Guidelines for Consultation and Referral”.

- That [local health district] consider implementing an information outreach program to local general practitioners about the services currently provided by [local health district] in relation to mothers wanting non-hospital births.

- Finally as I have stated, the lack of resources available to the [local] Community Services Centre at the relevant time is of grave concern. I direct that a copy of these findings be sent to the Minister for Family and Community Services, for his urgent consideration.
Coronial recommendations: Fatal facts

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<tr>
<th>Case number</th>
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<tr>
<td>Fatal facts edition</td>
<td>50 – cases closed between July and September 2016</td>
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</table>

Case summary

An older female died as a result of blood loss following an experimental stem cell procedure.

The adult suffered from dementia and underwent the procedure in the hope that it would improve their condition. Due to their diminished mental capacity, the decision to undergo the procedure was largely facilitated by the adult’s spouse.

The adult was taking blood thinners and did not cease taking them prior to the surgery.

Coronial findings

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

The coroner found the procedure was experimental and could not be classified as a clinical trial. No explanation was given as to how the procedure would benefit the adult, and it was not conducted in accordance with the protocols for clinical trials or scientific experiments.

Consent was given by the adult’s spouse on their behalf. The consent form did not, and could not, adequately describe the risks that may flow from the procedure.

The doctor did not enquire whether the adult had ceased taking their blood thinning medication on the morning of the surgery and failed to conduct a full pre-operative medical assessment. Vital sign observations were not recorded upon the adult’s discharge, and they were inappropriately discharged back to their nursing home.

The spouse and the nursing home relied on erroneous advice given to them by the doctor, and thus the adult’s serious deterioration was not recognised in time at the nursing home.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the Health Care Complaints Commission:

- I recommend that the Health Care Complaints Commission investigates the conduct of [doctor] in relation to this case.
To the Commonwealth Minister for Health and the NSW Minister for Health:

- I recommend that the Therapeutic Goods Administration (Commonwealth) and the NSW Ministry of Health consider how best to manage and regulate the provision of “experimental” or “innovative” medical or surgical procedures that have not yet been approved following clinical trials or other recognised peer-reviewed evaluation processes.
- Among the issues to considered, I recommend that the questions of potential conflict of interest and informed consent be given high priority.
- I recommend that National Health and Medical Research Council and NSW Clinical Excellence Commission consider formulating guidelines and protocols to ensure that “experimental” or “innovative” medical procedures conform with scientifically respectable clinical practice.

To the Cosmetic Physicians College of Australasia:

- I recommend that College consider formulating guidelines and protocols to ensure that “experimental” or “innovative” medical procedures performed by cosmetic physicians in Australia conform with scientifically respectable clinical practice.
- Among the issues to considered, I recommend that the questions of potential conflict of interest and informed consent be given high priority.

To [stem cell organisation]:

- I recommend that [stem cell organisation] develops and introduces a pre-operative preparation checklist that is given to patients, their carers and the relevant health professionals at some appropriate time before it carries out any procedures.
- I further recommend that [stem cell organisation] develops and implements another checklist for internal use to ensure that all appropriate preparations have been made before it commences any invasive procedure. That checklist should include a check that blood-thinning medications have been stopped a minimum of 7-10 days before the procedure is conducted.
- I also recommend that [stem cell organisation] undertake no invasive procedures in respect of any patient unless it is satisfied that the pre-operative preparations have been carried out.
- Finally, I recommend that [stem cell organisation] amends its patient consent form to ensure that it outlines in detail for the patient (or his/her carer) the procedure together with the alternatives to the procedure, and the risks and benefits of the procedure.

To Leading Age Services Australia and the Royal Australian College of Physicians:

- I recommend that Leading Age Services Australia and the Royal Australian College of Physicians consider working together and with providers in the nursing home segment of the industry towards the development and implementation of an appropriate patient observation chart of the type used by NSW Health under its Between the Flags protocols.

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Coronial recommendations: Fatal facts

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Case summary

An older female died due to sepsis resulting from a pressure ulcer.

The adult’s ulcer had developed some months prior to their death, and the wound deteriorated until they required hospitalisation.

It was the habit of the adult’s doctor to prescribe medication without personally assessing the patient. There were existing communication difficulties between the aged care facility at which the adult resided and the doctor.

Coronial findings

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

The coroner found that there was no risk assessment or wound management documentation for the adult at the aged care facility, which fell below the acceptable standards of care at the time. The coroner found that there were errors and omissions in the aged care facility’s records of the adult’s care.

The coroner noted that the aged care facility attempted to alert the doctor to the deteriorating wound but received no response for a week. The coroner found that given the aged care facility were familiar with the communication difficulties with the doctor, it was concerning that staff did not seek other external review. The coroner found that the care provided by the facility was well-intentioned but inadequate.

The coroner found that the adult did not have an Advanced Health Care Directive, and the decision to treat them palliatively was not adequately recorded.

Coronial recommendations

The coroner made the following recommendations related to this case:

To [location] Aged Care Centre:
An assessment such as the Braden Scale for Predicting Pressure Ulcer Risk should be completed by registered nurses in relation to each resident and should be repeated if there is a change or deterioration in their clinical condition.

To [aged care group] and to [location] Aged Care Centre:

- Adequate training should be provided to [location] Aged Care Centre staff with regard to guidelines, wound care, and the circumstances in which medical review should be sought.

To [location] Aged Care Centre:

- Practices and procedures should be formalised in relation to circumstances where there is no Advance Health Care Directive in place and a resident expresses views about ongoing care and treatment.
NORTHERN TERRITORY

The following cases summaries and recommendations relate to deaths reported to a coroner in the Northern Territory.
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 similar incidents: NT.2014.278, NT.2015.60</th>
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<td>Additional categories</td>
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<td>Fatal facts edition</td>
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</table>

Case summary – NT.2014.278

An adult female died after being assaulted by their spouse.

The couple had a long and documented history of domestic violence, resulting in the spouse being incarcerated several times.

Case summary – NT.2015.60

An adult female died after being assaulted by their spouse.

The couple had a long and documented history of domestic violence. The couple had mutual domestic violence orders against each other at the time of the adult’s death.

Coronial findings

The coroner found that the deaths were due to assault.

The coroner found that domestic violence in Aboriginal communities was a significant problem, and domestic violence orders and incarceration were not effective strategies in dealing with the problem.

The coroner found that there was a need to re-evaluate the strategies dealing with domestic violence in Aboriginal communities.

Coronial recommendations

The coroner made the following recommendations related to these cases:

- I recommend that Police continue to pursue the use of body worn cameras and a change to the legislation so as to allow those matters captured on camera to be used as evidence-in-chief.
- I recommend that consideration by the NT [Northern Territory] Government be given to introducing offender reporting legislation to allow NT Police to target and monitor recidivist offenders who continue to commit domestic violence at high rates.
I recommend there be more effort made in the processes of courts to ensure that domestic violence matters are dealt with in a faster process so that hearings have priority in listing.

I recommend that consideration be given by the NT Government to alternative (to the criminal justice system) intervention strategies that allow for a more flexible family and community focussed approach that will both ensure the victim’s safety and give the couple the choice to remain together or to separate (and support them in their choices).
Coronial recommendations: Fatal facts

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

Case summary

A middle aged male died after being transported to hospital in a police vehicle.

The adult was found to be intoxicated in a public place. They fell and hit their head. Police and an ambulance were called, and police agreed to transport the adult to hospital in the police van cage to relieve the busy ambulance officers.

On arrival at hospital, the adult was noted to have head injuries. They were palliated and died some days later.

The adult had experienced a large number of protective custody episodes under the *Alcohol Mandatory Treatment Act*.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the police were not in a legal position to transport the adult to hospital.

The coroner found that there was a fundamental failure of police to record all custody episodes, including protective custody episodes, on a searchable system. The coroner found this failure to be inadequate and non-compliant.

The coroner found that the police van did not have the capacity to observe the adult in the cage of the vehicle, and thus police were unable to monitor the adult’s safety during the journey.

The coroner found that the adult’s multiple protective custody episodes should have led to them being sent for mandatory assessment under the *Alcohol Mandatory Treatment Act*. This did not occur, as many of the protective custody episodes were not recorded by police. The coroner found that the system for mandatory assessment and treatment was ineffective, and the objects of the *Alcohol Mandatory Treatment Act* were not realised.
Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that Police Officers be reminded of the requirements that must be fulfilled for protective custody in the context of transport to hospital specifically where there is an ambulance available.
- I recommend that Police find a means to record on their database all episodes of custody including protective custody.
- I recommend that Police resolve the lack of compliance with sections 128(2A) and 128A Police Administration Act.
- I recommend that Police give serious consideration to installing a mechanism to provide Police Officers visibility into the cage area of the Police vans while transporting persons.
Coronial recommendations: Fatal facts

<table>
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Case summary

A middle aged female died due to natural causes while in a sobering up shelter.

The adult had been picked up by police in a legal drinking area. Police formed the opinion they were intoxicated and in need of protective custody, and took them to a sobering up shelter. The adult fell asleep outside the shelter. Staff attempted to rouse the adult but it was assumed they were intoxicated and being uncooperative. They were discovered to be deceased a short time later.

The adult was very unwell and had self-discharged from hospital in the days prior to their death.

Coronial findings

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

The coroner found that when the adult was picked up, the police did not attempt to identify them, and made no checks on the police systems to determine if there were any alerts for them. The coroner noted that if they had done so, the police would have found an alert noting the adult was at risk due to the state of their health and required monitoring.

The coroner found that there was a fundamental failure of police to record all custody episodes, including protective custody episodes, on a searchable system. The coroner found this failure to be inadequate and non-compliant.

The coroner found that the sobering up shelter had since altered their systems to respond to the issues that were illustrated by the death.

The coroner found that despite the issues raised by the circumstances of the death, the actions or omissions of police or staff at the sobering up shelter did not contribute to the adult’s death.
Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that Police resolve the lack of compliance with sections 128(2A) and 128A Police Administration Act.
- I recommend that Northern Territory Police take such steps as are necessary to ensure that all episodes of custody including protective custody are recorded in a searchable digital database.

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

An older male died as a result of a fall in which they struck their head.

The adult presented to hospital after suffering a heart attack at home. There were no vacant beds, so they remained in the emergency department. The adult suffered a fall during this time.

They were transferred to the local private hospital, where they deteriorated and underwent surgery. The surgery was unsuccessful, and the adult died the following day.

The adult’s family member had difficulty discovering that the adult had been transferred rather than discharged. The family member was not informed of the adult’s fall until immediately prior to the surgery.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the emergency department, unlike the wards of the hospital, did not have a falls risk policy.

The coroner found that the hospital failed to handover information regarding the adult’s fall to the private hospital. Without the proper handover, the changes in the adult’s neurology were not detected until they became disabling.

The coroner found that there was a lack of communication to the family after the fall, after the transfer to the private hospital, after the adult became unresponsive, and since the death.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I therefore recommend that [location] Hospital ensure through continued education and audit that the Falls Risk Policy is appropriately utilised in the Emergency Department.
• I also recommend that handovers (both nursing and medical) and transfers to [location] Private Hospital continue to be audited to ensure those systems are functioning in the intended manner.
TASMANIA

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

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

An adult male and adult female died due to injuries sustained in a motor vehicle incident in which they were a passenger and driver, respectively.

The driver was attempting to overtake a large truck when the two vehicles collided, causing a collision with oncoming vehicles.

The incident occurred on a stretch of road with a short section of dual lanes.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that excessive speed, inattention and an attempt to overtake the truck when it was not safe to do so were all factors in the crash.

Coronial recommendations

The coroner made the following recommendations related to these cases:

- I note [police officer’s] comments regarding the possibility of converting the overtaking lanes at both the [street] and [road] junctions to right turn only lanes. I recommend that such action be considered by the governing authority.

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Coronial recommendations: Fatal facts

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

A male child died due to drowning in an inflatable pool.

The child was playing in the yard of a residence with another child. The children were not supervised by the adults present at the house. After a short time, the adults went searching for the child and found them floating in the pool. They were conveyed to hospital but were unable to be resuscitated.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the inflatable pool was required to be fenced, but it was not.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the responsible State and local government bodies determine and monitor the extent of any increase in the number of portable and inflatable pools purchased in Tasmania, and, consequently, develop and implement appropriate water safety strategies relating to such pools.
- I recommend that the responsible State and local government bodies incorporate into existing water safety awareness and education strategies, a public education and awareness campaign highlighting the requirement for approved pool fencing relating to the installation of portable and inflatable pools.

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>
<tr>
<td>Fatal facts edition</td>
<td>50 – cases closed between July and September 2016</td>
</tr>
</tbody>
</table>

Case summary

A middle aged male died as a result of choking on food in the mental health facility where they resided.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult’s airway was completely blocked and noted the rarity of this occurring.

The coroner accepted that the choking event was a ‘perfect storm’ that created a situation where the adult’s life could not be saved, despite the prompt and appropriate endeavours of staff.

Coronial recommendations

The coroner made the following recommendations related to this case:

- The evidence of [intensive care doctor], which I accept, leads me to recommend that the [hospital] give consideration to putting in place a programme to train members of the [mental health unit] in the use of Magill forceps. (I need to note that it was [intensive care doctor]’s understanding that [mental health unit] had, subsequent to [the deceased]’s death, been equipped with Magill forceps. However, [facility nurse] “had not seen them.” This is a situation that requires clarification.)
- In addition to that recommendation which I have already set out, the Review made these further recommendations:
  - Update and upgrade of resuscitation equipment on [mental health unit].
  - Lab results to be signed as cited by medical team.
  - Development and implementation of an extensive suicide risk assessment where indicated.
  - Complex case review for all patients after 30 days admission.
  - Swipe access for code blue team members.
I accept these recommendations to be appropriate and support them.

- Allied to recommendation [regarding complex case review], [inquest consultant psychiatrist], during the course of his evidence, made the suggestion, which [facility consultant psychiatrist] supported, that a high risk and complex case panel be established to review long-term psychiatric patients, most particularly those held on an involuntary basis and to be at high risk from a clinical viewpoint. It was suggested that the panel could be state-wide, that it comprise two senior clinicians not associated with the patient, and that at 28 day intervals it provide review and feedback on a patient’s diagnosis and management to the treating consultant. I believe this suggestion to have merit and recommend its consideration by the Tasmanian Health Service.
Coronial recommendations: Fatal facts

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

Case summary

A middle aged female had cancer and died due to complications resulting from palliative care.

The adult had attended hospital to alter their pain relief. Their doctor prescribed morphine to be administered via a syringe driver, however calculated the dosage incorrectly from the existing pain relief. The adult died the following day.

Coronial findings

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

The coroner found that the doctor failed to appreciate that the existing pain medication dosage was for one hour, rather than 24 hours. As such, the coroner found that the adult was grossly overdosed with morphine while a patient in the hospital.

The coroner found that the adult was actively dying due to their cancer at the time of their presentation at hospital. The death was imminent and was accelerated by the overdose of morphine by a short but indeterminable period.

Coronial recommendations

The coroner made the following recommendations related to this case:

- This case highlights serious shortcomings within the [hospital] pharmacy concerning the safeguards required to prevent the dispensing of medications for prescriptions which are clearly questionable. It is my recommendation that the [hospital] undertake a review of its pharmaceutical protocols with a view to implementing practices which reduce the risk of drug overdoses such as has occurred on this occasion.

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Coronial recommendations: Fatal facts

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<td>Fatal facts edition</td>
<td>50 – cases closed between July and September 2016</td>
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Case summary

An older female died as a result of positional asphyxia at the aged care facility where they resided.

The adult’s bed was fitted with poles to assist them in mobilising. They were discovered deceased in the morning by facility staff. Their body was completely off the bed and their head and neck were trapped between the pole and the mattress.

The adult was immobile at the time of their death and were subject to checks by staff every half hour.

Coronial findings

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

The coroner noted that the dangers associated with bed poles were raised and known at the facility. The bed poles remained installed outside of the correct risk assessment guidelines for nearly two years.

The coroner was unable to determine how the adult rolled off the bed.

The coroner found that the facility staff were unable to adequately maintain written records, and as such it was unclear when the older person was last checked by a staff member. The coroner was unable to make a positive finding that the failure to provide the half hour checks contributed to the older person’s death.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That aged care services and approved providers immediately cease the use of bed poles of the [bed model] or similar style in aged care facilities.
- That the Department of Health and Ageing promptly draws these findings and recommendations to the attention of all Australian aged care services and approved providers.
• That the facility undertakes a program to provide all Extended Care Assistants (ECAs) with appropriate and current first aid qualifications.
• That the facility rosters a minimum of two ECAs in the [ward] during the night shift.
• That the facility reviews its current policy implementation processes to ensure that all staff are notified promptly of alerts, policies and alterations to policies concerning resident care and safety; these processes should also ensure that such notifications are the subject of regular updates and reminders.
• That the facility reviews its systems and processes for maintaining records, including resident’s files, to ensure that they are retained in a complete, ordered and accessible manner and retained for the required period of time as provided by archiving legislation.
• That the facility develops a consistent and rigorous process for internally investigating and responding to significant incidents.

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VICTORIA

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

Case summary
A middle aged male took their own life by ingesting a chemical substance.

The adult was facing stressors in relation to ongoing heart problems. They were under the care of a general practitioner for their heart condition and for treatment of anxiety and depression.

Some time after the adult had ingested the chemical, they contacted emergency services and requested an ambulance.

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

The coroner found that the initial call received by emergency services failed to identify the risk of poisoning overdose to the adult. As a result, the ambulance service did not respond to the case as a critical incident.

The adult made numerous additional calls to emergency services. The call-taker understood these calls to be seeking an estimate of the ambulance’s arrival time. The calls were not escalated to the duty manager as directed in the standard operating procedure until several calls later. There were no follow up questions asked of the adult to determine their deteriorating state of health.

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

- That Emergency Services Telecommunications Authority (ESTA) and Ambulance Victoria (AV) consider the circumstances surrounding [the deceased's] death, reflecting in particular on the evidence of [doctor], and craft as clear and seamless an arrangement as possible between them to ensure that cases of overdose or poisoning are appropriately prioritised for emergency ambulance response, bearing in mind the occult nature of the pathology, the need for timely specialist toxicological input particularly as to unusual
substances, and the risk to public safety inherent in waiting for overt symptoms to present. Whether this is achieved by an amended or a new Standard Operating Procedure or otherwise, is a matter for ESTA and AV to resolve between them but it would be sensible to consult with the Victorian Poisons Information Centre.
Coronial recommendations: Fatal facts

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

A young female took their own life in an incident involving a train.

The young person had been diagnosed with symptoms of depression, anxiety and negative body image. They had experienced episodes of self-harm and suicidal thoughts.

Coronial findings

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

The coroner found that the young person’s treatment team did not adequately assess the impact of treatment for anorexia nervosa on the young person’s mental wellbeing. A formal risk assessment was not conducted nor was there evidence of the young person’s treating team exploring the reasons for their underlying suicidal thoughts and self-harming behaviours.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That [mental health service] undertake a review of the training it provides staff in relation to risk assessment to ensure that it incorporates guidance specific to the risk assessment of adolescents.
- That [mental health service] review its processes in these areas to ensure that they address the frequency of risk assessments and how this clinical information is documented and shared.
- That [mental health service] encourage its Family Based Therapy clinicians engage with patients with eating disorders and their families early in the treatment process to develop two safety plans, one tailored to the needs of the patient and the other addressing the needs of the family.

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Coronial recommendations: Fatal facts

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<td>Fatal facts edition</td>
<td>50 – cases closed between July and September 2016</td>
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Case summary
A young male took their own life in an incident involving a train.

The young person was being treated for mental health issues by their general practitioner. They had a mental health plan in place. At the time of the incident, the young person was non-compliant with their prescribed medication.

Coronial findings
The coroner found that the death was due to intentional self-harm. The coroner found that the clinical management and care provided by the treating practitioners was appropriate. The young person was well engaged with a general practitioner and psychologist. The treating clinicians communicated well with each other, actively considered the risk of suicide and were all satisfied that the young person was not at high risk of taking their own life.

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

- That the Department of Economic Development, Jobs, Transport and Resources together with Public Transport Victoria, Metro Trains Victoria and Victoria Police (in its capacity as employer for Public Service Officers) ensure that all relevant staff be trained in identifying and responding to persons whose pattern of behaviour is out of the ordinary when around a train track to ensure vulnerable persons are not at risk of injury or death.
- That the Department of Economic Development, Jobs, Transport and Resources together with Public Transport Victoria and Metro Trains Victoria implement, at all train stations, billboards or signs advising people, if they are concerned about a person’s risk taking behaviour around a train station, to either call ‘000’ or to press the red button in the safety zone at train stations or the red button on board a train.

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Coronial recommendations: Fatal facts

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<td>Fatal facts edition</td>
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Case summary
An older adult female took their own life in a fall from height.

Prior to the incident, the adult had been a voluntary patient at a nearby hospital. They had left the facility on the morning of their death and attempts were made by hospital staff to contact them.

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

The coroner found that the incident location was known for intentional self-harm incidents. Some levels of the building had barriers to stop items or people from falling over the edge. The building was compliant with legislation and codes regarding public safety.

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

- That the Victorian Department of Environment Land, Water & Planning implement amendments to the Building Act 1993 and Building Regulations 2006 to provide Municipal Building Surveyor with powers to require modification to publicly accessible buildings which have been used as a suicide location; and
- That during the next review of the National Construction Code, the Australian Building Codes Board consider the implementation of a requirement for increased jumping suicide prevention measures on commercial, industrial and public buildings under the National Construction Code, with particular attention to car park facilities.

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Coronal recommendations: Fatal facts

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<th>Case number</th>
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<td>Fatal facts edition</td>
<td>50 – cases closed between July and September 2016</td>
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Case summary

A young male died due to complications of methadone toxicity.

The young person was known to have a substance abuse problem, which was exacerbated by their parent’s illicit substance abuse.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the young adult lived with their parent, who frequently engaged in illicit substance abuse and encouraged their children to do so as well. The parent was taking methadone, which was accessible to the young person as it was kept in the home.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Department of Health and Human Services (DHHS) review the safe methadone storage section of its Policy for Maintenance Pharmacotherapy for Opioid Dependence, and consider whether any further action can be taken to encourage safe storage of methadone. In particular, DHHS could consider whether distributing lockable boxes to methadone clients might be effective, as an appropriate response to the death of [the deceased] and in the context of six deaths between 2010 and 2013 of young people under the age of eighteen years.
Coronial recommendations: Fatal facts

Case number | VIC.2013.5525
Primary category | Drugs and alcohol
Additional categories | Adverse medical effects
Fatal facts edition | 50 – cases closed between July and September 2016

Case summary

An adult female died due to drug toxicity.

The adult suffered chronic pain following a serious vehicle incident several years earlier. They were prescribed opioid medication for pain management. The adult later admitted to their general practitioner that they were addicted to the opioid medication.

The adult often approached their general practitioner for early script renewal and dispensing. Their general practitioner was proactive in trying to address ways to manage their chronic pain while being aware of their dependence. The general practitioner was aware of the adult’s drug-seeking behaviour and believed they had implemented strategies to prevent it.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that there was a need for cooperation between doctors and pharmacists, as well as vigilance on the part of both when dealing with prescriptions for drug-dependent patients. The coroner noted that clear communication would be essential between the two parties on the allotment of prescriptions and that neither party should assume that the other had safeguards in place to prevent a drug-dependant individual from accessing prescribed pharmaceutical drugs in ways that might create an increased risk of misuse and overdose.

Coronial recommendations

The coroner made the following recommendations related to this case:

- The Royal Australian College of General Practitioners and the Pharmaceutical Board of Australia collaboratively consider how they might incorporate the lessons of this case into future training and the design of future interventions to reduce pharmaceutical drug-related harms.
- The Royal Australian College of General Practitioners and the Pharmaceutical Board of Australia collaboratively consider the need for the development of a joint guideline in relation to communication between the professions to ensure the safe prescribing and
dispensing of drugs of dependence, including methods of implementing daily dispensing, avoiding early dispensing and the provision of prospective prescriptions.

- The Royal Australian College of General Practitioners consider the need for further education and training or assistance to rural general practitioners dealing with complex patients suffering chronic pain and prescription drug dependence.
Coronial recommendations: Fatal facts

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

A male child died due to a house fire.

The fire started while the child was left unattended at home. The child had a fascination with a lighter that was used around the home. They knew how to use the lighter and could make a flame.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the lack of supervision, the child’s access to the lighter within the home and their fascination with the lighter were all factors in the incident.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That [name], the Commonwealth Minister for Small Business, introduce a mandatory safety standard for barbeque type stove lighters similar to the standards applied to disposable cigarette lighters, particularly noting the need for child resistance requirements.

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Coronial recommendations: Fatal facts

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

A young male died due to complications following a period of immersion in a public swimming pool.

The young person was an international visitor to Australia on a student visa. They had limited experience swimming and were in the company of a person who could not swim at the time of the incident.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the young person did not inform any of the workers of their lack of swimming ability before entering the pool. There was no signage available to prompt poor or non-swimming customers to alert lifeguards or pool staff of their swimming competence.

At the time of the young person’s arrival, the pool’s drop-off zone was marked by a removable boom. The boom separated the pool into two areas, shallow and deep. This zone featured a steep change in the pool’s depth.

The young adult was seen by other patrons on the shallow side of the boom. The boom was removed from the pool shortly afterwards.

The coroner found that the pool was not being monitored sufficiently by trained lifeguards, who were busy removing the boom at the time of the incident.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That [swim centre managing company] implement a system, not limited to, but which may be in the form of signage, requesting patrons to inform a staff member of their vulnerabilities before entering the water.
- That [swim centre managing company] in consultation with [local council] explore the options and means for best communicating with and encouraging patrons who have
English language challenges, to inform a staff member of their vulnerabilities before entering the water. The communication option may take the form of, but not be limited to, visual imagery on a monitor at the Reception area and multi-lingual written material.

- That the Secretary of the Department of Premier and Cabinet, work with the appropriate area of Victorian government to establish a central oversight and regulation body for public swimming pool operation in Victoria, to ensure safety standards are applied and upheld consistently across the industry.
Coronial recommendations: Fatal facts

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<td>Fatal facts edition</td>
<td>50 – cases closed between July and September 2016</td>
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Case summary

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

The adult was travelling in a ‘scanoe’ vessel equipped with a motor. The adult was a competent swimmer and experienced boat user, though they did not hold a current boating licence and the vessel was not registered. It was not common practice for the adult to wear a personal floatation device when operating their vessel.

The weather conditions for the day of the incident were cold, overcast and windy and the water was cold.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the exact circumstances of the adult’s death were unable to be determined but that there were several factors that could have prevented it.

Contributing factors to the death included the absence of a personal floatation device, an elevated blood alcohol level, the adult boating alone. In addition, there were incidental breaches of regulations; the scanoe was unregistered and the adult did not hold a recreational boating licence. The coroner also found that there was a lack of signage around the lake and near the boat ramp in relation to the dangers of boating and immersion in cold waters.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That [water company] erect additional safety signage adjacent or proximate to the boat ramp at [lake].

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Coronial recommendations: Fatal facts

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

An adult male died due to injuries sustained in a vehicle maintenance incident.

The adult was working underneath a car when the car rolled down the ramps it was positioned on, pinning the adult beneath it.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult had failed to brace the front wheels of the vehicle after it had been reversed onto makeshift ramps. The adult was not a qualified mechanic and was not qualified to undertake the repairs and rebuilding of the vehicle.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Australian Competition and Consumer Commission review the effectiveness of the outcomes and reach of its national ‘Do It Yourself’ vehicle safety campaign and consider further activities, such as, but not limited to, weekend radio advertisements to further highlight associated safety issues.
- That WorkSafe Victoria review its role in raising awareness amongst the Victorian community of important safety precautions for people engaging in ‘do-it yourself’ motor vehicle repairs.

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Coronial recommendations: Fatal facts

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Case summary
A young male died due to electrocution in a workplace incident.
The young person was an apprentice electrician. They were undertaking electrical works on a family member’s home at the time of the incident.

Coronial findings
The coroner found that the death was unintentional.
The coroner found that the house was not installed with a Residual Current Device. The house was built before such a device was required by regulations.

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

- That the Secretary of the Department of Environment, Land, Water and Planning conduct a feasibility assessment on implementing the Western Australian model in Victoria, whereby all homes that are sold and all rental properties would be fitted with a Residual Current Device.

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Coronial recommendations: Fatal facts

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Case summary
An older adult male died due to complications from a medical procedure to address bowel issues.

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

The coroner found that there was poor documentation and communication by the adult’s treating team during their admission to the medical centre. Due to the insufficient medical and nursing documentation of clinical assessments, it was unclear whether adequate nursing or medical assessments took place.

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

• That [medical centre] use this case as a training example to remind nursing staff of the importance of adequate nursing assessment and documentation and for surgical staff to remind them of the importance of adequate communication not just within the surgical team, but to nursing staff as well as patients and their families.

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Coronial recommendations: Fatal facts

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<td>Fatal facts edition</td>
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Case summary
An older adult male died due to presumed natural causes.

The adult had experienced trouble breathing and contacted emergency. They had given their address to the call taker but had failed mention that they lived in a residential caravan at a caravan park and failed to inform the call taker of the caravan’s site number.

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

The coroner found that the ambulance service had difficulties in locating the older adult due to the lack of information received from the emergency service call taker. The emergency service system did not indicate that the address supplied was a caravan park and so the call taker did not know to ask for further information. The call taker followed protocol at the time of the call. The protocol did not suggest asking the caller for information about the type of dwelling they resided in.

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

- That Emergency Services Telecommunications Authority protocols be amended to include an additional question after asking for the address such as 'What type of residence is that?' or 'Is that a house or a flat or something else?'

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Coronial recommendations: Fatal facts

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Case summary

An older adult male died due to a stroke.

In the lead up to the stroke, the adult had a mini stroke, which was diagnosed by an ophthalmologist. It was recommended that the adult follow up with their general practitioner.

Coronial findings

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

The coroner found that the care provided to the adult by the ophthalmologist was within the clinical guidelines. The adult failed to appreciate the urgency of the tests requested and the necessity to follow up with their general practitioner.

Coronial recommendations

The coroner made the following recommendations related to this case:

- The Royal Australian and New Zealand College of Ophthalmologists develop a safety alert or information guideline, in line with the 'Clinical Guidelines for Stroke Management 2010', to be provided to ophthalmology patients, when an Ophthalmologist has identified the patient has suffered from a transient ischaemic attack. The safety alert or information guideline should inform the patient that a transient ischaemic attack is a medical emergency, is a significant predictor of future stroke and it is necessary to seek urgent medical attention from a General Practitioner or a hospital Emergency Department.
## 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>
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<tr>
<td>Animal</td>
<td>Incidents where an animal was involved in the cause of death.</td>
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<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</td>
<td>Fatal incident that occurred as a result of domestic injury or event.</td>
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<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. Adamis was involved in the circumstances or cause of death.</td>
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<tr>
<td>Indigenous</td>
<td>Cases related to a specific demographic group.</td>
</tr>
<tr>
<td>Intentional self-harm</td>
<td>Cases determined intentional self-harm (ISH) by coronial investigation</td>
</tr>
<tr>
<td>Law enforcement</td>
<td>Includes police pursuit, death in custody, parole issues, pending or previous court cases including family court, restraining order and coronial investigation procedures.</td>
</tr>
<tr>
<td>Leisure activity</td>
<td>Any leisure actively that directly influence the circumstances including holiday.</td>
</tr>
<tr>
<td>Category</td>
<td>Description</td>
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</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>
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<tr>
<td>Sports related</td>
<td>Cases where a sports incident significantly impacted the cause of death.</td>
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<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>
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<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>
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<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>
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<tr>
<td>Work related</td>
<td>Includes cases where work is related to the death and also where unemployment is significant.</td>
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<tr>
<td>Weapon</td>
<td>Cases where the involvement of a weapon is significant.</td>
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<tr>
<td>Youth</td>
<td>Cases related to a specific demographic group.</td>
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</tbody>
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