Coronial recommendations: Fatal facts

A summary of cases and recommendations made between October and December 2017

Edition 55
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CORONERS’ RECOMMENDATIONS

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

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

Coronial recommendations: Fatal facts includes case summaries and recommendations for cases closed between October and December 2017.

Previous summaries and recommendations are available at: https://www.ncis.org.au/publications/fatal-facts/
AUSTRALIAN CAPITAL TERRITORY CASES

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>ACT.2017.184</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Intentional self-harm</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Mental illness and health, Law enforcement</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>55 – cases closed between October and December 2017</td>
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Case summary
An adult male took their own life by suffocation.

The adult had previously served in the Australian Army and was believed to be suffering undiagnosed post-traumatic stress disorder (PTSD). Prior to the adult’s death, they were involved in a family violence incident with their spouse where they were arrested and charged.

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

The coroner found that police acted appropriately in dealing with the adult’s arrest, but that police did not consider the adult’s background and history before granting bail.

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

- The ACT Government should review, and if necessary amend, section 9F of the Bail Act 1992 to ensure that it does not or can not operate as an irrebuttable presumption against police bail for family violence accused.

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NEW SOUTH WALES

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

Case number: NSW.2013.2173
Primary category: Natural cause death
Additional categories: Physical health, Drugs and alcohol
Fatal facts edition: 55 – cases closed between October and December 2017

Case summary
An adult male died in prison as a result of health complications.
The adult was a prisoner at the time of their death. They were morbidly obese and suffered from multiple health conditions for which they took prescribed medication. The adult was discovered in their cell not breathing and was unable to be revived.

Coronial findings
The coroner found that the death was due to natural causes.
The coroner found that a number of antipsychotic drugs the adult had been prescribed for their health problems should have been more closely monitored by clinical staff to best manage their associated risk factors.

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

- I recommend that Justice Health revise the 2011 Metabolic Syndrome Resource to include:
  - the provision of sufficient information and guidance to clinical staff regarding the use, and relevance of, baseline and ongoing ECG (electrocardiogram) testing as part of metabolic monitoring; and
  - to cross-refer to the recommended clinical timeframes for ongoing ECG (electrocardiogram) testing as set out in the 2017 Psychotropic Medication Guidelines, in particular in relation to additional monitoring recommended for specific antipsychotic medication.

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Coronial recommendations: Fatal facts

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

An adult male took their own life by hanging.

The adult was a prisoner at the time of their death. The adult had received a phone call from their partner who ended their relationship. They returned to their cell after the phone call and were later found deceased by prison staff.

Coronial findings

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

The coroner found that the adult was not believed to have been ‘at risk’ by prison staff and that their death may have been hastily planned and impulsive.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that urgent funding be provided to facilitate the removal of hanging points in prisoner cells in [prison] in accordance with the by Action Plan prepared by the [prison operator], dated 1 September 2017.

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Coronial recommendations: Fatal facts

Coronial findings

The coroner found that the death was unintentional.

The coroner found that several factors prevented the adult from receiving adequate care in hospital. The coroner found that junior medical personnel and nursing staff failed to appreciate and communicate the urgency of the adult’s clinical condition.

The coroner found that the delayed response by medical staff resulted in emergency life-preserving surgery being delayed until it was too late to alter the fatal outcome.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend to the Chief Executive, [local] Health District that consideration be given to amending the Patient Transfer: Inter-Facility Patient Transfer […] policy directive to require:
  - mandatory (rather than preferred) consultant-to-consultant referral, where consultants are immediately available, to expedite the transfer of time critical patients;
  - and in circumstances where consultants are not immediately available for time critical transfers, then clause 4.7 should be followed.
- I recommend to the Chief Executive, [Local] Health District that consideration be given to amending the Patient Transfer: Inter-Facility Patient Transfer […] policy directive to replace the term “Attending Medical Officer”, and its acronym, “AMO”, with the term “consultant”.

Case summary

An adult male died as a result of traumatic head injuries.

The adult was on a night out with a friend when they suffered an unwitnessed fall. The adult endured a head injury during the fall and was admitted to hospital several hours later. They were found to have sustained irreversible brain damage and passed away in hospital.
• I recommend to the Chief Executive, [Local] Health District that consideration be given to amending the Patient Transfer: Inter-Facility Patient Transfer […] policy directive to require that in all cases of time critical inter-facility transfers, consultants should provide direct supervision and support (whether by phone or in person) to junior medical staff involved in the transfer process.

• I recommend to the Chief Executive, [Local] Health District that consideration be given to amending the Patient Transfer: Inter-Facility Patient Transfer […] policy directive to require that in all cases of interfacility transfers, all written documentation relating to medication prescribed and administered to a patient is to be immediately available at the receiving facility.

• I recommend that a copy of these findings be forwarded to the NSW Minister for Health, together with a transcript of the evidence of [doctor] (Director of Medical Services, [hospital]) given on 7 November 2017, for the Minister’s consideration regarding [the following recommendation].

• Having regard to the evidence given by [doctor], I recommend to the NSW Minister for Health that consideration be given to the following matters as they apply to the inter-facility transfer of patients and the management of, and recording of information in, Patient Flow Portals within Local Health Districts:
  o Reviewing whether the creation of an additional patient category, with applicable principles, to govern the inter-facility transfer of patients deemed to require immediate clinical care and treatment to preserve life, is necessary; and
  o Reviewing whether the removal of any requirement to effect time critical and urgent inter-facility transfer of patients within a nominated time, for example “<4 hours” or “<24 hours”, is likely to improve the timeliness and effectiveness of the patient transfer process between facilities.
Coronial recommendations: Fatal facts

Case number: NSW.2014.3274
Primary category: Natural cause death
Additional categories: Child and infant death
Fatal facts edition: 55 – cases closed between October and December 2017

Case summary
A male child died from health complications caused by a viral infection. The child became unwell with fatigue and a sore throat. The child’s condition deteriorated over a couple of days and they were taken to hospital. Medical staff at the hospital failed to document and communicate all the child’s signs and symptoms. The child was recorded to be safe for discharge. After discharge, their condition worsened, and their parent returned them to hospital. The child suffered a cardiac arrest in hospital and could not be revived.

Coronial findings
The coroner found that the death was due to natural causes. The coroner found that if medical staff had acted differently, there was still no assurance this would have prevented the child’s death. The coroner found that changes had been made to the hospital’s discharge procedures since the child’s death.

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

- That [hospital] consider a review of the approach of nursing and medical staff in its Emergency Department to paediatric patients, with the view of ensuring that staff explore and encourage the expression of parent and carer concerns as part of a family centred approach to the care of paediatric patients.

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Coronial recommendations: Fatal facts

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<td>Fatal facts edition</td>
<td>55 – cases closed between October and December 2017</td>
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**Case summary**

A middle aged male died from heart disease.

The adult had a history of traffic infringements and their driver’s license had been cancelled. The adult continued to drive unlicensed and drove an unregistered vehicle. The adult resisted police arrest during a routine traffic stop.

When the adult exited their vehicle, a violent struggle occurred with police. The adult suffered a sudden cardiac death as a result of cardiac disease.

**Coronial findings**

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

The coroner found that the emergency response to the situation could have been handled better.

The coroner found that police were not responsible for the adult’s death as the adult had an underlying medical condition.

**Coronial recommendations**

The coroner made the following recommendations related to this case:

- I recommend that the NSWPF [New South Wales Police Force] review the provision of first aid to all operational officers to ensure it meets the requirements of the following Commonwealth government accredited courses: HLTA/0001 - Provide CPR; HL TA/0002 Provide basis emergency life support; and HL TAID003 Provide first aid. All officers should undergo annual refresher or proficiency assessment in the material covered by such courses.

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Coronial recommendations: Fatal facts

### Case number
NSW.2014.4582

### Primary category
Intentional self-harm

### Additional categories
Mental illness and health

### Fatal facts edition
55 – cases closed between October and December 2017

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

The adult had been experiencing mental health problems leading up to their death. The adult had been treated in hospital prior and had responded well to treatment. They had a supportive family who had agreed to monitor them at their home. The adult was found unresponsive at home and was unable to be revived.

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

The coroner found that the treatment and medications provided to the adult were appropriate.

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

- I recommend that the Minister of Health NSW consider the implementation of a “take home” document for families/patients that would contain information such as the treatment plan, follow up appointments, medications, emergency telephone numbers and other information relevant to the patient’s ongoing care and support. The document would be intended for patients who are not admitted, but who have undergone a mental health assessment at a Local Health District.

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Coronial recommendations: Fatal facts

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

An adult male died due to drug toxicity in police custody.

The adult had a history of drug abuse and mental health issues. They were placed into police custody due to violent behaviour in a public area. The adult lost consciousness soon after being placed in custody. After a delayed response, the adult was transported by ambulance to hospital. They did not regain consciousness and were declared deceased in hospital.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the delay in commencing chest compressions far exceeded what would be expected by paramedics and was inconsistent with their training and protocols.

Coronial recommendations

The coroner made the following recommendations related to this case:

- It is recommended that the NSWPF [New South Wales Police Force] further investigate why the defects in the taser used in this case were not detected before the death occurred and take remedial action either in the form of improvements to the data download software (if this is possible and still necessary) or in officer training.
- I recommend that the CCTV [closed circuit television] from within the charge room and the sad outcome of this case be incorporated in the Safe Custody training material when the curriculum is next revised.
- The paramedics involved in this case failed to demonstrate sufficient urgency in their response to a known cardiac arrest. This suboptimal performance should be drawn to their attention for remedial purposes. I recommend that their line supervisor do so promptly.

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Coronial recommendations: Fatal facts

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<td>Fatal facts edition</td>
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Case summary
An older female died due to complications of an existing disease.

The adult had weak bones and was at risk of fracture due to a medical condition. The adult visited hospital for a routine check on their condition. The adult sustained fractures during a transfer from their wheelchair to a bed. Their condition deteriorated and they later passed away in hospital.

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

The coroner found that the inappropriate handling of the adult from their wheelchair to the bed contributed to their death.

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

- All the Manual Handling Champions at [hospital] meet at least once a year with all the wardspeople (and manager) to discuss manual handling practices and training. This meeting to also address how to better integrate wardspeople and their experience into [hospital] manual handling training and procedures.
- Wardspeople receive clear and specific training to only lift in the presence of a nurse, to encourage them to ask questions in relation to whether they need to be informed of any particular requirements of the patient and ensure there is a communication line for wardspeople if they have issues in relation to proposed manner of lifting.
- Wardspeople receive clear training on approved lifting techniques and further specific education on what they should do if they are asked by a nurse or other person to perform a task outside the approved lifting methods.
- If a patient requires any special form of lifting because that person has special needs which fall outside usual approved practice, that a manual handling champion is required to assess the proposed method of lifting and approve it prior to its use.
• The biannual audits of implementation of manual handling procedures and training continue.
• Those audits be expanded to include assessment of whether safe and appropriate manual handling practices are being used (not just whether the recorded plan is carried out).
• Consideration be given to introducing a wrist band or some other clear ‘on the person’ identification for patients with conditions that make them particularly vulnerable to injury from handling.
• The manager or person nominated as responsible for the supervision of wardspersons provide an update the hospital every 6 months on the progress of education of wardspersons.

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Coronial recommendations: Fatal facts

Case number: NSW.2015.3814
Primary category: Work related
Additional categories: Falls
Fatal facts edition: 55 – cases closed between October and December 2017

Case summary

A middle aged male died due to a workplace incident.

The adult was operating elevated work platform equipment on a farm when they fell. They were found lying on the ground. Emergency services attended and commenced treatment. The adult’s condition worsened, and they passed away at the scene.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the area the adult was working in was on a slope, which caused the machine to tip. The machine was less stable than others being used on the property at the time.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the Executive Director, Safework NSW:

• That Safework NSW (in conjunction with corresponding agencies in other states, if applicable) convene a working party, in consultation with other relevant stakeholders (e.g., growers associations, farmers, and manufacturers) to
  o Develop best practice guidelines for the use of Mobile Elevated Work Platforms (MEWPS) in avocado (and other fruits with similar techniques) harvesting activities. In developing such guidelines, consideration should be given to the engineering design characteristics of MEWPS used to harvest avocados (and other fruits) and the training required for their safe use.
  o Promote awareness of the potential dangers and risks when using MEWPS to harvest avocados (and other fruits with similar harvest techniques) particularly on terraced farms.
  o Develop an educational booklet in relation to these issues specifically aimed at the avocado growing industry.
Develop best practice guidelines for engaging, training and supervising harvest workers, with a particular focus towards vulnerable workers. For example, those new to the industry, youth workers and those from non-English speaking background.
Coronial recommendations: Fatal facts

Case number | NSW.2016.1476
Primary category | Law enforcement
Additional categories | Drugs and alcohol, Physical health
Fatal facts edition | 55 – cases closed between October and December 2017

Case summary
An adult male died in custody after they were involved in a physical fight.
The adult was observed to have some wounds from the fight, but these were not fatal.
Following the fight, the adult went into cardiac arrest and an ambulance was called. Despite attempts to resuscitate the adult, they were unresponsive and passed away in custody.

Coronial findings
The coroner found that the death was unintentional.
The coroner found that the adult had ingested methamphetamine in the hours prior to their death.
The coroner found that the adult’s death was contributed to by their emotional distress from their involvement in a physical fight and the ingestion of methamphetamine. The coroner found that the adult also had a history of chronic coronary artery disease which further contributed to their death.

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

- The Department of Immigration and Multicultural Affairs [(the Department)] and [prison operator] should each review the circumstances of this matter and give consideration to whether two DSOs [Detention Services Officers] in the [compound] is sufficient to provide an adequate level of supervision and security.
- The Department should liaise with International Health and Medical Services ("IHMS") about developing and making available at [detention centre] a rehabilitation program specifically targeted at ice users.
- The Department should investigate ways to facilitate drug and alcohol rehabilitation programs being provided to detainees who require them.
- Search and seizure powers available at immigration detention facilities should be enhanced to:
prevent the entry of illegal drugs into immigration detention centres and
detect illegal drugs which have entered immigration detention centres.

• The Department and [prison operator] should review their procedures to facilitate greater
sharing of information about suspected drug and alcohol use by detainees with staff
members who have supervision or welfare responsibilities towards those detainees.

• [Prison operator] should review the way in which it manages intelligence holdings
suggesting detainees are using illegal drugs or alcohol in order to ensure that adequate
supervision arrangements are in place in relation to such detainees.

• The Department should investigate with NSW Corrective Services and NSW Justice
Health options for obtaining information from them about a detainee’s custodial history
including information regarding their behaviour whilst in custody, health and welfare and
any history of drug and alcohol use, and options for making this information available to
both [prison operator] and IHMS.

• The Department and [prison operator] should develop a protocol which:
  o clarifies their respective roles in enquiring into the background and circumstances
giving rise to a Critical Incident;
  o clarifies the means by which they will keep abreast of developments of any police
investigations.

• The Department and [prison operator] should develop a protocol for notifying in a
timely manner the next of kin of the death of a detainee and a representative of both
the Department and [prison operator] should communicate with the next of kin to
acknowledge with appropriate sensitivity the death of their loved one while in [prison
operator] and the Department’s care and control.
Coronial recommendations: Fatal facts

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<th>Case number</th>
<th>NSW.2016.2435</th>
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<td>Additional categories</td>
<td>Water related, Weather related</td>
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<td>Fatal facts edition</td>
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Case summary

A middle aged male drowned after driving in an area affected by flood waters.

The adult drove into a flood-affected street which had been closed off by police. The adult attempted to turn the vehicle but was surrounded by floodwaters. The vehicle floated downstream and sunk.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the council made the following recommendations following the flood:

- Road closure barriers being placed in the [area] to avoid access issues when flood cuts the road between [location A] and the northern areas of [location B].
- Additional road closure barriers to be casted and purchased through Council.
- Fixed flood warning signs and water depth markers to be purchased and installed in the relevant areas, for use during storm and flood emergencies.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I strongly recommend that water depth markers (as seen in many county areas across NSW) be placed in the area where [the deceased’s] vehicle was lost and in other key areas identified by council.

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Coronial recommendations: Fatal facts

Case number: NSW.2016.2880
Primary category: Location
Additional categories: Leisure activity
Fatal facts edition: 55 – cases closed between July and September 2017

Case summary

A young male died from carbon monoxide poisoning.

The young person was travelling on a yacht with their partner at the time of the incident. They had cooked dinner using the stove in the cabin. After dinner, the young person and their partner fell in and out of consciousness for a time. It was not until the following day that the partner gained a sufficient level of consciousness and was able to call for assistance. The young person had already passed away when ambulance officers arrived.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the young person’s death was a result of carbon dioxide poisoning, caused by the incomplete combustion from the burner in a sealed cabin.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the Minister for Roads, Maritime and Freight I recommend:
- That urgent consideration of the introduction of legislation to mandate carbon monoxide alarms in all recreational and leisure craft and vehicles with sealable cabins, including sailing and motor vessels, caravans and motor homes, that have potential carbon monoxide sources such as fuel burning heating and cooking appliances. These alarms should conform to an appropriately developed minimum standard. Consideration should also be given to the introduction of other compulsory safety mechanisms such as prominent warning stickers. Any system introduced should include provision for checking and enforcement.

To Transport for NSW (TfNSW) I recommend:
- That Transport for NSW convene a working party with other relevant organizations, including for example, Roads and Maritime Services, Fire and Rescue NSW and the...
Boating Industry Association to consider ways of further promoting community education about the dangers of carbon monoxide poisoning. Initiatives could include:

- Developing a joint public education campaign especially targeted at recreational and leisure use of sailing and motor vessels, caravans and motor homes with potential carbon monoxide sources such as fuel burning heating and cooking appliances.
- Developing a safety pamphlet about the issue for distribution at retail outlets and marinas.
- Strengthening the safety message about this issue in all online material for those applying for a boat driving licence and elsewhere as appropriate.

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Coronial recommendations: Fatal facts

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Case summary

A middle aged male died due to injuries sustained in a fireworks incident.

The adult was fatally injured by a firework that they let off at a beach. Emergency services were contacted. Despite attempts at resuscitation, the adult was unable to be revived.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the firework fired prematurely due to the fuse burning at a faster rate than was expected. The coroner noted that the incident highlighted the need for general public education of the danger posed by fireworks. At inquest, a qualified pyrotechnician noted that despite industry regulation and stock control, commercial type fireworks may be at large in the community, not appropriately secured and in the hands of unqualified persons.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the Minister administering the Explosives Act 2003, the Executive Director of SafeWork NSW, and the NSW Commissioner of Police, I recommend that:

• Consideration is given to further “amnesty” periods to allow surrendering illegally held fireworks.

To the Minister administering the Explosives Act 2003 and the Executive Director of SafeWork NSW, I recommend that:

• Advertising be undertaken through social and other media to raise public awareness of the dangers associated with fireworks, and in particular large commercial type fireworks.

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Northern Territory

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

Case number | NT.2016.180
Primary category | Intentional self-harm
Additional categories | Law enforcement
Fatal facts edition | 55 – cases closed between July and September 2017

Case summary

A young male took their own life by hanging.

The young person was driving a vehicle with a passenger. The young person's license had already been suspended at the time and they were borrowing a friend's vehicle to drive home in.

The vehicle crashed into a tree and the young person became very distressed. Police attended the scene following a noise complaint and the passenger was taken to hospital. Police were transporting the young person to hospital following questioning when the young person took their own life in the police van.

Coronial findings

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

The coroner found that the young person was in a vulnerable and distressed state at the time they took their life, and that they were under the influence of alcohol and ecstasy (MDMA).

The coroner found that the police had limited vision available into the cage of the vehicle.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that Police give serious consideration to installing a mechanism to provide Police Officers visibility into the cage area of the Police vans while transporting persons.
- I recommend that the Commissioner of Police review the Police risk registers to ensure they reflect appropriate risks in a form that provides the mitigation treatments for each identified risk.
- I recommend that the Commissioner of Police ensure ongoing analysis of all critical incidents and near misses to ensure that the actual level of risk is appreciated.
I recommend that the Commissioner of Police ensure the rollout of an appropriate camera system to ensure that front line police officers can observe those in the cage of the caged vehicles at all times.
QUEENSLAND

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

**Case number**
The coroner held a joint investigation into the following deaths which resulted from the same incident: QLD.2011.3172, QLD.2011.3177

**Primary category**
Transport and traffic related

**Additional categories**
Work related

**Fatal facts edition**
55 – cases closed between October and December 2017

Case summary

Two middle aged males died during a helicopter incident.

One of the adults was the pilot of a helicopter and the other was a passenger. The adult lost control of the helicopter, resulting in a crash. Both adults died as a result of injuries they sustained during the crash.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that an adverse wind gust caused the pilot to lose control of the helicopter.

Coronial recommendations

The coroner made the following recommendations related to these cases:

- Pilots who conduct pinnacle or high altitude landing site operations need to ensure they have sufficient documented experience and have completed appropriate current assessment for such competency before being tasked to conduct such flying duties. This is because pinnacle site competency was suggested, and identified as, a degradable skill. There needs to be a greater awareness of this amongst pilots, and company operators (particularly the responsible tasking person, the chief pilot), to ensure that pilots appreciate the specialised nature of such flying.

- Regulators need to consider whether any manufacturer issued Safety Recommendation, or CASA [Civil Aviation Safety Authority] issued Airworthiness Bulletins should, in appropriate circumstances, require timely replacement of parts or components when improved parts or components are recommended. The depleting or running down of existing non-conforming, or not recommended parts, is not a best practice. There should also be consideration of whether any Safety Recommendation should be the subject of a minimum compliance period, e.g. ‘within 90 days there must be compliance’. This will of
course depend upon the issue that is the subject of the Safety Recommendation and the availability of a 'fix'.

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

<table>
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<tr>
<th>Case number</th>
<th>The coroner held a joint investigation into the following deaths which resulted from the same incident: QLD.2011.3322, QLD.2011.3349</th>
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<tr>
<td>Primary category</td>
<td>Transport and traffic related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>55 – cases closed between October and December 2017</td>
</tr>
</tbody>
</table>

Case summary

A middle aged female and a male child died in a motor vehicle incident.

The adult was driving with their child as a passenger when they were involved in a collision with another vehicle. The adult passed away at the scene and the child passed away later in hospital due to their injuries.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the driver of the other vehicle failed to give way whilst attempting to overtake at an excessive speed.

Coronial recommendations

The coroner made the following recommendations related to these cases:

- The Queensland Government review, and consider implementing a specific legislative provision to allow for the admissibility, perhaps similar to s.95A Evidence Act (Qld), of the downloaded motor vehicle EDR [event data recorder] data Report, and
- The Queensland Government within 6 months review the laws regarding overtaking (particularly overtaking of multiple vehicles in a single manoeuvre) to determine if they are adequate or should be more appropriately expressed in the Transport Operations (Road Use Management) Act.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>QLD.2012.3636</th>
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<tr>
<td>Primary category</td>
<td>Water related</td>
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<tr>
<td>Additional categories</td>
<td>Leisure activity, Physical health</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>55 – cases closed between October and December 2017</td>
</tr>
</tbody>
</table>

Case summary

An older male drowned during a snorkelling incident.

The adult was in Australia with their partner for a holiday and undertook snorkelling as part of a tour group. During the snorkelling tour, the adult separated from the group and was later found floating unconscious. The adult was conveyed to the beach and resuscitation was attempted. They were unable to be revived.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult had a pre-existing cardiac condition which contributed to their death, and that a risk assessment was not conducted on the adult by the snorkelling tour’s staff.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend [tour operator] conduct a major review of its procedures, training, supervision and auditing relevant to the manner in which it conducts snorkelling activities.
- In light of the commitment of [tour operator] at inquest over 12 months ago to conduct a review with an independent expert, I recommend Workplace Health and Safety Queensland conduct an audit of snorkelling activities conducted by [tour operator] and report to the Coroners Court on its progress with any independent expert review as well as implementation of recommendations from the [Workplace Health and Safety] report.

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Coronial recommendations: Fatal facts

Case number: QLD.2012.3724
Primary category: Adverse medical effects
Additional categories: Physical health
Fatal facts edition: 55 – cases closed between October and December 2017

Case summary

A middle aged female died in hospital following surgery for a brain tumour.

The adult was admitted to hospital for surgery following diagnosis of a brain tumour. Following surgery, the adult's neurological condition continued to deteriorate. They suffered a cardiac arrest and later passed away.

Coronial findings

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

The coroner found that a delay in surgery contributed to the adult's neurological deterioration. The coroner also found that the surgical technique used by doctors carried a greater risk of causing neurological injury.

The coroner found that after surgery, recordkeeping by staff was not comprehensive and that there was no Intensive Care Unit (ICU) review plan in place for the adult.

Coronial recommendations

The coroner made the following recommendations related to this case:

I recommend that the [hospital] implement the following:

- Conduct in-service training on the importance of documentation and reinforce the policy requirements regarding documentation for all medical staff on the neurosurgical ward, including consultants.
- Regular follow-up audit of medical entries to ensure that policy 74 100/Proc: Documentation in the Patient Record is being complied with.
- The clinical/case pathway for a craniotomy patient with a brain tumour be amended. When a neurosurgical patient presents with preoperative communication deficits, a comprehensive review by either a speech pathologist or member of the neurology team is undertaken to ensure there is a timely baseline assessment undertaken.
• The clinical/case pathway for a craniotomy patient with a brain tumour be amended to require the operating surgeon(s) complete a preoperative comprehensive detailed high cognitive function neurological assessment. The assessment must be clearly documented on the record.

• That the clinical/case pathway for a craniotomy patient with a brain tumour be amended to consider a preoperative CT/MRI [computed tomography/magnetic resonance imaging] scan within 3-5 days prior to surgery. The surgeon be required to document the reason if a decision is made not to arrange such preoperative imaging.

• That [the deceased's] case be presented to the junior medical and nursing neurological training to highlight the importance of identifying changes in speech, restlessness and a change in the patient's ability to follow commands.

• An audit be undertaken to check whether consultant to consultant discharge of neurological patients is occurring in the intensive care unit in accordance with the root cause analysis recommendations.
Coronial recommendations: Fatal facts

<table>
<thead>
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<th>Case number</th>
<th>The coroner held a joint investigation into the following deaths which resulted from the same incident: QLD.2013.3316, QLD.2013.3345</th>
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<td>Additional categories</td>
<td>Work related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>55 – cases closed between October and December 2017</td>
</tr>
</tbody>
</table>

Case summary

A middle aged female and a male child died during a motor vehicle incident.

The adult was driving on a public road when they were struck by a crane. The crane was travelling downhill when the driver lost control and it crossed into the oncoming lane of traffic. The crane collided with the adult’s vehicle. The adult attempted to steer away from the crane but died immediately upon impact at the scene. The child later passed away in hospital as a result of injuries they sustained during the crash.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the driver of the crane was most likely travelling too fast for the conditions of the road and/or reacted inappropriately to an emergent situation.

Coronial recommendations

The coroner made the following recommendations related to these cases:

The National Heavy Vehicle Regulator:

- Urgently amend the National Class 1 Special Purpose Vehicle Notice to:
  - impose a speed restriction of 60km/h on all mobile articulated steering cranes (until such time as electronic stability control systems are developed and fitted); and
  - restrict access to mobile articulated steering cranes on roads and motorways where it is assessed that a speed restriction of 60km/h will be unsafe for other motorists.
- Propose an amendment to the Heavy Vehicle National Law to ensure that internal speed limiters are set to 60km/h on all mobile articulated steering cranes (or 80km/h when fitted with electronic stability control); and
- Conduct independent testing of each make and model mobile articulated steering crane to determine whether there are any inherent lateral stability issues that need to be addressed in terms of the design of the vehicles.
The National Transport Commission:

- Amend the national licensing scheme so that before a driver is authorised to drive a mobile articulated steering crane on a public road, they must undergo a:
  - practical assessment on a public road in a mobile articulated crane; and
  - theoretical assessment addressing the unique handling characteristics of mobile articulated cranes and emergency procedures in the event of a loss of control.

All State and Territory road regulators:

- Support an urgent amendment by the National Heavy Vehicle Regulator to the National Class 1 Special Purpose Vehicle Notice to:
  - impose a speed restriction of 60km/h on all mobile articulated steering cranes (until such time as electronic stability control systems are developed and fitted); and
  - restrict access to mobile articulated steering cranes on roads and motorways where it is assessed that a speed restriction of 60km/h will be unsafe for other motorists.
- Support a proposed amendment to the Heavy Vehicle National Law to ensure that internal speed limiters are set to 60km/h on all mobile articulated steering cranes (or 80km/h when fitted with electronic stability control); and
- Support an amendment by the National Transport Commission to the national licensing scheme so that before a driver is authorised to drive a mobile articulated steering crane on a public road, they must undergo a:
  - practical assessment on a public road in a mobile articulated crane; and
  - theoretical assessment addressing the unique handling characteristics of a mobile articulated crane and emergency procedures in the event of a loss of control;
- As the Northern Territory and Western Australia are not parties to the National Heavy Vehicle Regulator scheme, they should separately impose regulations that mirror [the recommendations] above.

Safe Work Australia:

- Amend the national workplace licensing scheme, so that before a person is authorised to drive a mobile articulated steering crane on a private or public road in the course of their employment, they must undergo a:
  - practical assessment on a road in a mobile articulated crane; and
  - theoretical assessment addressing the unique handling characteristics of a mobile articulated crane and emergency procedures in the event of a loss of control.

All State and Territory work health and safety regulators:

- Support an amendment by Safe Work Australia to the national workplace licensing scheme, so that before a person is allowed to drive a mobile articulated steering crane on a private or public road in the course of their employment, they must undergo a:
  - practical assessment on a road in a mobile articulated crane; and
• Theoretical assessment addressing the unique handling characteristics of a mobile articulated crane and emergency procedures in the event of a loss of control; and

• Amend relevant mobile crane Codes of Practice to include guidance about the unique handling characteristics of mobile articulated steering cranes and emergency procedures in the event of a loss of control.

[Crane manufacturer]:

• Develop electronic stability control systems that can be fitted or retrofitted to all mobile articulated steering cranes;

• Amend the Owners Manuals for all mobile articulated cranes to provide guidance to drivers in relation to the crane's unique handling characteristics and emergency procedures in the event of a loss of control; and

• Issue a Safety Bulletin containing guidance to drivers about the unique handling characteristics of mobile articulated steering cranes and emergency procedures in the event of a loss of control.

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Coronial recommendations: Fatal facts

**Case number**  
QLD.2016.973

**Primary category**  
Transport and traffic related

**Fatal facts edition**  
55 – cases closed between October and December 2017

**Case summary**

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

The adult was driving their vehicle when they were struck head-on by a second vehicle which had crossed onto the incorrect side of a busy main road. The adult took evasive action by braking heavily. The adult did not regain consciousness after the collision and passed away at the scene.

**Coronial findings**

The coroner found that the death was unintentional.

The coroner found that the reason for the second vehicle leaving its lane was that the driver had a ‘micro-sleep’ due to fatigue.

**Coronial recommendations**

The coroner made the following recommendations related to this case:

- That the present driving laws (s.83 TORUM, "Due Care and Attention") be amended to have a specific circumstance of aggravation:
  - For driving without due care and attention where the offending driver causes grievous bodily harm or death; and a further circumstance of aggravation, if:
    - the offending driver was then unlicensed; or
    - the offending driver was suspended or disqualified, at the time the alleged offence occurred, and that the government's announced amendments be passed into law within 1 month.

- That the issue of a new mid-range driving offence be referred to the Attorney General to consider changing the law to introduce a new mid-range driving offence of Reckless Driving between the existing Criminal Code s.328A Dangerous Driving offence, and the TORUM s.83 Driving without Due Care and Attention offence, and for that review to within two months determine whether it is appropriate:
  - To include a circumstance(s) of aggravation for offending drivers:
    - who cause death or grievous bodily harm;
    - where they were driving whilst unlicensed or their license was suspended.
– where they were driving whilst their license was disqualified;

○ That the recommended new mid-range offence be legislated in the Criminal Code.
SOUTH AUSTRALIA

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

<table>
<thead>
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<th>Case number</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Intentional self-harm</td>
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<td>Additional categories</td>
<td>Law enforcement</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>55 – cases closed between October and December 2017</td>
</tr>
</tbody>
</table>

Case summary

An adult male took their own life by poisoning.

The adult had a history of drug use and violence toward their partner. They had been to prison and was fearful of returning due to having been assaulted by other prisoners. The adult was on home detention at the time and was found deceased in a car on the premises they were residing in.

Coronial findings

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

The coroner found that the adult's mental health concerns had been adequately addressed and monitored whilst they were on home detention.

The coroner found that the adult had consumed illicit drugs prior to their death.

Coronial recommendations

The coroner made the following recommendations related to this case:

- The Court recommends that DCS [Department for Correctional Services] staff members responsible for compiling Bail Inquiry (Home Detention) Reports be instructed to make specific reference to any information that is relevant to the applicant’s risk of self-harm or suicide. I direct this recommendation to the Chief Executive of the Department for Correctional Services.

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.
TASMANIA

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

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<thead>
<tr>
<th>Case number</th>
<th>TAS.2009.370</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Adverse medical effects</td>
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<td>Fatal facts edition</td>
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</tbody>
</table>

Case summary

An older female died due to complications of a kidney infection.

The adult had suffered severe mental illness issues throughout their life and had resided in state-operated facilities. The adult became unwell and was incorrectly diagnosed and treated by medical staff at the facility they were residing in. The facility was not designed to treat patients with acute medical conditions. The adult's condition continued to deteriorate, and they were transferred to a hospital emergency department where they passed away.

Coronial findings

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

The coroner found that there was a failure by medical staff at the facility to recognise the adult was suffering from a bacterial infection, and that this failure contributed to their death.

The coroner found that if appropriate therapy was initiated at an earlier time, the adult would have had a significant chance of complete recovery.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that [facility] modify the Adult Observation and Response Chart to incorporate clear instructions regarding appropriate instances for invoking the use of the GP [general practitioner] Assist service during after-hours periods, such instructions being referenced to acute/non-acute presentations and/or Tiers 1-4 on the Chart.
- I recommend that [facility] provides ongoing training of nurses in managing acute medical conditions including procedures for liaison with consultants or medical officers, recording of escalation in patients' conditions, use of the GP Assist service, and training in the use of the Chart.
- I recommend that [facility] conduct a review of its procedures for supervision of medical practitioners holding conditional registrations requiring supervision, including the selection and training of the proposed supervisor and the recording and retention of all documentation relating to the supervision.
I recommend that [facility] implement a written policy and system to ensure that persons admitted to [the facility] who are incapable of giving informed consent to their admission, residency and/or treatment at [the centre] are identified and only admitted, treated and/or continue residence with the substitute consent of a legal guardian appointed pursuant to part 4 of the Guardianship and Administration Act 1995, or pursuant to a power or order under the Mental Health Act 2013.
Coronial recommendations: Fatal facts

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

Case summary

Two middle aged males died from carbon monoxide poisoning.

The adults were travelling on a boat. The boat was anchored in a bay overnight. A friend became concerned when they were unable to make contact with either of the adults the following morning. The friend gained access to the boat and found both adults deceased in the cabin.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the source of the carbon monoxide poisoning was a portable power generator, and that no carbon monoxide detector had been fitted in the cabin of the boat.

Coronial recommendations

The coroner made the following recommendations related to these cases:

- I recommend that all petrol driven generators only be used in accordance with manufacturer’s recommendations, and in particular, not be installed in a confined space and not have the exhaust system modified in any way.
- I recommend that all boats with enclosed cabins and which have petrol driven motors of any type installed be fitted with a carbon monoxide detector.

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Coronial recommendations: Fatal facts

Case number | TAS.2016.538
---|---
Primary category | Work related
Fatal facts edition | 55 – cases closed between October and December 2017

Case summary

A middle aged male died during a tree felling incident.

The adult was with their partner when they attempted to fell a tree. The tree hit the branch of another tree, causing that branch to snap off and strike the adult. The adult’s partner called emergency services but attempts to revive the adult were unsuccessful.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the death directly resulted from poor tree felling technique and a failure to wear appropriate personal protective equipment.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that all chainsaw operators must undertake approved chainsaw training prior to purchasing or using a chainsaw.
- I recommend that all persons selling chainsaws must be accredited chainsaw operators.
- I recommend that all chainsaw operators must undergo regular practical reassessment ideally every three years.
- I recommend that all land owners and managers be required to ensure that people permitted to use chainsaws on their land be appropriately qualified.
- I recommend that no person under the age of 16 years be permitted to own or use a chainsaw in any circumstances.
VICTORIA

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

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<tbody>
<tr>
<td>Primary category</td>
<td>Natural cause death</td>
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<td>Additional categories</td>
<td>Physical health</td>
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<td>Fatal facts edition</td>
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</table>

Case summary

An adult male died due to a blood clot.

The adult had struggled with their weight and travelled overseas for multiple plastic surgery procedures. When the adult returned home, they had severely infected wounds and were in significant pain. The day after returning home, the adult collapsed. Their parent called emergency services but the adult could not be revived.

Coronial findings

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

The coroner found that recent surgery and long-haul flights were relative risk factors for the development of deep venous thrombosis and subsequent pulmonary thromboembolism.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Chief Health Officer consider the merits of taking a similar approach to the Department of Health and Department of Foreign Affairs and Trade to publish a Health Advisory [...]. This will serve to increase the breadth of material available to advise Victorian consumers of medical services overseas to be aware that the quality of medical care provided in other countries may not be of the same standard as that provided in Australia.

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Coronial recommendations: Fatal facts

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

Case summary

A male child died due to complications of an infection.

The child developed a fever and was lethargic. Their condition was misdiagnosed in hospital as a viral illness, and the child was sent home. They continued to be unwell for several days. Upon the child’s final admission to hospital, they were diagnosed with a bacterial infection. There was a delay in administering a combination of antibiotics and intensive treatment after the diagnosis. The child’s condition continued to deteriorate in the intensive care unit, and they could not be revived.

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 missed opportunities for correct diagnosis leading up to the child’s death. The coroner found that this failure to carry out interventions and examinations which would have assisted diagnosis produced a delay in treatment for the infection.

The coroner found it likely that the child’s death would have been prevented had they received appropriate care at an earlier stage.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That each of the Royal Australian College of General Practitioners, the Royal College of Physicians (Paediatric and Child Health Division) and the Australian College for Emergency Medicine consider the educational opportunities posed by the circumstances of this case in particular in relation to the recognition of the possibility of sepsis despite absence of fever and despite the apparent existence of a viral illness.
- That [hospital] introduce a policy governing the circumstances in which it is acceptable for clinicians to make verbal orders for antibiotics and providing for mechanisms to
ensure the prompt administration of any verbally ordered antibiotics, including charting the order at the first available opportunity.

- That [hospital] introduce a formal policy governing the care of patients who present to the Emergency Department within 72 hours of a previous presentation requiring that such patients be personally reviewed by an Emergency Department consultant as soon as possible and that there be a concerted re-evaluation of the working diagnosis. In the event that an Emergency Department consultant is not available, the patient should be managed by a senior registrar and reviewed by a second senior registrar.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
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<tr>
<td>Primary category</td>
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<td>Older persons, Falls</td>
</tr>
<tr>
<td>Fatal facts edition</td>
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</tr>
</tbody>
</table>

Case summary

An older female died due to complications of multiple falls.

The adult had experienced multiple falls while residing at an aged care facility. The adult was admitted to the emergency department following a fall where they hit their head. No major injuries were detected, and the adult was returned to their aged care facility.

The adult began to exhibit escalated behavioural issues which caused them to be transferred to a different aged care facility. There was a lack of communication between medical and nursing management regarding the adult’s medication and care management during the transfer. The adult’s condition continued to deteriorate, and they passed away in hospital.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that there were a number of delays in appropriate care being administered to the adult in the months prior to their death. The coroner found that the inadequate medication arrangement for the adult contributed to their physical decline and death.

Coronial recommendations

The coroner made the following recommendations related to this case:

With respect to [aged care facility A], I make the following recommendations:

- The [facility] policy "Management of a resident after a fall" was updated in May 2015, with some generalised improvements and greater detail of required care. However, specific details of the complete actions required by nursing staff in response to an unwitnessed fall by a resident are convoluted, referring the reader to multiple other sections of the policy. I recommend that [aged care facility] revise this policy to include greater clarity regarding nursing staff requirements for unwitnessed falls management of residents.
Additionally, the [facility] "Management of a resident after a fall" policy requires neurological observations to be performed half hourly for at least four hours on a resident who has sustained an unwitnessed fall. Neurological observations were performed far less frequently following all three falls [the deceased] sustained. I recommend that [facility] provide internal education to staff on adequate post fall management, including neurological observations.

There was an apparent internal communication deficit at [facility] regarding documentation of [the deceased’s] known impending transfer location. This deficit, amongst other things, impeded visiting [general practitioner's] ability to handover relevant treatment and investigation information to the receiving RACF [Residential Aged Care Facility] and new primary GP [general practitioner]. I recommend that [facility] have an internal review of documentation to ensure that information pertaining to the impending transfer location of a respite or permanent resident, is easy to document and readily accessible.

With respect to [aged care facility B], I make the following recommendations;

- The array of practice changes and improvements undertaken by [facility] and summarised earlier in the finding adequately addressed many of the issues identified in this report. However, I further recommend that [facility] amend its policy to reflect that for every resident admitted from another health care service, for either respite or permanent residence, an up to date, written care plan or health summary should be requested/received. If such a document is unavailable, every effort should be made to seek a verbal handover from the transferring service.

- That [facility] provide internal education to all staff administering medications, as per Point 6 of the [facility] Medication Management Policy and Procedure. The internal education should serve as a reminder to staff of the importance of using "professional judgement in determining the appropriateness of a medication order". Specific high risk medications commonly used in RACFs include insulins, narcotics, sedatives and anticoagulants.

- That the Australian Aged Care Quality Agency (AACQA) review this case, pertaining to:
  - The adequacy of clinical governance of medication administration at [aged care facility B], which ceased operations in December 2014.
  - The inappropriate administration of medication (‘as required’ Oxazepam) by multiple nursing staff at [aged care facility B].
  - The adequacy of communication between RACFs.

- That the Australian Health Practitioner Regulation Agency (AHPRA) review this case, pertaining to:
  - The adequacy of clinical governance of medication administration at [aged care facility B], which ceased operations in December 2014.
The inappropriate administration of medication (‘as required’ Oxazepam) by multiple nursing staff at [aged care facility B].

The significant increase in Oxazepam prescribed by [doctor], as well as the absence of follow up review provided.

Finally, I recommend that the Royal Australian College of General Practitioners (RACGP) use this case as an educational tool for members to highlight the complexity of care requirements, and to demonstrate the importance of appropriate dementia management, the importance of early escalation of care to specialist services, adequate communication between health services and practitioners, and appropriate prescribing and follow up.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Intentional self-harm</td>
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<td>Fatal facts edition</td>
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</table>

Case summary

An adult female took their life in a mental health care facility.

The adult had a history of serious mental health problems and had previously attempted suicide. The adult was being observed by nursing staff on a regular basis at the facility. The adult was found unresponsive by staff at the facility. They were transferred to hospital where they passed away.

Coronial findings

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

The coroner found that the adult was psychiatrically unwell and had high acute and ongoing risks associated with frequent self-harming behaviours.

The coroner found that staff utilised interventions and strategies that were most relevant in promoting the adult’s safety and that the adult’s prescribed medicines were appropriate.

Coronial recommendations

The coroner made the following recommendations related to this case:

- To improve the effectiveness of the required ligature point auditing tools, auditor training and their application in acute care mental health units, the Department of Health and Human Services work with Area Mental Health Services to develop advice and examples of ligature audit tools that are assessed as being appropriate to the task, and effective in meeting their purpose.

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Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2015.4936</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Adverse medical effects</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Older persons</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>55 – cases closed between October and December 2017</td>
</tr>
</tbody>
</table>

Case summary

An older male died from the effects of a medical procedure.

The adult was diagnosed with cancer and underwent combined chemo-radiotherapy treatment. The adult suffered serious side effects following the treatment. The adult's condition continued to deteriorate, and they were diagnosed with multi-organ failure. They passed away in hospital.

Coronial findings

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

The coroner found that the death was the result of a rare toxic reaction to a chemotherapy drug rather than the natural progression of a disease process.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Medical Oncology Group of Australia (MOGA) consider whether testing for DPD [dipyrimidine dehydrogenase] deficiency should be standard care for patients proposed to be commenced on 5-FU chemotherapy treatment.
- That the Federal and Victorian Governments expedite the agreement for a single national repository for the oral antidote to 5-FU, Vistogard.
- That the Peter MacCallum Cancer Centre agree to establish and maintain a national repository for Vistogard.

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.2016.350</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Water related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>55 – cases closed between October and December 2017</td>
</tr>
</tbody>
</table>

Case summary

An adult male died due to drowning at a beach.

The adult was swimming at a beach with friends. The group swam away from the red and yellow flags and struggled to keep their footing as large waves broke over them. The adult was a weak swimmer and was unable to make it back to shore. The adult was retrieved by lifeguards and cardiopulmonary resuscitation (CPR) was commenced, but they were unable to be revived.

Coronial findings

The coroner found that the death was unintentional.

The coroner noted the following proposed changes made by the surf lifesaving club’s president to improve the beach’s safety:

- Changes to signage, to indicate more clearly the location of the patrolled section of beach.
- The erection of a large flagpole, indicating when the beach patrol is in operation.
- Redesigning traffic flow in the [beach] car parks, so that drivers are forced to pass through the car park for the patrolled section of the beach before they can proceed on to the car park for the unpatrolled section of the beach.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That Victoria Police liaise with Life Saving Victoria, local lifesaving clubs, and other stakeholders, for the purpose of establishing a [location] surf safety working group.
- That the surf safety working group give specific consideration to the changes suggested by the President of the [location] surf lifesaving club set out above [...].

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Coronial recommendations: Fatal facts

Case number | VIC.2016.3409
Primary category | Fire related
Additional categories | Older persons, Aged care
Fatal facts edition | 55 – cases closed between October and December 2017

Case summary
An older male died during a house fire.

The adult lived alone and was in declining health. They used an electrical heater in their living room. The adult’s medical alert pendant was activated and ambulance services attended their property. The house was found to be alight and the fire brigade were called. The adult was found deceased in their home.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the fire started accidentally due to the electrical heater being placed too close to combustibles.

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

I direct the following recommendations to agencies who fund programs who provide ‘in-home’ services to older people in Victoria, specifically the Aged Care Branch, Victorian Department of Health, the Commonwealth Department for Health and Ageing and the Commonwealth Department of Veterans’ Affairs:

- That aged care service providers should identify clients that may require or benefit from a personal alarm pendant during the initial home assessment.
- That the assessor should advise elderly clients of the availability of personal alarm pendants that connect to smoke alarms and encourage and promote the appropriate wearing of personal alarm pendants to minimise the risk of harm in an emergency situation.

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Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2017.2637</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Transport and traffic related</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Older persons</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>55 – cases closed between October and December 2017</td>
</tr>
</tbody>
</table>

Case summary

An older male died due to a vehicle incident in which they were a motorcyclist.

The adult was riding their motorcycle when they approached an intersection and a car turned directly into their path of travel. The adult had no opportunity to avoid the collision. Ambulance services attended the scene and the adult was transported to hospital. They passed away in hospital from complications of injuries sustained in the collision.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the driver of the car was elderly and had impaired vision.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the Secretary to the Department of Economic Development, Jobs, Transport and Resources, and VicRoads, develop a legislative framework which would require a medical practitioner to report to VicRoads when that practitioner forms an opinion that his/her patient has a medical condition that may render it inappropriate for the patient to continue to drive.

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WESTERN AUSTRALIA

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>The coroner held a joint investigation into the following deaths which resulted from similar incidents: WA.2013.245, WA.2014.1835, WA.2014.1985, WA.2012.1618, WA.2012.1619</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Transport and traffic related</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Law enforcement</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>54 – cases closed between October and December 2017</td>
</tr>
</tbody>
</table>

Case summary – WA.2013.245

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

The adult had been involved in a theft prior to the incident. Their accomplice, the driver of another vehicle, was being pursued by police. The adult’s vehicle collided with their accomplice’s vehicle, and the adult suffered fatal injuries as a result.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult’s death resulted from their accomplice’s decision to continue evading police and driving in a dangerous manner.

The coroner found that the actions of police did not cause or contribute to the adult’s death.

Case summary – WA.2014.1835

A young female died due to a motor vehicle incident in which they were a passenger.

The young person was travelling in a stolen vehicle being pursued by police. Police terminated the pursuit, however the vehicle crossed onto the incorrect side of the road, colliding with an oncoming vehicle. The young person was not wearing a seatbelt at the time of the collision and suffered fatal injuries.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the actions of police did not cause or contribute to the young person’s death.

Case summary – WA.2014.1985

An adult male died due to a motor vehicle incident in which they were a driver.
Police noted that the adult’s vehicle bore a numberplate that was not affixed properly. Police followed the vehicle, at which point it sped away. The adult lost control of the vehicle and it collided with a tree. They died at the scene.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the actions of police did not cause or contribute to the adult’s death.

Case summary – WA.2012.1618 and WA.2012.1619

Two adult males died due to motor vehicle incident in which they were the driver and passenger of a taxi.

Police sighted a stolen vehicle on the night of the incident and attempted to intercept it. The driver of the vehicle evaded police and drove away at speed. While the vehicle was evading police, it travelled through an intersection at speed against a red signal. As a result, it collided with the taxi, causing the deaths of the two adults.

Coronial findings

The coroner found that the deaths were unintentional.

The coroner found that the actions of police did not cause or contribute to the adults’ deaths.

Coronial recommendations

The coroner made the following recommendations related to these cases:

- I recommend that the Police Airwing be allocated greater resources for the acquisition and operation of an additional helicopter and to this end, that consideration be given to allocating appropriate funding to the Western Australia Police Service.
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: WA.2016.1412, WA.2016.882</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Water related</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Leisure activity</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>55 – cases closed between October and December 2017</td>
</tr>
</tbody>
</table>

Case summary

Two middle aged males died during a fishing incident.

The adults were both experienced fishers who had been fishing together for many years. The adults travelled out to sea despite predicted worsening weather conditions. Their friends became concerned when they had not heard from the adults in some time. A search operation was later conducted, and no evidence was found to suggest that either adult was still alive.

Coronial findings

The coroner found that the bodies were not recovered and was satisfied that both persons were deceased.

The coroner was unable to determine precisely how the adults died but was satisfied that the fatal incident was accidental.

Coronial recommendations

The coroner made the following recommendations related to these cases:

- All recreational activities on the water be undertaken with the wearing of personal flotation devices activated on contact with water.
- Where recreational activities are undertaken in conditions where EPIRBs [electronic position radio beacons] are used, those EPIRBs include a water activated device which is located externally to the cabin and does not require manual activation.
- Those intending to fish recreationally off shore notify the local marine volunteer search and rescue group, or at the very least, friends and family of their intended route, and of changes directed by weather conditions where possible.

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.</td>
</tr>
<tr>
<td>Domestic</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 contributed to 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 activity that directly influenced the circumstances of death.</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 type 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. Note: mental illness 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.</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 where the agedness 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 was not necessarily the cause of death.</td>
</tr>
<tr>
<td>Sports related</td>
<td>Cases where a sporting incident contributed to 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 activities in either a recreational or commercial context.</td>
</tr>
<tr>
<td>Weather related</td>
<td>Cases where the environmental conditions such as heatwave or storm conditions contributed to death.</td>
</tr>
<tr>
<td>Work related</td>
<td>Includes cases where work is related to the death.</td>
</tr>
<tr>
<td>Weapon</td>
<td>Cases where the involvement of a weapon is significant.</td>
</tr>
<tr>
<td>Youth</td>
<td>Cases where the youth of a person was a factor in the death.</td>
</tr>
</tbody>
</table>