Coronial recommendations: Fatal facts

A summary of cases and recommendations made between January and March 2017

Edition 52
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ACKNOWLEDGMENTS
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CORONERS’ RECOMMENDATIONS

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

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

Coronial recommendations: Fatal facts includes case summaries and recommendations for cases closed between January and March 2017.

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.
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<table>
<thead>
<tr>
<th>Case number</th>
<th>ACT.2015.5</th>
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</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Natural cause death</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>52 – cases closed between January and March 2017</td>
</tr>
</tbody>
</table>

Case summary

A middle aged male died due to natural causes.

The adult was a recluse who refused to accept medical treatment and services offered to them following discharge from hospital on several occasions.

Coronial findings

The coroner found that the death was due to natural causes. The coroner found that the case offered unique opportunities to consider issues concerning understanding of privacy laws, their application by health care professionals and the establishment of a mechanism to allow health care providers access to patients’ health records.

Coronial recommendations

The coroner made the following recommendations related to this case:

- ACT health care providers should be reminded through either ongoing professional development and/or training about the extent and application of privacy and particularly its relationship to the lessening or prevention of a serious threat to the life, health or safety of an individual within the ACT. Additionally, they should be reminded that they have the capacity to ensure referrals can be made to relevant agencies that might potentially provide support to a person within the Territory, recognising that it will always remain that person’s right not to accept that support or to consent to any treatment - provided they are not incapacitated or incompetent to do so.

- That ACT health services examine their capacity to cross reference relevant data management systems, in particular mental health and physical health service providers, to enable health service providers to interact with respective data management systems so as to provide timely access to relevant medical information for health care professionals to effectively diagnose, treat and deliver in hospital or post discharge care having been able to consider holistically a patient’s various medical conditions.

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

The following cases summaries and recommendations relate to deaths reported to a coroner in New South Wales.
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<thead>
<tr>
<th>Case number</th>
<th>NSW.2013.1966</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Natural cause death</td>
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<tr>
<td>Additional categories</td>
<td>Adverse medical effects, Child and infant death</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>52 – cases closed between January and March 2017</td>
</tr>
</tbody>
</table>

Case summary

A female child died due to natural causes.

The child was born with a congenital heart disease among other conditions that required ongoing management. The child underwent surgery shortly after birth and on several occasions in the following months. They were unwell and presented to hospital in the period before their death.

The child was found unresponsive one morning by their caregiver. Ambulance officers attended and found that the child was deceased.

Coronial findings

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

The coroner found that the observations performed while the child was in hospital were inadequate and that they should have been kept in hospital for overnight observation and admitted rather than discharged.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That nursing and medical staff at [hospital] undergo education and training regarding the use of graphical observation and response charts and on the importance of taking and recording standard observations on them.
- That [doctor] undergo education and training as to the importance of making an entry in the clinical notes for each occasion upon which a patient is reviewed and as to who has responsibility for making such entries.

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

Case summary

An adult male died due to an aircraft incident.

The adult was flying an agricultural aircraft and performing firebombing duties. During the flight, one of the aircraft's wings separated, causing the aircraft to crash to the ground.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the aircraft's wing's separation was caused by corrosion pitting and fatigue cracking, and that recent inspection of the aircraft was inadequate.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that consideration be given to the issuing of an airworthiness directive pursuant to regulation 39.001 of the Civil Aviation Safety Regulations 1998 requiring that visual inspections and magnetic particle inspections of the wing attachment joints of M18 Dromader aircraft, and its variants, be performed with the outboard wings removed.
- I recommend that consideration be given to the issuing of an airworthiness directive pursuant to regulation 39.001 of the Civil Aviation Safety Regulations 1998, or a direction given under regulation 43 of the Civil Aviation Regulations 1988, that aircraft factored time in service should be recorded on all maintenance releases in order to accurately determine an aircraft's time in service for service life limitation considerations and maintenance scheduling purposes.
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<tr>
<th>Case number</th>
<th>NSW.2013.4437</th>
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<tr>
<td>Primary category</td>
<td>Work related</td>
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<tr>
<td>Fatal facts edition</td>
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</tbody>
</table>

Case summary

An adult male died due to a workplace incident.

The adult was working for a steel company at an industrial factory. The adult’s colleague was operating a crane when they lost control of the equipment. As a result, the adult was struck by a swinging magnetic lifter. They were conveyed to hospital where they later passed away.

Coronial findings

The coroner found that the death was unintentional.

Coronial recommendations

The coroner made the following recommendations related to this case:

- Keeping loads under travel in sight at all times: [company] give consideration to including in the [company] Work Instruction ‘Safe Operating Procedure for Overhead Cranes’ the requirement that the load shall be constantly in view of the operator when being moved.
- Stopping the crane if incapacitated: [company] give consideration to including in the [company] Work Instruction ‘Safe Operating Procedure for Overhead Cranes’ and ‘Do’s and Don’ts of Steel Handling’ the requirement that if an operator becomes incapacitated through injury or illness whilst operating a crane and unable to continue crane-operating duties, the crane must be stopped and the matter reported to a supervisor.
- The term ‘load’ includes anything suspended from the crane hook: [company] give consideration to providing in its ‘Safe Operating Procedure’ and ‘Do’s and Don’ts of Steel Handling’ documents that the term ‘load’ includes any item suspended from overhead cranes, including all crane accessories and lifting equipment.

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<th>Case number</th>
<th>NSW.2014.4116</th>
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<td>Additional categories</td>
<td>Law enforcement</td>
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<td>Fatal facts edition</td>
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</tbody>
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Case summary

A middle aged male took their own life using a firearm. The adult had experienced several personal difficulties and suffered from depression and bipolar disorder.

On the day of their death, the adult cancelled their admission to a mental health clinic and contacted emergency services. They were transferred to a Policelink customer service representative and indicated that they intended to take their own life. Police proceeded to the adult’s residence, and the phone conversation continued for several minutes. It was subsequently terminated at the direction of police, and the adult was later found deceased.

Coronial findings

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

The coroner found that improvements could be made to police telephony and dispatch procedures and to police training to assist in dealing with suicidal persons.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the NSW Police Force seek to implement (with expedition) the proposed amendments to the triple ‘000’ emergency PoliceLink/ROG [Radio Operations Group] Telephony and Dispatch SOPs [Standard Operating Procedures] providing for telephonists to transfer suicidal callers to nominated police officers at the scene.
- That the NSW Police Force give consideration to appropriate training for first responders in dealing with suicidal persons in high risk situations including with respect to the potential implications of terminating existing communication, the possibility of having telephonists transfer calls to the scene, and the need for gathering contextual information.

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<th>Case number</th>
<th>NSW.2014.5554</th>
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<tr>
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<td>Additional categories</td>
<td>Homicide and assault</td>
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<td>Fatal facts edition</td>
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</table>

Case summary
An adult male disappeared and was reported missing to police.
The adult was suspected to have links to an outlaw motorcycle gang.
Despite police investigations and proof of life checks, the adult’s whereabouts remained unknown.

Coronial findings
The coroner found that the body was not recovered and was satisfied that the person was deceased.
The coroner found it likely that the adult’s death occurred in suspicious circumstances.

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

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

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NORTHERN TERRITORY

The following cases summaries and recommendations relate to deaths reported to a coroner in the Northern Territory.
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<tr>
<th>Case number</th>
<th>NT.2015.106</th>
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<tr>
<td>Primary category</td>
<td>Adverse medical effects</td>
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<td>Fatal facts edition</td>
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</table>

Case summary
An older female died due to sepsis following a high-risk elective surgery.

The morning following the surgery, the adult went into septic shock. There was a delay in the adult being transferred to intensive care. By the time a reoperation took place, the adult’s condition had deteriorated significantly and they passed away.

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

The coroner found that there were many points at which the bile leak that caused the adult’s death should have been addressed and that the medical treatment provided by the hospital was inadequate.

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

- I recommend that [hospital] not permit high risk surgery to be undertaken where it does not have the resources to mitigate those risks.
- I recommend that [hospital] implement an escalation system to provide a proper rapid team response when the rapid response criteria are met.
- I recommend that should the [hospital] continue to operate a High Dependency Unit that it be properly and appropriately resourced and in conformity with Standard 9 of the National Standards on Safety and Quality in Health Care and the Guidelines of the College of Intensive Care Medicine of Australia and New Zealand.
- I recommend that the Department of Health and the Top End Health Service consider these findings and recommendations in their dealings with and licensing of the [hospital].

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Coronial recommendations: Fatal facts

Case number: NT.2016.98
Primary category: Water related
Additional categories: Transport and traffic related, Leisure activity
Fatal facts edition: 52 – cases closed between January and March 2017

Case summary

An older adult male died due to drowning following a boating incident on a river.

The adult was operating a private boat that they had modified by adding side panels. They had also placed chairs in the boat. While fishing, the boat overturned, and the adult and their companion were thrown into the water. The adult was not wearing a life jacket.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the modifications made to the boat and the use of chairs impacted its stability and contributed to the incident.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the Department of Infrastructure, Planning and Logistics alert users of small boats to the dangers of:
  - modifying vessels without expert advice or assistance; and
  - operating vessels beyond their design capabilities, including exceeding the requirements detailed in an Australian Builders Plate where one is fitted.

I note that it has been a requirement in the Northern Territory since 1 April 2013 to fit Australian Builders Plates to all new recreational vessels sold. The Australian Builders Plate provides key information on a boat’s capability and capacity and includes detail on boating operations, maximum number of people and load allowed, engine rating and weight.
QUEENSLAND

The following cases summaries and recommendations relate to deaths reported to a coroner in Queensland.
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<tr>
<th>Case number</th>
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<td>Fatal facts edition</td>
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Case summary
A middle aged female took their own life using an animal euthanasia drug.

The adult worked as an animal groomer at a veterinary clinic, which enabled them access to the drug.

The adult was noted to not be their usual self in the period leading up to their death. They had recently communicated some personal and work-related issues to a colleague that appeared to be impacting their mental health.

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

The coroner found that:
- the product labelling and instructions provided with Pentobarbitone, while adequate at the time, would be inadequate for future prevention of human Pentobarbitone misuse
- the storage and access control procedures of the veterinary clinic, while adequate at the time, would be inadequate in future
- the national and state regulatory regime regarding Pentobarbitone storage, access control, monitoring and auditing in veterinary clinics was inadequate.

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

I recommend that:
- The Therapeutic Goods Administration (TGA) upschedule Pentobarbitone in injectable form to a Schedule 8 drug in the Commonwealth Poisons Standard.
- Queensland Health and all relevant State and Territory regulatory authorities adopt the TGA’s upscheduling of Pentobarbitone in injectable form to a Schedule 8 drug, and the stricter controls that this entails.
• If the TGA decides not to upschedule Pentobarbitone in injectable form to Schedule 8, it is recommended that State and Territory regulatory agencies introduce stricter regulations for the drug, in line with Schedule 8 controls anyway.
• Manufacturers of Pentobarbitone introduce a warning on Pentobarbitone animal euthanasia Product Labels and within Safety Data Sheets that the drug ‘must be stored in a locked safe/vault/receptacle’. Contextual information as to why this is important should be included in the Safety Data Sheets.
• Manufacturers of Pentobarbitone introduce measures to ensure Veterinarians are notified when important changes to Safety Data Sheets are made (for example by notifying State Veterinary boards, who should in turn, publish a bulletin to registered Veterinarians).
• Distributors of Pentobarbitone ensure that appropriate safeguards are in place so that only authorised persons under the relevant regulations can order and take physical delivery of the drug. Delivery should not be made to any staff member of a Veterinary practice. It is not just the responsibility of the recipient to ensure that only authorised persons take possession of the drug. Distributors need to take more responsibility.
• [Pentobarbitone manufacturer] should consider ways to encourage employees to report their knowledge of adverse events relating to their products (even if it is based on anecdotal evidence), to enable the company to investigate and pro-actively address such issues. Reliance should not be solely placed on the receipt of formal adverse reports from external parties to the company.
• Veterinary professional organisations should improve the education and support they provide to the Veterinary industry about:
  o the obligation to manage Pentobarbitone and other dangerous drugs in a manner that is consistent with Workplace Health and Safety, Health, and criminal law regulations. It should be noted that compliance with minimum standards in health regulations (i.e. Schedule 4 storage and access controls) will not necessarily result in compliance with Workplace Health and Safety or criminal law obligations.
  o important changes to drug Safety Data Sheets. (For example, some drug manufacturers do not have direct contact with Veterinarians because they use distributors. In such cases, the manufacturers and Veterinary professional organisations should work together so that important drug safety information can be communicated through the professional organisations to their members).
  o suicide awareness and prevention (for example - increased advertising campaigns, mentoring programs, mental health first aid courses, and counselling hotlines).
Coronial recommendations: Fatal facts

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<th>Case number</th>
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Case summary

A young adult male took their own life by hanging.

The adult was a prisoner at the time of the incident. The adult had been escorted into an exercise yard and had smuggled a ligature with them. They were not subject to formal observations and were not considered at risk of self-harm.

A short time later the adult was found hanging by correctional staff. Paramedics attended and the adult was transferred to hospital where they later passed away.

Coronial findings

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

The coroner found that the death may have been prevented had the adult been more closely observed via closed-circuit television (CCTV) monitors. However, the coroner noted that observations could not be easily carried out due to the limited quality of the single camera angle available in the exercise yard.

Coronial recommendations

The coroner made the following recommendations related to this case:

- Prisoner and officer safety in the MSU [Maximum Security Unit] depends on the capacity of control room operators to clearly see what is happening within the unit. I recommend that in considering the replacement of current CCTV monitoring systems, QCS [Queensland Corrective Services] take into account the evidence heard during this inquest, with a view to ensuring that any new recording system clearly displays all relevant camera angles. Consideration should be given to potential hanging points within the cells and exercise yards in the MSU, and ensuring that the best available camera angle, with reference to the potential hanging points, can be fed clearly to the main control room monitors.

- Having regard to the evidence about working in the control room I consider that it is likely that staff simply become fatigued, and lose focus, after looking at a large number
of images on screens for an extended period of time. I recommend that QCS explore the merits of a policy of more frequent rotations of officers through the control room as a way of minimising that risk.
Coronial recommendations: Fatal facts

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<th>Case number</th>
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<tr>
<td>Primary category</td>
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<td>Additional categories</td>
<td>Adverse medical effects</td>
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<td>Fatal facts edition</td>
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Case summary

An older adult female died due to drug toxicity.

The adult had been unwell for some time prior to their death and had recently suffered a fall. They were placed in the care of their family with the assistance of a general practitioner.

Investigations revealed that a nurse (who was a friend of the adult’s family) had been provided with medication from the adult’s former nursing home. This medication was misapplied and administered in excess, leading to the adult’s death.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the medications were given to the adult in a careless fashion and were not applied appropriately.

Coronial recommendations

The coroner made the following recommendations related to this case:

- It is recommended that the Therapeutic Goods Administration consider a recommendation that the prescribers or the manufacturers of Ordine or indeed all other strong narcotic medication be directed that the dosage be stated specifically in the number of hours between taking the next dose and if there should be clear warnings placed on insert material and on the packet that a failure to take the medication strictly in accordance with instructions may have serious consequences including death.

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SOUTH AUSTRALIA

The following cases summaries and recommendations relate to deaths reported to a coroner in South Australia.
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<th>Case number</th>
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<tr>
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<td>Child and infant death</td>
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<td>Fatal facts edition</td>
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Case summary

A male infant died due to natural causes a few days after birth.

During delivery, the infant experienced hypoxia and required intensive management after birth. They were found to have suffered extensive brain damage and their medical care was withdrawn.

Coronial findings

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

The coroner found that there was room for improvement regarding ‘decision to delivery’ interval expectations across the state, and that had the infant’s mother presented to a better-resourced hospital, the infant’s chances of survival would have been greater.

Coronial recommendations

The coroner made the following recommendations related to this case:

The Court makes the following recommendations directed to the Chief Executive Officer of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, the President of the SA Branch of the Australian Medical Association, the Chair of the Royal Australian College of General Practitioners (SA Faculty) and the Chief Executive of the Department of Health:

- Given the potential catastrophic outcomes in cases of severe birth hypoxia, medical practitioners should candidly discuss these risks with their patients at an early stage of pregnancy to enable them to make an informed decision about which Tier level hospital they will be admitted to for delivery.
- Where a caesarean section is thought to be a real likelihood, practitioners ought not wait until the last moment to put arrangements in place where simple standby arrangements could be organised by hospital staff or obstetricians.
• Considerations should be given to improving the way CTG [cardiotocography] recordings are transmitted to obstetricians who are supervising labour from outside the hospital.
TASMANIA

The following cases summaries and recommendations relate to deaths reported to a coroner in Tasmania.
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<th>Case number</th>
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<td>Adverse medical effects</td>
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<td>Fatal facts edition</td>
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Case summary

An older adult female died due to complications following cannulation of an artery.

The adult had been admitted to hospital several days prior to death. Their condition appeared to improve, but later worsened. A central venous catheter (CVC) was inserted to enable the administration of fluids and medication. The adult’s condition deteriorated, and it was later noticed that the CVC had been mal-positioned and required removal.

The adult suffered multiple complications following the CVC removal and died a few weeks later.

Coronial findings

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

The coroner found that there were a number of errors and shortcomings following the CVC insertion that resulted in the death.

Coronial recommendations

The coroner made the following recommendations related to this case:

- In his statement [Executive Director of Services, Tasmanian Health Service] has advised me that [the deceased’s] death was the subject of review by the [hospital’s] Death Review Committee and that such review did not lead to any recommendations being made. To my mind this is an extraordinary outcome given the multiple failings associated with [the deceased’s] death. In the very least it is my view that this death highlights serious deficiencies associated with the hospital’s MET [medical emergency team] team and it is my recommendation that the [hospital] initiate a review of that team with a focus upon consultancy input and supervision.

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<th>Case number</th>
<th>TAS.2015.367</th>
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<td>Fatal facts edition</td>
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Case summary

A middle aged male died due to an intentional drug overdose.

The adult experienced poor health most of their life and had been diagnosed with depression.

The adult had recently undergone surgery and was last seen alive on the day they were discharged home. The adult’s family became concerned when they were unable to make contact with the adult, and later found them deceased at home.

Coronial findings

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

The coroner found that no serum samples were obtained at autopsy, which delayed and compromised the investigation into the adult’s death.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend in future that where an insulin overdose is suspected care is taken by the pathologist conducting the autopsy to obtain a serum sample and that that sample is frozen immediately.

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VICTORIA

The following cases summaries and recommendations relate to deaths reported to a coroner in Victoria.
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<th>Case number</th>
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<td>Fatal facts edition</td>
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Case summary

A middle aged female took their own life by hanging.

The adult was an involuntary patient at a psychiatric hospital. The adult’s partner had recently visited them in hospital, and noted they were agitated. The adult was found later that evening having attempted to take their own life. They were transferred to intensive care where they later passed away.

Coronial findings

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

The coroner found that there were failures in management of process that contributed to the death, coupled with availability of potentially dangerous personal items, hanging points and a management approach that allowed staff to become distracted from maintaining an appropriate level of focus on the adult’s mental state.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that [public health service] amends its protocol to emphasize the dangerous aspects of allowing patients accommodated within the LDU [Low Dependency Unit] to bring in belts, cords or like, which may be employed as a ligature and henceforward institute admission and periodic search policies, which will help ensure a rigorous management of this amendment.
- I recommend that [public health service] maintains its ligature review process but seeks to ensure that a person properly qualified in psychiatric unit risk management analysis who is not part of [public health service] hospital administration, is engaged to assist in that work.
- I recommend that [public health service] provide direction to senior staff in regard to the nomination of a designated person within each particular unit, to collect, preserve and provide safekeeping of all materials which are or maybe relevant to any (future)
investigation into a suspected incident of self-harm. I accept [the view of Executive Clinical Director of Mental Health Program and Clinical Director of Adult Mental Health at public health service] that the ANUM [nurse unit manager] in each particular Unit would be a suitable designated person.

- I further recommend that [psychiatric unit] nursing staff be counselled as to the importance of making clinical notes and completing clinical records.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>The coroner held a joint investigation into the following deaths which resulted from the same incident: VIC.2013.5633, VIC.2013.5634</th>
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<tr>
<td>Primary category</td>
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<td>Additional categories</td>
<td>Work related, Leisure activity</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>52 – cases closed between January and March 2017</td>
</tr>
</tbody>
</table>

Case summary

A middle aged male and a young male died when the gyroplane they were travelling in crashed. The gyroplane was piloted by the middle aged person with the young person as a commercial passenger.

Coronial findings

The coroner found that the deaths were unintentional.

The coroner found that the pilot was considered competent, however their conduct on the day of the incident fell well short of the standards required by the Australian Sports Rotocraft Association (ASRA), the Civil Aviation Safety Authority (CASA) and the general community.

The coroner found that there was missing information around flight times and aircraft types, which suggested the pilot had taken a careless approach to essential documentation in the lead-up to the fatal incident.

The coroner found that the pilot was conducting an illegal, paid ‘joy flight’ with the passenger rather than a legal, training-focused, trial introductory flight. The coroner found that the pilot’s decision-making during the flight was highly flawed, including flying below the required height and across terrain in which there was no safe location to land in case of an emergency.

The coroner found that no formal oversight of the pilot was undertaken by ASRA between the time they obtained their instructor rating and their death – a period of some months. As such, the pilot’s significant lack of compliance with policies and procedures remained undetected until after the incident.

The coroner found that there was significant confusion and ambiguity surrounding the provision of ‘trial introductory flights’ and the circumstances in which payment can and cannot be legally received by a pilot.
Coronial recommendations

The coroner made the following recommendations related to these cases:

• With the aim of preventing like deaths, I recommend that, as foreshadowed during the Inquest, the Australian Sports Rotorcraft Association Inc. implement a more robust audit system of the duties undertaken of newly appointed instructional staff, to include, but not necessarily limited to, an initial audit within six months, and involve more frequent, formal oversight of both flights and documentation.

• I further recommend, as foreshadowed during the Inquest, that the Civil Aviation Safety Authority expand its desktop audit of the Australian Sports Rotorcraft Association Inc.’s student records to also encompass oversight of its instructors.

• With the aim of preventing like deaths, I recommend that the Civil Aviation Safety Authority produce an advice guide, which clarifies the circumstances in which instructors can obtain payment for ‘trial introductory flights’ and provide this guide to the Australian Sports Rotorcraft Association Inc. to distribute amongst its instructors.

• I further recommend that the Australian Sports Rotorcraft Association Inc. require new instructor applicants to provide a business case which indicates how they intend to represent their business to the public.

• With the aim of preventing like deaths and improving the oversight of sporting aviation in Australia, I recommend that the Commonwealth Minister for Infrastructure and Transport commission a review of the funding made available to recreational aviation administration organisations through the Civil Aviation Safety Authority.

• I further recommend that the Commonwealth Minister for Infrastructure and Transport consider the need to provide funding to the Australian Sports Rotorcraft Association Inc. to aid the investigation of fatal gyroplane incidents, in circumstances that the Australian Transport Safety Bureau have declined to do so.

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

Case number | VIC.2014.2496
Primary category | Drugs and alcohol
Fatal facts edition | 52 – cases closed between January and March 2017

Case summary
A middle aged male died as a result of combined prescription drug toxicity.
The adult had a history of mental ill-health and had been prescribed benzodiazepines and quetiapine for many years. They had a history of opioid dependency and prior overdose.

Coronial findings
The coroner was unable to determine the intent of the deceased.
The coroner noted that the adult’s treating doctors did not form the impression that the adult was engaged in drug-seeking behaviour or suffering a deterioration in their mental health.
The coroner found that the adult had not been reported to the Drugs and Poisons Regulation, as the treating doctors assumed they had already been reported due to their history of opioid dependency.

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

• The Royal Australian College of General Practitioners consider the need for further education of its members in relation to the potential for misuse of quetiapine given the circumstances of this death.
• The Royal Australian College of General Practitioners consider the circumstances of this death in the context of its existing guidelines on coordinating care between general practitioners and specialists, and determine whether more practical guidance is required for general practitioners in areas such as:
  o How long a general practitioner should rely on specialist prescribing advice before seeking updated advice.
  o How often a general practitioner should be in contact with a specialist if the general practitioner is relying on that specialist’s advice to inform ongoing 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.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2014.4211</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, Drugs and alcohol</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>52 – cases closed between January and March 2017</td>
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Case summary

A young male died due to self-inflicted asphyxia.

In the months leading up to their death, the young person suffered from a physical condition, the cause of which was unable to be determined by investigating doctors. The condition had a detrimental impact on their mental health that led to social withdrawal and a depressed and anxious mood. The young person had been prescribed desvenlafaxine in the weeks prior to their death and were due for a review with the doctor in the days after their death.

Coronial findings

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

The coroner found that desvenlafaxine was not the preferred antidepressant in the National Health and Medical Research Council (NHMRC) Guidelines, but that there was no evidence that desvenlafaxine was more likely to cause adverse events or less likely to be effective in treating the young person’s anxiety and depression than the recommended drug.

The coroner found that while the doctor’s management of the young person following the diagnosis of anxiety and depression did not adhere to all aspects of the NHMRC Guidelines, their management was not unreasonable in the circumstances.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Royal Australian College of General Practitioners draws its members’ attention to the National Health and Medical Research Council (NHMRC) Clinical Practice Guideline on Depression in Adolescents and Young People (2011).
- That the NHMRC considers how it might improve the way in which it promulgates clinical guidelines and draws the attention of clinicians to them.

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.2015.2474

Primary category
Transport and traffic related

Additional categories
Older persons

Fatal facts edition
52 – cases closed between January and March 2017

Case summary
An older male died following a vehicle incident in which they were riding a mobility scooter.

A vehicle collided with the adult’s mobility scooter, causing them to be ejected from the scooter and fall to the ground.

The adult was driving their mobility scooter on the footpath at the time of the incident. The vehicle struck them as it exited a car park. The adult was transported to hospital where their condition deteriorated, and they died some weeks later.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the driver of the vehicle was unable to see the footpath as they exited the car park due to parked cars blocking their view.

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

• With the aim of preventing like deaths and protecting pedestrians and drivers, I recommend that the [council] implement safety measures at its car parks - including the car park on the [incident corner] - with such measures as, but not necessarily limited to, mirrors, signage and/or ‘no standing’ parking spaces.

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.2015.3644
Primary category | Adverse medical effects
Fatal facts edition | 52 – cases closed between January and March 2017

Case summary
An older female died in hospital due to an undetected aortic dissection. The adult presented at hospital with a pericardial effusion causing tamponade following a collapse in their home. They underwent a computed tomography (CT) scan and were treated for a pericardial effusion. The adult experienced worsening blood pressure over some hours and became unresponsive, passing away soon after.

Coronial findings
The coroner found that the death was due to complications of medical or surgical care. The coroner found that the CT scan showed no evidence of the aortic dissection, but that the report contained comments regarding the suboptimal images which could not fully exclude an aortic dissection.

The coroner found that the CT report was less than satisfactory, and that the cardiology unit’s interpretation of the report was also wanting. The coroner noted that the imperfect CT report may be starker with the benefit of hindsight.

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

- With the aim of preventing the recurrence of missed opportunities for diagnoses and like deaths, I recommend that the Royal Australian and New Zealand College of Radiologists utilise [the deceased]’s case in education regarding report writing, inclusion of all important information in reports’ conclusions, and communication of this information with the treating doctors.
- I recommend that [hospital] conduct a review of its 'Provision of Medical Imaging Reports' procedure, to ensure clarity about the need to include references to further imaging or investigations in the conclusion of a diagnostic imaging report.

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

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<th>Case number</th>
<th>VIC.2015.4958</th>
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<tr>
<td>Primary category</td>
<td>Adverse medical effects</td>
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<td>Drugs and alcohol</td>
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<tr>
<td>Fatal facts edition</td>
<td>52 – cases closed between January and March 2017</td>
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</table>

Case summary

An older male died due to a stroke in the days after a surgery.

The adult was prescribed anticoagulants to reduce their risk of stroke. They were booked for surgery and on the advice of the anaesthetist they ceased the anticoagulants in the lead-up to surgery. The surgery was uncomplicated and the adult recommenced on anticoagulants upon discharge. They were found unresponsive the following day having suffered a stroke. The adult was palliated and died some days later.

Coronial findings

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

The coroner found that the need for anticoagulation must be carefully considered pre-operatively by balancing surgical bleeding risk and stroke prevention benefit. The coroner found that the adult’s discharge summary made no mention of anticoagulant management.

The coroner found that post surgery, the hospital passed the responsibility for the adult’s International Normalised Ratios (INRs) and anticoagulant management onto their general practitioner. The coroner found that this was not clearly communicated to the adult or the general practitioner.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the [hospital] review the process of communicating the discharge warfarin management plan and assigning responsibility for assessing and educating patients at discharge on warfarin changes, for the benefit of future patients.

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.2016.260</th>
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<td>Transport and traffic related</td>
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<td>Additional categories</td>
<td>Water related</td>
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<td>Fatal facts edition</td>
<td>52 – cases closed between January and March 2017</td>
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</table>

Case summary
An adult male drowned after they crashed their bicycle and continued into a creek.

The adult was an experienced cyclist who was safety conscious and kept their bicycle well maintained. They often rode along the trail where the incident occurred.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the collision occurred near a footbridge crossing the creek where the trail took a sharp turn to enter the footbridge. The coroner noted that this turn could be dangerous if taken at speed.

The coroner found that the adult collided with a marker post on the sharp corner. The marker posts and a sign indicating possible flooding were the only safety measures implemented on the footbridge.

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

- With the aim of preventing injuries and like deaths, I recommend that the [operating group] conduct a risk assessment of the [trail]'s footbridge which crosses the [creek] and review any opportunities for safety improvements, such as, but not limited to, warning signs regarding speed, speed bumps, and additional fencing.
Case summary

An adult male took their own life in a deliberate fall from a lookout tower.

The adult suffered from depression and anxiety in the lead up to their death. They were living in accommodation that was impinging on their ability to see their child, which affected their mental state.

Coronial findings

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

The coroner found that the adult’s depression, anxiety and accommodation circumstances were contributing factors in their decision to end their life. The coroner noted that the adult had a significant level of alcohol in their blood at the time of their death.

Coronial recommendations

The coroner made the following recommendations related to this case:

- With the aim of improving public safety and preventing like deaths, I recommend that the [council] conduct a feasibility study to assess whether safety enhancements can be made to the [location], for example, but not limited to, erecting suicide prevention barriers on each platform.

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

<table>
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<tr>
<th>Case number</th>
<th>VIC.2016.1725</th>
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<tr>
<td>Primary category</td>
<td>Child and infant death</td>
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<tr>
<td>Fatal facts edition</td>
<td>52 – cases closed between January and March 2017</td>
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Case summary

A female infant died after becoming wedged in their bassinet between the side and the mattress.

The mattress in the bassinet was an additional mattress that was shorter than the length of the bassinet, and thus left a gap at the top. On the night of the incident, the infant’s parents had put them in the lower half of the bassinet and wrapped them in blankets. The infant was discovered the following morning in the mattress gap at the top of the bassinet.

Coronial findings

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

The coroner found that the infant died of Sudden Infant Death Syndrome (SIDS) Category 2.

Coronial recommendations

The coroner made the following recommendations related to this case:

- In light of a home visit being conducted by a Maternal Child and Health Care Nurse from the [health centre]; I suggest that all Maternal Child and Health Care Nurses are counselled not only to provide oral advice to families of babies, but to also thoroughly review the environment in which the baby is living.
Coronial recommendations: Fatal facts

<table>
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<tr>
<th>Case number</th>
<th>VIC.2016.2432</th>
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<tr>
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<td>Location</td>
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<td>Fatal facts edition</td>
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</table>

Case summary

An adult female died in hospital as a result of heroin toxicity.

The adult had a long history of heroin use. They had recently been administered naloxone by outreach workers and had discussed their efforts to obtain treatment for their drug dependence with the outreach workers.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult was not a naïve drug user, and that they experienced a range of complex, interrelated health and social issues. The coroner found that this was a recurring theme in heroin overdose deaths investigated by Victorian coroners.

The coroner found that the most crucial commonality between Victorian heroin overdose deaths in recent years was the local government area in which the overdoses occurred. The coroner found that the local government area consistently had the highest frequency and rate of heroin overdoses in Victoria over several years.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that [Member of Parliament] as Minister for Mental Health take the necessary steps to establish a safe injecting facility trial in [suburb].
- I recommend that [Secretary], Department of Health and Human Services Victoria [DHHHS], take the necessary steps to expand the availability of naloxone to people who are in a position to intervene and reverse opioid drug overdoses in the [local government area].
- I recommend that [Secretary], Department of Health and Human Services Victoria, review current DHHS-funded services that support the health and wellbeing of injecting drug users in the [local government area], and consult with relevant service providers and
other stakeholders, to identify opportunities to improve injecting drug users’ access to and engagement with these life-saving services.
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.2012.509</th>
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<tr>
<td>Primary category</td>
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<td>Fatal facts edition</td>
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</table>

Case summary

A middle aged female died following a vehicle incident in which they were a driver.

The adult was driving their vehicle through an intersection on a green signal. They were struck by a marked police vehicle that was travelling through a red signal with lights and sirens activated as part of a police operation. The adult was not involved in the police operation prior to the collision.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the police internal affairs unit had concluded that the police driver had failed to comply with the Police Emergency Driving Policy and Guidelines.

The coroner found that the police driver incorrectly assumed the adult had registered the police vehicle and was coming to a stop. The coroner found that the police driver realised their error too late to take evasive action.

Coronial recommendations

The coroner made the following recommendations related to this case:

- The need for a public education campaign to remind the driving public of their obligations under the Road Traffic Code 2000:

  * Keeping clear of police and emergency vehicles
    - A driver shall give way to, and make every reasonable effort to give a clear and uninterrupted passage to, every police or emergency vehicle that is displaying a flashing blue or red light (whether or not it is also displaying other lights) or sounding an alarm.
    - Points: XX Modified penalty: XX
This regulation applies to a driver despite any other regulation that would otherwise require the driver of a police or emergency vehicle to give way to the driver.
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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</table>

Case summary

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

The adult was under a Community Treatment Order under the Mental Health Act at the time of their death. They had been seeing psychiatrists and receiving treatment for mental health issues for several years. The adult had been a voluntary patient at a psychiatric ward a month prior to their death.

The adult experienced somatic symptoms that they believed were due to their medications and was therefore reluctant to remain compliant with their medication regime.

Coronial findings

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

The coroner found that there was no effective discharge planning surrounding the adult’s discharge from the psychiatric ward, nor was there effective communication between relevant agencies and organisations regarding their ongoing treatment and support.

The coroner noted the need for a coordinated care framework for the treatment of mentally ill persons in the community.

Coronial recommendations

The coroner made the following recommendations related to this case:

- Patients with mental health issues which require treatment in either the public or private health system be provided with a community liaison person (coordinator) who understands the treatment/management plan in place for that patient and is in a position to ensure proper coordination of the patient’s care between all relevant facilities and practitioners.
- Discharge planning from a facility, or referral from one mental health practitioner to another, always include the nominated community liaison person, in person, at any
conference when the deceased and their community carers are present to ensure understanding and continuity of management for the patient.

- The issue of patient confidentiality not to include the fact of treatment and management as between a community liaison person and other mental health practitioners, only the content of private disclosures.
Coronial recommendations: Fatal facts

<table>
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<tr>
<th>Case number</th>
<th>WA.2012.1848</th>
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<tr>
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<td>Fatal facts edition</td>
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</table>

Case summary

An adult female died in police custody due to natural causes.

The adult was an indigenous person who suffered from physical ill health that was exacerbated by alcoholism. At the time of the incident they lived an itinerate lifestyle.

On the night of the incident, the adult was arrested in connection with street drinking. The police plan was to detain the adult while they sobered up and release them in the morning. The adult was discovered unresponsive in the early hours of the morning and was unable to be revived.

Coronial findings

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

The coroner found that the police did not apprehend how fragile the adult’s overall health was at the time they were admitted to custody, as the police were primarily focused on the issue of intoxication. The coroner found that the adult refused to answer questions about their health and welfare at the time of their arrest, thus preventing an opportunity for appropriate medical intervention.

The coroner found that the adult’s intoxication on the night of the incident was symptomatic of a more far-reaching decline in their health and social circumstances. The adult’s decision not to engage with a primary health care centre meant that there were missed opportunities for clinicians to commence a holistic approach to their health needs.

The coroner found that there were risks inherent in detaining a heavily intoxicated person in a lock-up overnight. The coroner found detention in a lock-up for street drinking an undesirable response when no other criminal activity is suspected or identified. The coroner found that such arrests and detentions have the potential to impact disproportionately upon Aboriginal persons.
Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that Parliament consider the abolition of the power to arrest and detain an intoxicated person for street drinking where the police officer reasonably suspects the person will continue street drinking unless the person is arrested.
- As an alternative to Recommendation 1, I recommend that arrest of an intoxicated person under s 119(1) of the *Liquor Control Act 1988*, read together with section 128(3) of the *Criminal Investigation Act 2006*, for street drinking, be a last resort.
- I recommend that the WAPOL [Western Australia Police Service] Manual be amended to specify that detention in a lock-up be a last resort in cases where an intoxicated person is apprehended under the *Protective Custody Act 2000* in order to protect their health or safety, or arrested under the *Liquor Control Act 1988*, read together with section 128(3) of the *Criminal Investigation Act 2006*, for street drinking.
- I recommend that the WAPOL Manual be amended to provide that a welfare screening of an intoxicated person for the purpose of admission to custody in a lock-up is not complete unless the person has had a health assessment by a nurse, or if a nurse is not available and present, a health assessment at the hospital. This is particularly important in the case of a proposed overnight detention.
- I recommend that at every police station where detainees are held, there must be a dedicated lock-up keeper. Alternatively that a minimum of two officers are rostered for custodial care duties at any time.
- I recommend that a mandatory training course on the roles and responsibilities of lock-up keeper/supervisor be developed and introduced across Western Australia and that a component of the training be undertaken face-to-face. Successful completion of the course ought to be mandatory before an officer can be assigned lock-up keeper/supervisor duties.
- I recommend that the Western Australia Police Service develops its cross-cultural diversity training to address the following:
  - That there be mandatory initial and ongoing cultural competency training for its police officers to assist in their dealings with Aboriginal persons and to understand their health concerns;
  - That Aboriginal persons be involved in the delivery of such training;
  - That successful trainees should be able to demonstrate cultural competency – that is a well-developed understanding of Aboriginal issues and the skills to deal effectively with Aboriginal communities; and
  - That the initial training and at least a component of the ongoing training is to be delivered face-to-face.
- I recommend that the Western Australia Police Service develops its training for police officers who are transferred to a new police station to address the following:
That it be a standard procedure for all police officers transferred to a location with a significant Aboriginal population to receive comprehensive cultural competency training, tailored to reflect the specific issues, challenges and health concerns relevant to the location;
That members from the local Aboriginal community be involved in the delivery of such training, and that it be ongoing to reflect the changing circumstances of the location; and
That the initial training and at least a component of the ongoing training is to be delivered face-to-face.

I recommend that Parliament consider whether legislative change is required in order to allow medical clinicians to provide the Western Australia Police Service with sufficient medical information to manage a detainee’s care whilst in police custody. Allied to this is a consideration of the safeguards concerning that information.

I recommend that a policy be introduced by the Western Australia Police Service that requires the police to contact by telephone the Aboriginal Visitors Scheme once a decision has been made to detain an Aboriginal offender in a police lock-up. In addition, any APLO [Aboriginal police liaison officer] attached to the station should also be made aware by police that they may contact the Aboriginal Visitors Scheme at any time on behalf of a detainee. Furthermore, once a decision has been made to take an Aboriginal detainee for medical treatment, contact by telephone must be made by the police to the Aboriginal Visitors Scheme advising it of that fact, the name of the detainee and which hospital or medical treatment facility the detainee is being taken to.

I recommend that the State Government gives consideration as to whether a state-wide 24 hours per day, seven days per week Custody Notification Service based upon the New South Wales model ought to be established in Western Australia, to operate alongside and complement the Aboriginal Visitors Scheme.

I recommend that the lock-up procedure manual be amended to make reference to the following in relation to the care of detainees:

- A greater degree of regular monitoring should be provided to any detainee complaining of severe symptoms that necessitate repeated hospital attendances within a short space of time;
- New or changing symptoms in an unwell detainee may signify deterioration warranting medical review;
- Drug and alcohol use are risk factors for serious illness, and can both mimic and obscure the symptoms of serious illness; and
- A person found to be unconscious or not easily rousable whilst in police custody must be immediately conveyed to hospital by ambulance.
Coronial recommendations: Fatal facts

Case number: WA.2013.391
Primary category: Intentional self-harm
Additional categories: Law enforcement, Mental illness and health, Indigenous
Fatal facts edition: 52 – cases closed between January and March 2017

Case summary
A young male took their own life by hanging. They were a sentenced prisoner at the time of their death.

The young person was discovered hanging in a storeroom in the communal area of the prison. They were not discovered for some time as the incident occurred during the day when prisoners were free to leave their cells. The storeroom was routinely left unlocked during the day to allow prisoners to access materials to clean their cells.

The young person was indigenous and had a background of depression, substance abuse and interactions with the justice system. They had been transferred from a different prison in the months before their death. They were undergoing psychiatric treatment in the previous prison but had not seen a psychiatrist in the new prison prior to their death.

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

The coroner found that ligature minimisation in the storeroom would be impractical for its purposes. The young person’s cell had not been ligature minimised. The coroner found that changes that had been made to the access and observation of the cleaning storeroom since the incident were made as part of a balancing exercise between reducing the risk of impulsive acts of self-harm and the practicality of allowing prisoners access to cleaning products for their cells.

The coroner found that the psychiatric treatment provided to the young person prior to their death was inadequate. The failure to give the young person access to a psychiatrist after their prison transfer was a lost opportunity for a psychiatrist to assess their mental health and associated risk of self-harm. The young person had many features known to indicate higher risk of self-harm, and it was important for them to have an opportunity to establish a rapport with a new psychiatrist.
Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the Department of Corrective Services, when planning what future changes are to be made to the mental health services it provides to prisoners, should invest significantly more resources in ensuring that prisoners are given regular access to psychiatrists and that overall an emphasis be placed on providing a more holistic approach to mental health care. Efforts should also be made where possible to hire some Aboriginal mental health workers to form part of the mental health team.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>WA.2013.1813</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Intentional self-harm</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Law enforcement, Mental illness and health</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>52 – cases closed between January and March 2017</td>
</tr>
</tbody>
</table>

Case summary

A middle aged male took their own life by hanging. They were a sentenced prisoner at the time of their death.

The adult was placed on the At-Risk Management System (ARMS) at the time of prison intake due to a history of self-harm and protection issues. They were housed in a single occupancy cell at the time of their death.

The adult was discovered hanging in the cell during the first nightly check. Resuscitation attempts were made but were discontinued.

Coronial findings

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

The coroner found that the decision to cease resuscitation attempts was appropriate, as the adult had a poor probability of survival. The coroner found that they were deceased by the time ambulance officers arrived to transport them to hospital, and as such the transportation did not take place.

The coroner found that the adult’s cell had been 3-point ligature minimised, which removed window bars, light fittings and shelving brackets. The coroner found that despite this, there were still numerous ligature points remaining in the cell, as is the case in most prison cells other than those in the Crisis Care Unit.

The coroner found that the adult was awaiting a review by a prison psychiatrist at the time of their death. There was a severe shortage of psychiatric appointments available within the prison at the time. The adult’s medication prescription was allowed to expire without renewal during this time.

The coroner found that a lack of psychiatric review in a reasonable time period contributed to the adult’s decision to take their life, in the sense that more prompt psychiatric review and considered thought about their medication regime may have prevented their suicide.
Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the Department of Corrective Services, when planning what future changes are to be made to the mental health services it provides to prisoners, should invest significantly more resources in ensuring that prisoners are given regular access to psychiatrists and that overall an emphasis be placed on providing a more holistic approach to mental health 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 health</td>
<td>Incidents where the existence of mental illness issues were involved in the circumstance on death, both diagnosed and anecdotal. Please note mental health is included as a contributing factor to death at the discretion of the coroner.</td>
</tr>
<tr>
<td>Misadventure</td>
<td>Risk taking behaviour such as train-surfing, unintentional drug overdose.</td>
</tr>
<tr>
<td>Natural cause death</td>
<td>Cases where the death is due to natural causes.</td>
</tr>
<tr>
<td>Older persons</td>
<td>Cases related to a specific demographic group or where the age of a person was a factor in the death.</td>
</tr>
<tr>
<td>Physical health</td>
<td>Cases where the existing physical health of the person contributed but were not necessarily cause the death.</td>
</tr>
<tr>
<td>Sports related</td>
<td>Cases where a sports incident significantly impacted the cause of death.</td>
</tr>
<tr>
<td>Transport and traffic related</td>
<td>Cases involving road, water and air vehicle incidents, motorised or naturally powered. Also includes cases where pedestrians are impacted by transport vehicles.</td>
</tr>
<tr>
<td>Water related</td>
<td>Includes swimming, scuba, snorkelling, boating, fishing and all water related activity in both a recreational or commercial context.</td>
</tr>
<tr>
<td>Weather related</td>
<td>Cases where the environmental conditions such as heatwave or storm conditions were significant to the cause of death.</td>
</tr>
<tr>
<td>Work related</td>
<td>Includes cases where work is related to the death and also where unemployment is significant.</td>
</tr>
<tr>
<td>Weapon</td>
<td>Cases where the involvement of a weapon is significant.</td>
</tr>
<tr>
<td>Youth</td>
<td>Cases related to a specific demographic group.</td>
</tr>
</tbody>
</table>