Coronial recommendations: Fatal facts

A summary of cases and recommendations made between October and December 2016

Edition 51
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National Coronial Information System
CORONERS’ RECOMMENDATIONS

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

The National Coronial Information System (NCIS) maintains a repository of information on deaths reported to a coroner in Australia and New Zealand. Subject to coronial approval, the NCIS publish summaries of Australian cases in which a coroner has made a recommendation. *Coronial recommendations: Fatal facts* includes case summaries and recommendations for cases closed between October and December 2016.

AUSTRALIAN CAPITAL TERRITORY

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

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<th>Case number</th>
<th>ACT.2015.25</th>
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</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Sports related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>51 – cases closed between October and December 2016</td>
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Case summary
A middle aged male died after their racing bicycle broke and they fell onto the road.

The front fork of the bicycle unexpectedly and catastrophically failed while the adult was riding along a road. They suffered fatal head and neck injuries and died in hospital.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the failure of the fork was caused by a fatigue fracture inside the fork, and occurred in a location where it was not visible to persons inspecting and servicing the bicycle. The coroner found that the fork design had a finite structural life and, upon reaching that point, could fail catastrophically without warning.

The coroner found that prior servicing of the bicycle was adequate, and the other components fitted to the bicycle had no causal connection to the fork failure.

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

- Although [bicycle company]'s owner manuals already warn owners that bicycles are not indestructible and every part of a bicycle has a limited useful life, I recommend that [bicycle company] update its owner's manuals and consumer information to expand upon this warning and to note the risk of catastrophic failure without warning in some circumstances.

- I note that [bicycle company] has already committed to amending its owner’s manuals in this respect, and to notify consumers of this change by creating a temporary notice on its Australian website to direct [bicycle company] owners to the new version of the manuals. [Bicycle company] will also communicate directly with the owners of [bicycle company] bicycles who have registered their purchase with [bicycle company], to direct them to the website and new manual.
• I recommend that [bicycle company] undertake public education activities within Australia, and particularly within the Australian Capital Territory, to bring the issue of bicycle component life to the attention of existing [bicycle company] bicycle owners, in addition to purchasers of new bicycles.

• I note that [bicycle company] has committed to publish material on its Australian social media assets, including Facebook and Twitter, about the importance of rider safety and to encourage consumers to visit their local dealer if they own an older bicycle or a bicycle that has been involved in an accident. [Bicycle company] will also include a reference and hyperlink to its Australian website, where consumers can access further information on rider safety and the updated owner's manual.

• I also note that [bicycle company] intends to post a notification to its Australian dealers that will encourage them to educate consumers who pass through their shop about the issue of inspections, bicycle component life and, where appropriate, suggest replacing the component or the bicycle with a new model. [Bicycle company] will also remind its dealers to inform existing owners about the updated owner's manual available on [bicycle company]'s website.

• I also note that [bicycle company] has indicated it is prepared to undertake outreach to bicycle advocacy groups to educate the cycling community on the issues of metal fatigue and bicycle component life. In particular, [bicycle company] will contact ACT Pedal Power, which is a local cycling advocacy group, and the Cycling Promotion Fund, which is a national advocacy group, to publicise these issues to cyclists throughout Australia.

• I recommend that Standards Australia and other relevant international standards bodies investigate fixing an upper "safe life" limit (safe life) for the bicycle front steering fork, depending on the manufacturing process and material construction of the part, after which the owner is encouraged to replace the part irrespective of whether damage is visible.

• I note that [bicycle company]'s bicycles sold in Australia meet or exceed the Australian Standard (AS/NZS 1927:1998- Pedal Bicycles- Safety Requirements), and also pass ISO 4210, an international standard that specifies the safety and performance requirements for the design, assembly and testing of bicycles and certain sub-assemblies. However, these standards do not address the issue of safe life, and the Australian Standard also has no reference to metal fatigue. [Bicycle company] has advised me that previous attempts internationally to introduce this type of standardisation have failed due to industry views that individual bicycle usage is subject to such wide variability that assigning a safe life would not be meaningful or of assistance to a consumer. However, [inquest consultant engineer]'s advice to me is that safe lifes are routinely fixed in respect of aerospace components. Given aerospace materials such as carbon fibre and aluminium alloys are now routinely used in high end racing bicycles such as [the deceased]'s bicycle, it seems to me that similar product safety considerations should apply.

• [Bicycle company] has undertaken to me that it will request international standardisation bodies to reconsider their prior rejections of safe life limits, and it will approach
Standards Australia to reconsider the lack of reference in the Australian Standard to safe life or metal fatigue.
Coronial recommendations: Fatal facts

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<tr>
<th>Case number</th>
<th>ACT.2015.264</th>
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<tr>
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<td>Water related</td>
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<td>Fatal facts edition</td>
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Case summary
A male child drowned in a backyard in-ground swimming pool.

The child was staying with their parents at a relative’s house. The child was left to be supervised by the relatives while the parents underwent other tasks. After a short time, the child was noticed to be missing. They were subsequently discovered at the bottom of the swimming pool.

The swimming pool was not fenced. The water was murky, and the bottom of the swimming pool was not visible.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the swimming pool was not fenced and access to it was directly from the back door of the house. The coroner found that the back door did not have specific child locks or self-closing mechanisms to deter access to the back yard and the pool.

Despite this, the coroner found that the swimming pool was compliant with the applicable state pool fencing legislation. The coroner noted that the current law did not require historically and lawfully erected pools to be retrofitted with pool barriers.

The coroner found that a key factor in the child’s death was a lack of supervision.

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

- That the ACT Government develop and implement as a matter of some urgency, bearing in mind the advent of summer, a public awareness campaign with two key messages:
  - First, to remind the community of the importance of active and close adult supervision of small children in the vicinity of home swimming pools; and
o Second, to raise awareness in the community of the efficacy of prompt resuscitation in reviving children who have fallen into water, and to encourage adults involved in supervising children in water to obtain and maintain appropriate life saving skills.

• That the ACT legislative framework applying to home swimming pools be amended to require that all existing home swimming pools, irrespective of when they were constructed or installed, be required to comply with the latest version of the Building Code. I note that it is a matter for government as to what transitional periods or arrangements might be adopted, but the outcome of having all home swimming pools protected by child-resistant safety barriers should be achieved as soon as possible.

• That the ACT legislative framework applying to home swimming pools be amended to provide methods for ensuring all existing pools continue to comply with the latest standards as they change over time. It is not necessary for the purpose of this inquest for me to recommend a method, but I note that other jurisdictions have employed the following tools, often in combination, which are worthy of consideration:
  o A register of all home swimming pools and a compliance certificate regime;
  o A regime of periodic safety inspections;
  o Sale or lease triggering a requirement to make the pool barrier compliant with the standard in force at the time.

• That the ACT have regard to the findings and recommendations of Coroners in other States and Territories since March 2011, in so far as they are relevant, and to the material in evidence in this inquest, in taking the actions recommended by me.
NEW SOUTH WALES
The following cases summaries and recommendations relate to deaths reported to a coroner in New South Wales.
Coronial recommendations: Fatal facts

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<th>Case number</th>
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<td>Fatal facts edition</td>
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Case summary
An adult male was presumed deceased. They were reported missing and subsequent investigations were unable to uncover evidence regarding their disappearance.

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

The coroner found that the police investigation raised a strong suspicion that the adult’s death was due to homicide.

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

- I recommend that the death of [the deceased] be referred to the Unsolved Homicide Unit of the NSW Police Homicide Squad for further investigation in accordance with the protocols and procedures of the Unit.

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

<table>
<thead>
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<th>NSW.2013.4467</th>
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<td>Primary category</td>
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<td>Fatal facts edition</td>
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Case summary

A middle aged female died after a surgery to remove a brain tumour.

They lost a significant amount of blood during the surgery and there were complications with administering blood products. At the end of the surgery, they were noted to have suffered brain damage due to low blood supply to the brain. They did not recover 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 the surgeon and the anaesthetist had differing opinions about the risk of blood loss during the surgery, and found that this difference in opinion was not communicated. The coroner found that there should have been better communication from each doctor prior to the surgery commencing.

The coroner found that the intraoperative blood salvage device utilised during the surgery was not adequately or appropriately connected, and therefore did not retain the expected amount of blood to continue the surgery without complication.

The coroner found that the middle aged person’s quality of life would have deteriorated slowly and consistently if the tumour had not been removed. The coroner found that the complications during surgery were unexpected and life-threatening, and that both the surgeon and anaesthetist acted appropriately once the surgery became an emergency.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That a copy of the coronial findings and reasons, and the transcript of evidence be forwarded to the Chief Executive Officer of the [location health district] with a view to:
  - the findings being used to review the outcomes of the morbidity and mortality meetings (surgery and ICU) that have taken place to date; and
consideration of a joint review between surgery and anaesthetic representatives to discuss expectations around communication between specialities in the lead up to, and during, surgery.
Coronial recommendations: Fatal facts

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<th>Case number</th>
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<td>Location, Misadventure, Drugs and alcohol</td>
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<td>Fatal facts edition</td>
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Case summary

An adult male drowned when they fell from a boardwalk into the ocean.

The adult was attending an event at the location. They were intoxicated at the time of their death.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that there were several significant system failures relevant to the circumstances in which the adult, as a patron attending the event, fell into the ocean.

The coroner found that alcohol intoxication was a contributing factor.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the directors of [event organiser group]:

- That the directors of [event organiser group] give urgent consideration to the retention by the company of an appropriately qualified risk management consultant to perform a review of the company’s risk management policies, practices and procedures.
- That the directors of [event organiser group] give urgent consideration to the provision of formal, documented training to directors, officers and employees who are required, from time to time, by the company to conduct risk assessments and to prepare event management and emergency management plans. Such training should be provided by an appropriately qualified risk management consultant or registered vocational training organisation specialising in the provision of risk assessment and risk management training.

To the Minister responsible for Property NSW and the Chief Executive Officer of Place Management NSW [formerly the Sydney Harbour Foreshore Authority]:

- That the Minister and the Chief Executive Officer give urgent consideration to the establishment of an independent review of the risk assessment and risk management
systems utilised by Place Management NSW (including the divisions known or formerly known as the "Operations" and "Events" divisions) in relation to the planning and conduct of events to be held on the land managed by Place Management NSW (including events organised by a third party).

- That the independent review referred to in recommendation 3 above should include a review of the steps taken to ensure that officers in charge of Place Management NSW vessels operated in the waters of [location] are appropriately licenced and qualified.
- That the Minister and the Chief Executive Officer give urgent consideration to the development by Place Management NSW of documented, identified and quantifiable criteria for the purpose of defining “major” or “large scale” events to be held in the [location] precinct at which the event manager must be required, for the safety of the public, to erect temporary barriers to isolate the open waters’ edge of [location].
- That the Minister and the Chief Executive Officer give urgent consideration to establishing a systematic review, using historical incident data, of the corporate ‘Risk Decision Criteria’ used by Place Management NSW, in particular, as used in the assessment of the risks to public safety associated with the open waters’ edge at [location] (as outlined in the Reliance Risk Shoreline Risk Assessment report dated 2 November 2015 compiled for Sydney Harbour Foreshore Authority). The purpose of the review is to ensure that an appropriate balance is maintained between the design objectives associated with the preservation of an open waters’ edge to [location] and the need to ensure public safety in relation to the ongoing operation by Place Management NSW of the [location] precinct as a major local and international tourist destination.
Coronial recommendations: Fatal facts

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<th>Case number</th>
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Case summary

An older male died in hospital as a result of a head injury sustained in a fall.

The adult had two falls in the days prior to their admission to hospital, and attended general practitioners for assessment after each fall. They were taking blood thinning medication at the time of their death.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the general practitioners who assessed the adult after each fall conducted their assessments appropriately. The coroner noted that the adult was not a usual patient of either general practitioner.

The coroner accepted that the adult did not display any significant change or cognitive depreciation at the time of their presentation to the general practitioners. However the coroner found that the general practitioners’ decisions were open to them to take a more conservative approach and refer the adult to hospital for a computed tomography (CT) scan.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the Royal College of General Practitioners consider including an anonymised report of this death and the issues involved in its weekly newsletter to assist in the ongoing education of GPs on the subject of the assessment of closed head injuries in older people who are taking anticoagulation medication. I request that a copy of these findings is sent to the Royal Australian College of General Practitioners for this purpose.

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Coronial recommendations: Fatal facts

Case summary
An adult male died of a head injury sustained when they were struck by a cricket ball during a professional cricket match.

The adult was batting at the time of the incident. They mistimed a shot and the ball struck them in the head below the line of the cricket helmet. They collapsed and were taken to hospital. They did not regain consciousness and died some days later.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the rules around dangerous and unfair bowling were difficult to interpret unambiguously, and there were differing opinions among experienced umpires as to how they should be applied. The coroner found that the relevant rules were not breached on the day of the incident.

The coroner found that the medical systems in place to respond to such an incident were inadequate. However, the coroner found that the injury suffered by the adult was unsurvivable, irrespective of the efficiency and skill of the emergency response. The coroner noted that significant improvements in the medical systems have been made since the incident.

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

- Review of dangerous and unfair bowling laws
  - In view of apparent inconsistencies in the drafting of Sheffield Shield Playing Conditions Laws 42.2.1 and 42.3.1 and the uncertainty even among senior umpires as to how those laws interrelate, it is recommended that Cricket Australia review them with a view to eliminating any anomalies and that umpires be provided with more guidance as to how the laws should be applied.
- Research and development into neck protectors
• It is recommended that Cricket Australia continue its collaboration with sports equipment developers, consultation with players’ associations and testing of existing and yet to be developed devices with a view to identifying a neck protector that can be mandated for wearing at least in all first class cricket matches.

• Medical briefing
  o It is recommended that the Trust and Cricket NSW review the implementation of the policy governing the daily medical briefing to ensure that all key staff members are aware of its purpose. Consideration should be given to mandating that a single page document is created at the beginning of each day’s play that identifies the individuals who will discharge the key functions should an emergency occur, and that records the contact numbers of those people. Each participant should leave the meeting with a copy of that document.

• The role of the umpires
  o It is recommended that the training of umpires be reviewed so that they can ensure medical assistance is summoned effectively and expeditiously.

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Coronial recommendations: Fatal facts

Case number | NSW.2014.5058
Primary category | Work related
Fatal facts edition | 51 – cases closed between October and December 2016

Case summary
A young male died in the course of their employment.

The young person was employed to harvest turf. Their role involved standing on a platform attached to the rear of a harvester while the harvester towed by a tractor to the unloading point. They had been employed in this role for some time.

On the day of the incident, the driver of the tractor was required to reverse the tractor and harvester to the unloading point while the young person stood on the rear platform. The driver lost sight of the young person and stopped the tractor. They discovered the young person trapped underneath the tractor. Ambulance officers attended and declared the young person deceased.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the driver of the tractor had been undertaking the work for several years without incident.

The coroner found that there was evidence of the young person operating the platform while the harvester was in motion, which was considered dangerous practice. The coroner noted that the young person’s colleagues and superiors had warned them of the dangers of the practice.

The coroner found that there was no simple or unequivocal resolution about whether the tractor should have been removed prior to the attendance of ambulance personnel.

The coroner was unable to make a finding on how the young person fell into the path of the tractor.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the Minister for Health:
• That the NSW Ambulance Service conduct a review of the evidence and findings in relation to the death of [the deceased] for the purpose of determining whether any changes are necessary to its protocols and procedures for persons trapped under heavy equipment, with a view to improving patient outcomes prior to the arrival of emergency service personnel.

To the Minister for Innovation and Better Regulation and the Chief Executive Officer for Safework:
• Prior to sale, suppliers of sod (turf) harvesters should consider the provision of mirrors/devices that allow the operator a larger field of vision to the rear of the plant and a reversing obstruction alarm to be installed.
• Currently owned /operated sod (turf) harvesters, persons conducting a business or undertaking (PCBU’s) should consider retro fitting mirrors/devices that allow the operator a larger field of vision to the rear of the plant and a reversing obstruction alarm where there is a risk of a person being struck.
• Turf harvesting businesses are to implement a system of work where:
  o the operator is to remain in control of the harvester at all times whilst the plant is in operation/use.
  o whilst in operation the harvester is only to be driven in reverse when absolutely necessary
  o stackers leave the harvester and move into a safe position where they can be seen by the operator
  o the operator does not reverse until identifying that the stackers are in the safe location
  o whilst reversing the operator monitors the path of travel and that stackers remain in sight out of the travel path, and
  o the operator stops when the obstruction alarm sounds until they check the path is clear,
  o workers are trained in the system of work
• Turf harvesting businesses are to regularly monitor the work through supervision and consultation to ensure the system is being used and is effective.

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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

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<td>Fatal facts edition</td>
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Case summary
An adult female died of a heart condition.
They were discovered unresponsive at home and were transported to hospital where they died later that day.

Coronial findings
The coroner found that the death was due to natural causes.
The coroner found that there was a significant delay between the police compiling their investigation file and providing this file to the coroner’s office. The coroner found that this presented a failure of the death investigation process to fulfil the expectation of the family for a conclusion within a reasonable time.
The coroner found that the mortuary facilities were not of a contemporary standard, and noted that the Department of Health aimed to remedy the problems with the old design.

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

- I recommend that the Northern Territory Police do all things necessary to successfully ensure that coronial investigations are conducted and finalised in as timely a fashion as possible in all circumstances.
- I recommend that the Department of Health apply their best efforts to successfully ensure that there are a minimum of two forensic pathologists employed in the Forensic Pathology Unit.
- I recommend that the Department of Health do all that is necessary to successfully bring to a contemporary standard the on-site grieving, mortuary and body storage facilities.

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Coronial recommendations: Fatal facts

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<th>Case number</th>
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Case summary

A male child drowned in a backyard plunge pool.

The child was in the process of moving into a rental property with their family. The child was being supervised by a family member who was undertaking tasks indoors. After a short time, the child was noticed to be missing. They were subsequently discovered at the bottom of the pool. Resuscitation attempts were made, but they could not be revived.

The child had not had swimming lessons and could not swim. The child had spent much time at the property and around the pool prior to the family moving in.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that children require active supervision around water, but noted that children can drown quickly, easily and quietly. The coroner noted that if the system of supervision fails, there is no further system between that failure and potential disaster. The coroner noted that the *Swimming Pool Fencing Act* was implemented to rectify this issue.

The coroner found that due to the large size of the block, there was no legal requirement for the pool to be fenced, despite its proximity to the house or its rental status. The coroner found that this seemed inconsistent with the intent of the *Swimming Pool Fencing Act*.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the Northern Territory Government give consideration to the breadth of the exemption from the fencing requirements for pools on properties over 1.8 hectares.

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

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

Case number: QLD.2012.4553
Primary category: Location
Fatal facts edition: 51 – cases closed between October and December 2016

Case summary
An adult male died due to injuries sustained when they were struck by a falling awning.
The adult was standing outside a retail building when its awning collapsed, trapping them.
The adult was freed by bystanders, but was unable to be revived.

Coronial findings
The coroner found that the death was unintentional.
The coroner found that corrosion of the awning due to water damage contributed to its collapse.

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

- All local authorities, or their suitably qualified and authorised nominee, at the direction of and with the assistance of the Department of Infrastructure, Local Government and Planning conduct an immediate inspection of all awnings over public footpaths in Queensland.
- That where necessary, appropriate orders be made to rectify any awnings presenting a danger of collapse, and that appropriate legislation be put in place to enforce such orders.
- That an ongoing awning inspection program should be introduced in Queensland for structures over public land, to be administered by Local Authorities. The Minister for the Department of Infrastructure, Local Government and Planning should consider the establishment of a Departmental Taskforce to develop a suitable program, which can effectively reduce the risk posed to the community by aged awnings. The suggestions made by the expert engineers in this case as to the features that could be included in such a program, should be considered by the taskforce. It is crucial that any program introduced ensures that Local Authorities/Councils have the power to conduct effective inspections of awnings over public lands, and can ensure effective compliance by building owners with any enforcement/remedial action that is deemed necessary to remove the risk posed.
That a review of Australian Building Standards be undertaken in relation to awnings generally and cantilevered awnings particularly, to ensure that issues, such as minimum required design life prior to major maintenance, corrosion protection, facilitation of the inspection of primary support fixings, the specification of minimum mechanical anchor embedment and structural soundness are adequately addressed.
TASMANIA

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

Case number
TAS.2013.297

Primary category
Falls

Additional categories
Aged care, Older persons

Fatal facts edition
51 – cases closed between October and December 2016

Case summary
An older male died in hospital following a fall in their aged care facility.

The older person suffered from dementia. They had a fall some days prior to the incident.

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

The coroner found that the adult’s Individual Service Plan (ISP) noted that their fall risk was high, however this information was not transferred to the section outlining the adult’s significant risks, nor onto the Alert Sheets used to inform staff of patient risks.

The coroner found that there was no fall risk conducted by the aged care facility until many days after the adult fell the first time.

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

• I now turn to consider issues surrounding the assessment of [the deceased] for falls risk. In my view the evidence highlights a number of shortcomings. They are:
  o The failure to promptly conduct a falls risk assessment of [the deceased]. Clearly an unexplained delay of nine days before his assessment took place was unsatisfactory.
  o Although the assessment undertaken by [registered nurse] placed [the deceased] in the High category as a falls risk this finding was not recorded on his Alert Sheet and hence this tool was unable to serve as a notice to staff of a significant risk that needed to be managed in providing [the deceased] with proper care.
  o The failure to show [the deceased]’s high falls risk rating as a Significant Risk in his Individual Service Plan (ISP) thereby diluting the value of this document as a tool to alert staff to this risk.
  o The apparent failure to devise and record a plan to manage [the deceased]’s falls risk. The evidence indicates that a plan could have included the use of a low bed, a floor mat and hip protectors.
o Although [registered nurse] testified that [the deceased] would have been shown to be a high falls risk on an office notice board there is not any evidence that satisfies me that on the night [of the fall] nursing staff had implemented any strategy to address this risk. Notably he was not, prior to his fall, provided with hip protectors or a floor mat.

o Although [the deceased]’s ISP indicates that he required a walking stick or a wheelie walker to assist with his mobility, I am satisfied, accepting the evidence of [the deceased’s family member], that neither of these items was provided to [the deceased] whilst he was at [aged care facility].

• All of the foregoing leads me to recommend that [aged care facility] undertake a review of its processes surrounding falls risk with a view to ensuring that assessments are promptly carried out, that risks identified on assessment are properly recorded on patients’ ISPs and, if appropriate, on Alert Sheets, and that suitable strategies to address falls risk are planned, recorded and implemented.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>The coroner held a joint investigation into the following deaths which resulted from similar incidents: TAS.2014.200, TAS.2014.201, TAS.2015.47, TAS.2015.90, TAS.2015.108, TAS.2015.226</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Intentional self-harm</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Location</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>51 – cases closed between October and December 2016</td>
</tr>
</tbody>
</table>

Case summary – TAS.2014.200

A young male drowned after jumping from a bridge with the intention to end their life. They had a history of depression and suicidal thoughts.

Coronial findings

The coroner found that the death was due to intentional self-harm. The coroner found that despite the young person suffering from depression and suicidal thoughts, there was no warning to family or friends of their intention at the time. The coroner found that their existing depressed mood, combined with alcohol and drug intoxication, contributed to their decision.

Case summary – TAS.2014.201

A middle aged female died as a result of a deliberate fall from a bridge. They had a history of depression, alcohol abuse and suicidal thoughts.

Coronial findings

The coroner found that the death was due to intentional self-harm. The coroner found that the adult had work and relationship issues, as well as an impending court case. The coroner found that these issues caused them significant distress in the lead up to their death.

Case summary – TAS.2015.47

An adult female drowned after jumping from a bridge with the intention to end their life. They had a history of suicidal ideation and a prior suicide attempt.
Coronial findings

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

The coroner found that they made the decision to end their life in the context of their worsening mental state.

Case summary – TAS.2015.90

An older male died as a result of a deliberate fall from a bridge.

They had a history of mental ill health and prior suicide attempts.

Coronial findings

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

The coroner found that their ongoing struggle with mental ill health contributed to their decision.

The coroner found that the adult had recently been discharged from a mental health facility. The coroner found that the facility provided a good standard of care and the adult was discharged appropriately.

Case summary – TAS.2015.108

An adult female died as a result of a deliberate fall from a bridge.

They had recently gone through a relationship breakdown.

Coronial findings

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

The coroner found that the adult did not have a diagnosed mental illness, and had planned to end their life the day prior to their death. The coroner found that the adult was unable to cope with the breakdown in their relationship.

Case summary – TAS.2015.226

A middle aged male died as a result of a deliberate fall from a bridge.

Their spouse and parent had died in close succession some months prior. The adult had expressed suicidal ideation in the past.

Coronial findings

The coroner found that the death was due to intentional self-harm.
The coroner found that the adult’s mental state declined severely in the lead up to their death.

Coronial recommendations

The coroner made the following recommendations related to these cases:

- I recommend that the government formulates a plan for the implementation of structural modifications to the [bridge], such structural modifications having a key aim of eliminating the [bridge] as a method of suicide.
- I recommend that the Department of State Growth install additional and enhanced camera surveillance on the [bridge] to provide improved quality footage and complete coverage of all pedestrian areas.
- I recommend that Tasmania Police continues the operation with respect to the reporting of incidents involving suicide, attempted suicide or persons in crisis on the [bridge], and further, Tasmania Police review the accuracy of the current reporting and implement any necessary measures to reinforce to police officers the requirement for complete and accurate reporting of such incidents.
- I recommend that the government continue its commitment as expressed in the Tasmanian Suicide Prevention Strategy to pursue the development of a Tasmania Suicide Register, so as to accurately inform suicide prevention strategies, including strategies for suicide prevention at the [bridge].
- I recommend that the Department of Health and Human Services implement a system for the ongoing monitoring of the use of the telephones and signage on the [bridge], assess the efficacy of those telephones and that signage at regular intervals and report results to the relevant ministers and the cross agency working group.
- I recommend that the cross agency working group continues to operate in accordance with its terms of reference as a principle source of advice to government regarding suicide prevention at the [bridge].
- I recommend that the cross agency working group considers these findings, comments and recommendations in executing its functions in accordance with its terms of reference.
Coronial recommendations: Fatal facts

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<tr>
<th>Case number</th>
<th>TAS.2014.386</th>
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<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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<td>Fatal facts edition</td>
<td>51 – cases closed between October and December 2016</td>
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</table>

Case summary

An older male died in hospital from an overdose of heart medication in the context of heart failure.

They suffered from a heart condition and presented to hospital with declining health. It was discovered they had taken a high dosage of their heart medication and was treated accordingly. They were unable to survive the effects of their underlying heart condition and died.

Coronial findings

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

The coroner found that monitoring of the particular heart medication is important when used for the treatment of heart failure such as that from which the adult suffered.

The coroner found that the adult’s treatment at the hospital was appropriate.

Coronial recommendations

The coroner made the following recommendations related to this case:

- The evidence shows that [the deceased]'s digoxin toxicity was a consequence of him taking digoxin in a dosage which exceeded the capacity of his impaired kidneys to process. I am satisfied that this situation evolved because of a failure to monitor [the deceased]'s digoxin levels on a regular basis and in particular during the two years prior to his death. This leads me to adopt the suggestion of [coronial medical adviser] and recommend that for elderly patients taking digoxin for systolic heart failure, their treating general practitioners ensure that the level of digoxin are monitored by repeat blood testing undertaken every 3 to 6 months.

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

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<th>Case number</th>
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<td>Primary category</td>
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<td>Older persons</td>
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<td>Fatal facts edition</td>
<td>51 – cases closed between October and December 2016</td>
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</table>

Case summary

An older male died in hospital from multi-organ failure as a result of severe pancreatitis.

The adult presented to a small hospital with abdominal pain. They were shortly transferred to a regional hospital and admitted to the surgical ward. They underwent tests on the ward and were later transferred to the intensive care unit. The adult deteriorated and 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 it could have been anticipated that the adult’s illness would have required their management in intensive care for several weeks, and found that it was preferable for the adult to be transferred to a major hospital.

The coroner found that the adult’s decline and eventual death may have been avoided if they had received more proactive care within the first 24-48 hours of their presentation in the regional hospital.

Coronial recommendations

The coroner made the following recommendations related to this case:

- A review of the circumstances leading to [the deceased]’s death was undertaken by the [hospital]’s Morbidity and Mortality Committee. That Committee had access to an internal review undertaken by the hospital’s Quality and Safety Department along with reports upon [the deceased]’s death sought from Upper Gastro-intestinal Specialist and from the Director of ICU at [second hospital]. The Committee concluded, inter alia, that the delay in transferring [the deceased] to the ICU did not negatively affect the outcome. Nevertheless its review led to these recommendations being made:
  - For protocols be set up for patients with pancreatitis to determine if they are mild or severe and for a pathway to follow with severe pancreatitis that assists when to transfer a patient to a higher level of care.
For ongoing staff training for the early recognition and timely management of the deteriorating patient.

To review staffing at [the hospital]’s Critical Care Department to ensure 24 hour onsite qualified senior staff coverage.

- The [hospital] is to be commended for undertaking this comprehensive review. I support its recommendations. It is to be hoped that they are implemented and that they serve to reduce the likelihood of a similar death occurring in the future.
Coronial recommendations: Fatal facts

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<tr>
<th>Case number</th>
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<tr>
<td>Primary category</td>
<td>Aged care</td>
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<td>Older persons, Physical health</td>
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<td>Fatal facts edition</td>
<td>51 – cases closed between October and December 2016</td>
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</table>

Case summary

An older adult male died from aspiration pneumonia due to complications from entrapment of their right arm in a bathroom hand rail.

The adult was a resident in a nursing home. They had care plan in place that addressed the need for assistance with hygiene including toileting and bathing.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the care plan for the adult was not complied with by the staff at the aged care facility.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That [the aged care facility] carry out an audit of all its residents’ Plans of Care with a view to ensuring firstly, that those staff responsible for compliance with the requirements of each Plan are aware of its contents and secondly, that strategies are in place to ensure that each Plan is complied with.

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>Additional categories</td>
<td>Drugs and alcohol</td>
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<td>Fatal facts edition</td>
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</table>

Case summary
An older female died from injuries sustained in a motor vehicle incident in which they were a driver.

The adult was suffering from the effects of a cold and cough and was taking over the counter cough mixture.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the adult had a greater than therapeutic level of dextromethorphan, an active ingredient of the cough medicine, in their system. This impaired the adult’s driving ability, causing inattention, confusion, impaired memory and slowed judgement and reaction speed.

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

- That the drug [brand] carry a warning on both the box and bottle as to the risk of adverse impact upon driving capability.

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VICTORIA

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2013.779</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Drugs and alcohol</td>
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<td>Additional categories</td>
<td>Adverse medical effects</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>51 – cases closed between October and December 2016</td>
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</tbody>
</table>

Case summary

An adult male died from mixed drug toxicity.

The adult had a previous history of illicit drug use and drug-related criminal activity. At the time of the incident, the adult was a voluntary patient at a clinic, participating in a drug rehabilitation program.

Coronial findings

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

The coroner found that there were inadequate practices at the clinic during the treatment and care of the adult. The registered nurses failed to perform hourly visual observations as required. As a result of the inadequate frequency and quality of the observations, the likelihood of the nurse detecting a change in the adult’s respiration rate, pallor and colour was low. The lack of observations resulted in a missed opportunity to intervene in a timely way to provide medical attention to the adult.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That [clinic] amends Policy 9.07 ‘Risk Assessment and Observations-Patient’ to include greater guidance to nursing staff regarding the intensity of purposeful visual observations, especially overnight.

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Coronial recommendations: Fatal facts

<table>
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<tr>
<th>Case number</th>
<th>VIC.2013.1842</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>
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<td>Fatal facts edition</td>
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Case summary

An adult male died from unknown causes, presumed to be natural in nature.

The adult suffered from mental health issues and was under the care of a mental health team. They were compliant with their care and medication, though absconded on several occasions. The episodes of absconding were premeditated and pre planned and began with the adult not collecting their medication. A plan was in place by the mental health team to act when this occurred. This resulted in the adult being listed as a missing person within 24 hours.

Coronial findings

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

The coroner found that the adult’s mental health team reported them missing promptly and provided the police with pertinent information. The concern for the adult’s mental health particularly if it were left untreated was articulated to police on more than one occasion.

The coroner found that at the time the missing persons report was made, the adult was categorised as a medium risk. Early investigations to locate or contact the adult were unsuccessful and the manner of contact was found to have added little value to the investigation. There was no follow up by police after attempts to contact the adult had failed in the first days of disappearance. The coroner found that the efforts to locate the adult were inadequate given the information that was given to police about the adult at the time of disappearance.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Chief Commissioner of Police consider revision of Form LI8A, and in particular, the Risk Factor Guide that appears in Part 2, so that:
  - Risk indicators include the missing person’s status under mental health legislation; and
The instructions provide clear guidance for nominal and supervising members assessing the identified risks, especially by resolving the apparent inconsistency between the mandatory instructions applicable to risk indicators 1 to 8 and the general instruction that weighting of risk factors ‘will depend on the circumstances of each case’.

- That the Chief Commissioner of Police consider introducing a process and policy through which risk assessments are reviewed by a supervising officer at specified intervals to account for the likelihood that a missing person’s risk of harm is not static over time and which monitors compliance with this process.
Coronial recommendations: Fatal facts

<table>
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<tr>
<th>Case number</th>
<th>VIC.2013.2130</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Intentional self-harm</td>
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<tr>
<td>Additional categories</td>
<td>Mental illness and health, Location</td>
</tr>
<tr>
<td>Fatal facts edition</td>
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</table>

Case summary

A middle aged male died due to self-inflicted strangulation.

The adult was an involuntary patient at a mental health facility at the time of the incident.

Coronial findings

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

The coroner found that the adult was transferred to the mental health facility from the emergency room. They were placed in the low dependency unit after an examination and assessment deemed them to have low suicidal thoughts. Potential ligature items were not confiscated prior to the adult being released into the low dependency unit of the facility.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I repeat the recommendation in Finding with Inquest into the death of [VIC.2013.596] where I adopted [the Coroner's] recommendation 1 in the Finding without Inquest into the Death of [the deceased] and urge [mental health facility] to change its current policy that allows patients in the Low Dependency Unit to retain items that are capable of being used as a ligature.
- I refer to the Chief Psychiatrist's guideline Criteria for searches in an inpatient unit which states: 'For patients admitted to an inpatient service dangerous items may also include: ... any objects that could be used to assist in a suicide attempt (for example, plastic bags, scarves, belts, shoe laces or headphone cords.)
- Further, to avoid confusion it is preferable for Psychiatric In-patient Units to take a consistent approach on this point and I urge [mental health facility] to follow the position adopted by [mental health facility and hospital].

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Coronial recommendations: Fatal facts

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<th>Case number</th>
<th>VIC.2013.4547</th>
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<tr>
<td>Additional categories</td>
<td>Youth</td>
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<td>Fatal facts edition</td>
<td>51 – cases closed between October and December 2016</td>
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</table>

Case summary

A young female died from an intentional prescription drug overdose.

The young person had been in foster care since they were an infant. From a young age, the young person had been placed with a foster family that became their own family.

In the days before death, the young person had been removed from the family home into a residential care facility due to behaviour. The young person was assured that the move was temporary, however they were distressed by the move.

Coronial findings

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

The coroner found that the care provided to the young person from both the family and the care facility was reasonable. The coroner was unable to determine if the death of the young person could have been prevented.

Coronial recommendations

The coroner made the following recommendations related to this case:

- In the event of the death of a child under its care the Department of Health and Human Services consider including any agency contracted to care for that child in its internal review process and distribution of its report to that agency.

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Coronial recommendations: Fatal facts

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<th>Case number</th>
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<td>Primary category</td>
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<td>Law enforcement</td>
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<td>Fatal facts edition</td>
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Case summary

An older male took their own life by hanging.

At the time of the incident, the adult was on bail after being arrested. The arrest and pending charges contributed to a deterioration in the adult’s wellbeing and mental health.

Coronial findings

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

The coroner found that the adult had not been supported with welfare management after their arrest. The advice supplied by their solicitor to refrain from all family contact overburdened the adult with loneliness and solitude. The adult was not offered support by the police or their solicitor after being arrested.

Coronial recommendations

The coroner made the following recommendations related to this case:

In my finding into the death of [VIC.2011.2861] made on [date], I made the following recommendations connected with [VIC.2011.2861]’s death. I reiterate those recommendations in this case for the benefit of those interested parties.

- In light of [expert doctor]’s report, Victoria Police should consider reviewing the training provided to officers involved with the interviewing of persons suspected of child related sex offences. Training should encompass an understanding of the psychological reactions of individuals arrested or interviewed for these types of offences. These reactions include, the loss of psychological defences, difficulties dealing with arrest, isolation, effects on those with children, community attitudes, ignorance of the criminal justice system, and cultural, linguistic and mental health issues. For further details about reactions see Attachment ’A’ Excerpt from [expert doctor]’s Report to the Coroners Court of Victoria. The purpose of training is to increase police awareness regarding the ongoing risk of self-harm among this cohort of alleged offenders while an investigation is in process.
• A pamphlet is currently provided by Victoria Police to suspects regarding support information. This pamphlet should also include information about the police investigation, the judicial process regarding police charges, the potential involvement of other agencies, and how to seek appropriate assistance for well-being and mental health. Victoria Police is the obvious point of dissemination for such a pamphlet; however the material should be prepared in conjunction with relevant bodies, such as the Law Institute of Victoria, Victoria Legal Aid, and agencies such as Suicide Prevention Australia and Beyondblue.

• Victorian lawyers who act for persons who are investigated and charged with child related sex offences have an important role to play to prevent their clients from self-harming. Lawyers should also receive training to understand the psychological reactions of individuals arrested or interviewed for these types of offences. These reactions include, the loss of psychological defences, difficulties dealing with arrest, isolation, effects on those with children, community attitudes, ignorance of the criminal justice system, and cultural, linguistic and mental health issues. For further details about reactions see Attachment ‘A’ Excerpt from [expert doctor]’s Report to the Coroner’s Court of Victoria. The Law Institute of Victoria and Victoria Legal Aid should consider the provision of specific training for lawyers acting for this cohort of clients. Lawyers should be aware that the risk of self-harm does not necessarily abate after initial questioning regarding alleged offences but can develop over time. Many suicides occur before the first court date, therefore follow up contact should take place as that date approaches. The likelihood of self harm may build as the court date approaches which can be months or years after the commencement of an investigation. Lawyers acting for those clients should reinforce the role of mental health professionals and encourage their clients to seek advice from their general practitioner. With a referral from their GP for a mental health plan, they can receive six sessions with a psychologist, and, if approved after review, a further four sessions. I note the concerns expressed by the Law Institute of Victoria and Victoria Legal Aid that clients will sometimes either not act on a referral or attend appointments if a mental health plan is developed. Mandatory requirements as bail conditions can be problematic and not all people charged with child sex related offences are placed on bail. Services such as the Court Integrated Services Program (CISP) are utilised by lawyers for clients who are on bail, however CISP is not available once a matter proceeds beyond the Magistrates’ Court.

• Magistrates and all judicial officers should be made aware that any person who is regarded as a suspect and being investigated or charged with child sex offences is an increased suicide risk. Many suicides take place before the first court date, and in this cluster, two took place after a court date. Judicial officers should be aware of the psychological reactions of individuals arrested or interviewed for these types of offences. These reactions include, the loss of psychological defences, difficulties dealing with arrest, isolation, effects on those with children, community attitudes, ignorance of the criminal justice system, and cultural, linguistic and mental health issues. For further
details about reactions see Attachment 'A' Excerpt from [Expert Doctor]'s Report to the Coroners Court of Victoria.
Coronial recommendations: Fatal facts

Case number | VIC.2014.6404
---|---
Primary category | Intentional self-harm
Secondary category | Law enforcement
Fatal facts edition | 51 – cases closed between October and December 2016

Case summary

A middle aged male died from complications after self inflicted hanging.

The adult suffered from Attention Deficit Hyperactivity Disorder (ADHD), depression and anxiety. They were prescribed medications for these conditions. They were under the care of a psychiatrist and reported to act impulsively and suicidal ideation was noted to be possible when the adult was acting impulsively.

Coronial findings

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

The coroner found that the call logged with emergency services was received by a police call taker and appropriate procedures were followed and the call was redirected to the ambulance call takers as per the work flow.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Victoria Police structured call taking manual and Emergency Services Telecommunications Authority (ESTA’s) structured [software system] protocol be reviewed, and where appropriate amended, in order to ensure their workflow procedures reflect a consistent approach in post-dispatch instructions.
Coronial recommendations: Fatal facts

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<th>Case number</th>
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<tr>
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<td>Additional categories</td>
<td>Transport and traffic related</td>
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Case summary

An older male died injuries sustained in a motor vehicle incident in which they were a driver. The incident occurred during an organised racing event. The adult’s vehicle collided with another vehicle that had stalled on the circuit’s starting grid. The adult was an experienced racer and driver, and had been competing in racing events for many years.

Coronial findings

The coroner found that the death was unintentional.

The adult was wearing the required personal protection equipment for the race but was not wearing a frontal head restraint, which was not required. The coroner found that if the adult had been required to wear a frontal head restraint when competing, the risk of sustaining injuries likely to prove fatal would have been significantly reduced.

The coroner found that that hazard warning system in place to warn racers of potential hazards was inadequate at the time.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Confederation of Australian Motor Sport and event organisers collaborate with engineering and human factors experts to formulate strategies to prevent and mitigate the severity of adverse events occurring in motor races at [location] Grand Prix Circuit any all other venues where races are conducted under its auspices.
- That the Confederation of Australian Motor Sport circulate this finding among its members.

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Coronial recommendations: Fatal facts

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Case summary

An adult female died from impact injuries sustained when they were struck by a falling tree branch.

The adult had been camping along a river with a group of friends. The group heard a crack and the branch falling. The grounds on which the party were camping was unreserved crown land.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the land the adult was camping on was subject to a Department of Environment, Land, Water and Planning (DELWP) water frontage grazing licence under section 130 Land Act, which prohibits camping. The free hold for the site was owned by private farmers and only access to the water front was though the farmer’s private property. One of the campers had an agreement with monetary exchange for access to the private property for the purposes of camping.

The coroner found that the campers had chosen to camp in an area that was void of inspection and appropriate management from Parks Victoria. The inability for Parks Victoria to assess the camp ground for risk management, health and safety did have an impact on the death of the adult.

Coronial recommendations

The coroner made the following recommendations related to this case:

- With the aim of improving the clarity of the relevant legislative framework and preventing harms and like deaths, I recommend that the Secretary of the Department of Environment, Land, Water and Planning, coordinate a review of the Land Act 1958 (Vic), in particular reviewing the purpose of the Act; the remedies available for contravention of the Act - including whether penalty units are appropriately substantial and deterring; the application of the Act; and the consistency of the Act with relevant policy issues.
• With a view to ensuring that Parks Victoria is able to discharge its duties to control and monitor crown land, and with the aim of preventing harm and like deaths, I recommend that the Secretary of the Department of Environment, Land, Water and Planning, include a clause within standard licenses for reasonable vehicle access by Department of Environment, Land, Water and Planning (DELWP) or Parks Victoria staff through the licensee's freehold land adjacent to the licensed crown land for the purpose of managing that land, including reviewing and amending existing licenses.

• With the aim of preventing harm and like deaths, and improving the public health and safety for campers on the relevant crown land, I recommend that the Secretary of the Department of Environment, Land, Water and Planning, consider whether [the farmers] have conducted a recreational activity on crown land for profit without a tour operator licence, contrary to section 140H of the Land Act, and whether prosecution is warranted.
Coronial recommendations: Fatal facts

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<thead>
<tr>
<th>Case number</th>
<th>VIC.2014.6048</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Older persons</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Adverse medical effects</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>51 – cases closed between October and December 2016</td>
</tr>
</tbody>
</table>

Case summary
An older female died from complications from a blood clot after hip surgery.
The adult was suffering from the effects of osteoarthritis in their hip and was recommended by their doctor to have a hip replacement performed.

Coronial findings
The coroner found that the death was unintentional.
The coroner found that the adult was exposed to many risk factors due to the hip surgery. The care provided to the adult both prior to and following the surgery was adequate.

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

- The National Health and Medical Research Council (NHMRC) request the Australian Commission on Safety and Quality in Health Care expedite its review of current venous thromboembolism (VTE) guidelines to provide relevant, evidenced based, best practice guidelines for Australian clinicians in 2016, with a particular focus on consideration of the risks verses the benefits of thromboprophylaxis for this group of patients, taking into account complications after surgery related to the use of routine anticoagulants.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2015.2962</th>
</tr>
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<tbody>
<tr>
<td>Primary category</td>
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<td>Older persons</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>51 – cases closed between October and December 2016</td>
</tr>
</tbody>
</table>

Case summary
An older male died from complications of hypothermia whilst suffering from bladder cancer.

The adult had presented to the hospital emergency department for treatment after days of confusion and slurred speech.

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

The coroner found that the treating doctor at the hospital emergency department failed to appreciate the significance of the older person’s hypothermia and symptoms. The adult was discharged from hospital when there were indications of a potential significant illness.

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

- The Department of Health and Human Services Emergency and Trauma Program, responsible for Victorian Hospital Emergency Departments and Urgent Care Centres develop a ‘Track and Trigger’ vital sign system to identify vital signs that fall into a zone of concern which would mandate discussion with senior medical staff.

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

Case number: VIC.2015.3575
Primary category: Transport and traffic related
Additional categories: Location
Fatal facts edition: 51 – cases closed between October and December 2016

Case summary

A young male died from injuries sustained in a motorcycle incident.

The young person was riding through bushland. Visibility of the track was poor due to vegetation and bends in the road. A sign on the section of road noted that it was for use by management vehicles and walkers only.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that while the sign depicted that the use of the track was exclusively for management vehicles and walkers, there was no direct sign stipulating that motorcyclists should not use the track.

Coronial recommendations

The coroner made the following recommendations related to this case:

- With the aim of deterring off-road motorbike riders from entering upon dangerous and inappropriate tracks and with the aim of preventing like deaths, I recommend that the [location] Shire Council conduct a feasibility study regarding the erection of appropriate signage that assists with these aims.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2015.4294</th>
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<td>Primary category</td>
<td>Transport and traffic related</td>
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<tr>
<td>Additional categories</td>
<td>Physical health</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>51 – cases closed between October and December 2016</td>
</tr>
</tbody>
</table>

Case summary

An adult male died from injuries sustained in a motorcycle incident.

The adult suffered from a medical condition which caused them to have seizures. They were under the care of a medical practitioner and taking medication for the condition. The adult was advised by their doctor to not drive a vehicle.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult was non-compliant with their medical regime at the time of the incident. The adult did not inform VicRoads that their doctor had advised them not to drive a vehicle, and as such, continued to ride their motorcycle with a valid license.

The coroner found that the adult had cannabis and methylamphetamine present in their system, which would have impeded their ability to control the motorcycle.

Coronial recommendations

The coroner made the following recommendations related to this case:

- With a view to reducing harms to others and preventing like deaths, I recommend that consideration be given by the Secretary of the Department of Economic Development, Jobs, Transport and Resources, and VicRoads, to adopting a framework requiring mandatory reporting to VicRoads when a medical practitioner forms an opinion that a person with a permanent or long-term injury or illness, is not medically fit to drive.

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Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2015.6474</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Natural cause death</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Child and infant death</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>51 – cases closed between October and December 2016</td>
</tr>
</tbody>
</table>

Case summary

A male child died due to complications arising from pneumonia.

The child had been unwell for a week with high temperatures and illness before their parent took them to a medical centre. The child was treated at the medical centre and sent home. Their condition worsened overnight and the parent took the child to the hospital for treatment.

Coronial findings

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

The coroner found that the hospital had put actions in place to better treat unwell children by the time the coronial investigation concluded.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the [hospital] Practice Protocol for seeking paediatric advice when caring for an unwell child be amended to include the use of visual ‘face time’ calling when the GP [general practitioner] contacts the Paediatric Registrar to discuss the presentation of an unwell child.
- That member practitioners operating in rural and regional areas ensure that their practices include formalised protocols for consultation and referral practices including formalised relationships with nearest specialist paediatric service and the inclusion of the protocol of a preference for visual face time calling when discussing the presentation of an unwell child.

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WESTERN AUSTRALIA

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>WA.2013.495</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Intentional self-harm</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Law enforcement, Location</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>51 – cases closed between October and December 2016</td>
</tr>
</tbody>
</table>

Case summary

A middle aged male took their own life by hanging.

At the time, the adult person was a prisoner in a medium security prison. They had made several suicide attempts throughout their life.

Whilst in prison, the adult was prescribed medication to treat depression and diagnosed Attention Deficit Hyperactivity Disorder (ADHD).

Coronial findings

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

The coroner found that the adult was apparently healthy, fit and well, made no complaints and appeared to enjoy their work and living arrangements in view of the severity of their offending. It was only with hindsight and listening to the phone calls made from the prisoner to their partner that the true indications of how the adult was feeling were revealed.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend telephone calls recorded prior to the death of a prisoner in custody be provided to the coroners court as they were in the past. All prison deaths are mandated to be inquested, and while I appreciate not all telephone calls, although recorded are listened to within the prison system, nor is it feasible, they may provide some insight, post the event, as to what may have been in operation in the prisoner’s mind at the time. This may indicate strategies which may be of use in the future in preventing some suicides.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>WA.2014.281</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Natural cause death</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Older persons</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>51 – cases closed between October and December 2016</td>
</tr>
</tbody>
</table>

Case summary

An older female died from organ failure due to sepsis.

The adult suffered from several age-related illnesses, including type II diabetes and ischaemic heart disease with severely impaired right ventricular function. They self-administered insulin with the help of their family.

Coronial findings

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

The coroner found that the adult died due to the choices that they consciously made about their own self-care. The coroner found that while there were systemic failures in the in-home service provider’s care and treatment of the adult, those failures did not contribute to their death.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That, if reasonably practicable, organisations providing home-care generate a document describing the roles and responsibilities of each person involved in a patient’s care, including where applicable the patient’s family or friends, and provide a copy of such a document to those persons at the outset of that care and from time to time as is reasonably necessary.
- That, home-care providers assess their patients’ needs on an on-going basis and, where a home-care provider considers that the care it is able to provide to a patient under a home-care package cannot meet the patient’s needs, the home-care provider meet with the patient and the patients’ next of kin where appropriate to so inform the patient and to discuss the patient’s further care.

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 incident</td>
<td>Fatal incident that occurred as a result of domestic injury or event.</td>
</tr>
<tr>
<td>Drugs and alcohol</td>
<td>Death where drugs or alcohol or both were a primary or secondary cause of death.</td>
</tr>
<tr>
<td>Electrocution</td>
<td>Cases where electrocution is the primary cause of death.</td>
</tr>
<tr>
<td>Falls</td>
<td>Incidents where a fall was involved in the circumstances or cause of death.</td>
</tr>
<tr>
<td>Fire related</td>
<td>Incidents where a fire was involved in the circumstances or cause of death.</td>
</tr>
<tr>
<td>Geographic</td>
<td>Cases where the geographic region is significant to the cause of death, for example remote location.</td>
</tr>
<tr>
<td>Homicide and assault</td>
<td>Includes interpersonal violence and family domestic violence.</td>
</tr>
<tr>
<td>Indigenous</td>
<td>Cases related to a specific demographic group.</td>
</tr>
<tr>
<td>Intentional self-harm</td>
<td>Cases determined intentional self-harm (ISH) by coronial investigation.</td>
</tr>
<tr>
<td>Law enforcement</td>
<td>Includes police pursuit, death in custody, parole issues, pending or previous court cases including family court, restraining order and coronial investigation procedures.</td>
</tr>
<tr>
<td>Leisure activity</td>
<td>Any leisure actively that directly influence the circumstances including holiday.</td>
</tr>
<tr>
<td>Category</td>
<td>Description</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Location</td>
<td>Cases where the location of either the incident or the discovery of the body is of significance, does not refer to geographic location.</td>
</tr>
<tr>
<td>Mental illness and</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>health</td>
<td></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>