Coronial recommendations: Fatal facts

A summary of cases and recommendations made between January and March 2018

Edition 56
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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 January and March 2018.

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

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>ACT.2013.94</th>
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</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Adverse medical effects</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>56 – cases closed between January and March 2018</td>
</tr>
</tbody>
</table>

Case summary

An older male died due to respiratory failure complicated by lung disease, damage and infection. The adult had been a long-term smoker. They had been diagnosed with lung cancer in the months prior to their death, for which they underwent chemotherapy treatment. They later developed a respiratory infection and were admitted to an intensive care unit, 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 a biopsy sample taken from the adult was incorrectly diagnosed as malignant. Clinicians relied upon this diagnosis to inform treatment decisions. The usual review process for lung core biopsies did not take place, and clinicians erroneously assumed that the original diagnosis had been reassessed.

Coronial recommendations

The coroner made the following recommendations related to this case:

- The [hospital] continue to periodically review its quality assurance processes for core biopsies, to ensure that such processes appropriately balance the need to minimise the risk of errors with the costs of associated control measures. Such processes should involve an element to check and ensure compliance.
- The [cancer treatment centre] consider reviewing the words used within its reports for the Epidermal Growth Factor Receptor Mutation Analysis to ensure that treating clinicians are disabused of any erroneous assumption that the test either reassesses the original diagnosis or positively identifies tumour cells.
- The [hospital] consider introducing a protocol that requires appropriate records be made of Lung Multidisciplinary Meetings, and that such records be appropriately stored.
Coronial recommendations: Fatal facts

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<thead>
<tr>
<th>Case number</th>
<th>ACT.2015.45</th>
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<tr>
<td>Primary category</td>
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<td>Additional categories</td>
<td>Law enforcement</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>56 – cases closed between January and March 2018</td>
</tr>
</tbody>
</table>

Case summary

An adult female died due injuries sustained in an assault by their ex-partner.

The adult had taken out a domestic violence order against the ex-partner. The ex-partner forced entry to the adult’s home and inflicted fatal injuries upon the adult.

Coronial findings

The coroner found that the death was due to assault.

The coroner found that process improvements could be made in relation to Australian Federal Police handing of family violence issues.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend a review of court and police processes and practices with a view to:
  - The possible involvement of FVCU [Family Violence Coordination Unit] in all family violence order applications, not only those brought by Police; and
  - Timely notification to affected persons when service of an order on a respondent has taken place.

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  | ACT.2016.304
Primary category  | Aged care
Additional categories  | Falls, Older persons
Fatal facts edition  | 56 – cases closed between January and March 2018

Case summary
An older male died due to injuries sustained in a fall.

The adult resided in an aged care facility, and required assistance with daily activities. The adult and a nurse were waiting for another staff member prior to using a stand-up lifter. Upon arrival of the staff member, the adult fell and struck their head on the lifter.

Observations were undertaken and the adult was conveyed to hospital the following day. The adult’s condition deteriorated and they later passed away in hospital.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the adult’s injuries may have been prevented had the lifter not been placed in front of them while awaiting the additional staff member.

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

- I recommend that [aged care facility] review and revise their practices, any relevant policies, and staff training in respect of the positioning of sling lifters around patients prior to active deployment of the equipment.

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.
Coronial recommendations: Fatal facts

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<td>Fatal facts edition</td>
<td>56 – cases closed between January and March 2018</td>
</tr>
</tbody>
</table>

Case summary

An adult male died due to multiple gunshot wounds.

Coronial findings

The coroner found that the death was due to assault.

The coroner found that the adult was shot by unknown assailants. After extensive police investigation, limited evidence had been uncovered regarding the circumstances surrounding the adult’s death.

Coronial recommendations

The coroner made the following recommendations related to this case:

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

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Coronial recommendations: Fatal facts

Case number | NSW.2014.817
Primary category | Intentional self-harm
Additional categories | Mental illness and health
Fatal facts edition | 56 – cases closed between January and March 2018

Case summary
An adult male died by hanging.

The adult was an involuntary patient at a mental health facility and had a long history of mental health issues.

They were found unresponsive by staff in their room. Despite resuscitation attempts, the adult was unable to be revived.

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

The coroner found that the adult was a vulnerable patient and was to be observed at set regular intervals. These observations were not performed, and the adult had been left unobserved for a lengthy period of time.

The coroner found that the adult’s death highlighted serious shortcomings in relation to the health district’s policies and compliance with them.

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

- I recommend that the [local health district] develop policies and procedures to ensure that an appropriate skill mix is available within the nursing staff in mental health units and, in particular, with the Mental Health Inpatient Unit (MHIPU) at [hospital], to enable patient engagement and observations to be properly performed.
- I recommend that the [local health district] develop practices and procedures to ensure the identification and communication by all mental health clinical staff of the rationale for the setting and/or changing of patient observation status and levels.
- I recommend that the [local health district] develop policies and procedures to clearly identify the nurse assigned responsibility for the conduct and the recording of a patient’s engagement and observations under the NSW Health Policy Directive: Engagement In
Mental Health Inpatient Units and to ensure that the nurse assigned responsibility is clearly identified in the patient’s health care record.

- I recommend that the [local health district] develop policies and procedures to ensure that the responsible nurse documents patient engagements and observations when they occur and to avoid the practice of “block recording” of observations where observations are recorded collectively and subsequent to the time of actual observations.

- I recommend that the [local health district] develop and maintain regular ongoing education programs in relation to the development and/or maintenance of procedural knowledge and nursing skill sets relevant to the proper conduct of mental health patient engagements and observations.

- I recommend that the [local health district] develop and maintain an auditing program designed to test compliance with the NSW Health Policy Directive: Engagement and Observation in Mental Health Inpatient Units and, also, compliance with local procedures.

- I recommend that the [local health district] develop and maintain policies and procedures to ensure that the results of the auditing process are used to inform relevant ongoing education programs in relation to compliance by all mental health clinical staff with the NSW Health Policy Directive: Engagement and Observation in Mental Health Inpatient Units.

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Coronial recommendations: Fatal facts

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<td>56 – cases closed between January and March 2018</td>
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</table>

**Case summary**

An adult male died from injuries sustained when a wall collapsed on them.

The adult was working as a retained fire fighter, fighting a blaze in a commercial building at the time of the incident.

**Coronial findings**

The coroner found that the death was unintentional.

The coroner found that a number of changes had been made by Fire and Rescue NSW and the local council since the adult’s death, but that further improvements could be made.

**Coronial recommendations**

The coroner made the following recommendations related to this case:

**To Fire and Rescue NSW:**

- That Fire and Rescue New South Wales (FRNSW) provides a copy of these coronial findings to their Education and Training Unit and requests that consideration is given to using the facts of this tragedy as a case study in the training of retained fire fighters (RFFs) in relation to both structural collapse and incident control, in accordance with the new policies which have been developed.
- That FRNSW develop a mentoring program between PFFs [permanent fire fighters] and RFFs to support and encourage professional development of RFFs, particularly at the level of Captain and Deputy Captain.
- That FRNSW review organisational capability statements every 12 months (including local critical risks) with a view to identifying gaps in essential knowledge so that appropriate evaluation and training programs can be effectively implemented.
- That FRNSW provide a copy of these coronial findings to the Emergency Information Coordination Unit, Spatial Services NSW, with a view to encouraging all relevant parties to assist in obtaining up-to-date spatial information across New South Wales.
immediately and to facilitate the ongoing update of such information on a quarterly basis.

- That FRNSW audit its internal policies to ensure that the timely notification of the official next of kin occurs in tragedies of this kind and considers instituting a system where a support person is appointed to the next-of-kin where a casualty occurs.
Coronial recommendations: Fatal facts

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<td>Fatal facts edition</td>
<td>56 – cases closed between January and March 2018</td>
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Case summary

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

The child was in the care of a foster family. They were left unattended on the day of the incident and were found floating face down in the swimming pool. Emergency services were called to the scene. Despite attempts to resuscitate the child, they were unable to be revived.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the swimming pool was unregistered and had never received approval from the council. The pool and the enclosing fences did not comply with Australian Standards.

No physical check of the residence was undertaken at the time the decision was made to place the child with the foster family. Following the pool’s installation and prior to the child’s placement with the family, support carers for the foster family had reviewed the house as being safe on multiple occasions. They had no knowledge of the pool’s installation.

The coroner found that just prior to the arrival of the child at the foster carer’s residence, the foster family had been through several large changes and adjustments which could have impacted the care and support given to the child. However, such concerns were not identified prior to the incident no review of the home or foster family was carried out.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the Office of The Children’s Guardian:

- That [care provider] and other providers of Out of Home Care accredited by the Office of the Children’s Guardian, ought, at the agency’s expense, offer psychological evaluation and support when a foster carer ceases to be the carer for a foster child for whom the carer provided care for an extensive period. This should occur before any new child is
placed with the carer. The undertaking to provide such psychological assistance should be made a condition of accreditation.

To [care provider]:

- That a copy of these findings, reasons and recommendations, together with i) tabs 7 & 7A and 73 and 74 of the [deceased's] Coronial Brief, ii) the joint Child Death Report concerning the death of [deceased] and iii) the statement of [care provider consultant] dated 5/7/17 and the transcript of [their] evidence on 1/9/17 be provided by [care provider] to the Office of the Children’s Guardian for the purpose of the next reaccreditation of [care provider] as a provider of out of home care.

- That [care provider consultant] or the person at the time occupying [their] position, provide a copy of these findings, reasons and recommendations, together with i) tabs 7 & 7A and 73 and 74 of the [deceased's] Coronial Brief, ii) the joint Child Death Report concerning the death of [deceased] and iii) the statement of [care provider consultant] dated 5/7/17 and the transcript of his evidence on 1/9/17 to each member of the Board of Directors of [care provider] and advise the Coroners Court when this has been done.

To the Department of Family and Community Services (FACS):

- That where FACS retain care and case management responsibility of a child, FACS should undertake a visit, together with the accredited agency and with the foster carers at the carer’s home to satisfy itself that the home environment is suitable and that the foster child is settling in and so that the foster parents have any opportunity to raise any issues with both FACS and the agency together.
Coronial recommendations: Fatal facts

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

The child had been playing in the pool with friends on the day of the incident. They had been wearing a life vest as they were unable to swim. The pool was surrounded by a temporary fence.

The group left the pool, but the child later re-entered the pool unattended. They were found floating in the pool, and were not wearing their life vest. Emergency services were contacted, and resuscitation commenced. The child was conveyed to hospital where they later passed away.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the absence of supervision, together with the absence of a life vest and an opening in the temporary fence were all contributing factors to the child’s death.

The coroner found that the pool should not have been in use as the council had not issued a Final Occupation Certificate. A letter stating this had been sent by the council to the owner of the property. However, they did not receive the letter as it had been addressed to the pool company. The pool company did not forward the information to the property owner.

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

To the General Manager of [local council]:
- I recommend that consideration be given to ensuring that correspondence relating to the granting of a Complying Development Certificate for the construction of a swimming pool, and all conditions relating to such a Certificate, are sent directly to swimming pool owners.
To [company] Pty Ltd, trading as [company]:

- I recommend that consideration be given to including within the Client Acknowledgement of the [company] Pool Owner’s Manual, explicit written instructions that a pool is not to be used until a Final Occupation Certificate has been issued by a consent authority, a local council, or an accredited certifier.

To the Minister for Innovation and Better Regulation:

- I recommend that a copy of the these findings be provided to the Minister for Innovation and Better Regulation and that, having regard to these findings, consideration be given to amending the *Swimming Pools Act 1992* and *Swimming Pools Regulation 2008* to provide for warning notices to be erected and maintained during the construction of a swimming pool, which stipulate that a swimming pool is not to be occupied or used until a Final Occupation Certificate by a certifying authority is issued.

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Coronial recommendations: Fatal facts

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<th>Case number</th>
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<td>Adverse medical effects</td>
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<tr>
<td>Fatal facts edition</td>
<td>56 – cases closed between January and March 2018</td>
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</table>

Case summary

An adult female died from sepsis arising from an infection after a caesarean section. The adult had previously undergone two uncomplicated caesarean sections.

After discharge from hospital following the caesarean section, the adult returned to hospital with wound pain. They were provided with pain medication and sent home. They represented to hospital the following day with worsening symptoms. Following admission to hospital, the adult was found unresponsive in bed.

Coronial findings

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

The coroner found that the care provided to the adult was grossly inadequate. The coroner found that the treating doctor had inadequate knowledge of sepsis and how it can occur post-caesarean. The doctor failed to notify colleagues of the seriousness of the adult’s condition, and provided inadequate notetaking and clinical handover.

Coronial recommendations

The coroner made the following recommendations related to this case:

To [local health district]:
- I recommend that consideration is given to using [the deceased’s] story of rapid deterioration from maternal sepsis as a case study for educating midwives and other staff at the [hospital] Maternity Unit.

To the Health Care Complaints Unit:
- I recommend that a copy of these findings be forwarded to the Health Care Complaints Commission (HCCC) so that consideration may be given to an investigation of [doctor’s] clinical conduct.

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Coronial recommendations: Fatal facts

Case number: NSW.2015.2420
Primary category: Adverse medical effects
Fatal facts edition: 56 – cases closed between January and March 2018

Case summary

A middle aged male died due to complications of multiple drug toxicity.

The adult was recovering in hospital following reconstructive knee surgery. They were noted to have shallow breathing and were experiencing episodes of apnoea. Resuscitation was attempted but the adult was unable to be revived.

Coronial findings

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

The coroner found that the adult’s death was due to a prescribing error by the anaesthetist, which lead to the adult receiving medication for another patient. The error was not detected by hospital staff before the adult’s death.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the [hospital]:
- That a working party be established to consider lessons learned and possible reforms which could be implemented at [hospital] (“the Hospital”) as a result of the death of [the deceased] on [date]:
  - That the working party comprise a representative from at least Information Technology (“IT”), the Anaesthetics & Perioperative Services Department (“Anaesthetics Department”), the Nursing directorate, the [pharmacy] (“the Pharmacy”) and the Patient Safety and Quality Manager.
- That the working party consider, or in the alternative, the Hospital considers, the most effective way to implement the following suggested reforms:
  
  **Presentation of [the deceased’s] Case**
  - A staff seminar or seminars be conducted with the participation of staff from at least the Anaesthetics Department, nursing staff and the Pharmacy about the missed opportunities to detect the prescribing error in [the deceased’s] case and the lessons learned from his death;
That the nursing staff involved in [the deceased's] care be consulted about how that seminar be presented and have the opportunity to address the seminar if they wish; and

That the seminar address, at a minimum, communication, handover, opioid policy, observation of patients on high-risk medication, Schedule 8 checks and responding to patient deterioration.

TrakCare Changes

Give ongoing consideration to a method of verifying patient identity before medical practitioners submit medication orders on TrakCare, including specific consideration of:
- Urgent short term methods of ensuring patient identity verification if software changes are likely to be prolonged in implementation; and
- The manual entry of the patient’s name prior to submitting a medication order;

A field/box labelled “current medications” or “medications history” (as determined appropriate) be included in the pre-anaesthetic assessment [...];

A field labelled “post-operative pain plan” (or other description as determined appropriate) be added to the Recovery Progress Notes template [...];

That investigation be undertaken into the feasibility and efficacy of an alert when medications are added to a patient’s chart after the patient file is allocated to PACU [post-anaesthesia care unit]/Recovery;

That representatives of at least IT and the Anaesthetics Department consider the most effective way of ensuring that TrakCare alerts enhance patient safety without unduly distracting or diverting anaesthetists; including
- How to safely reduce the number of alerts;
- Removing the default ‘batch’ override system;
- Creating a hierarchy of alerts;
- Creating a distinct alert for identical duplicate “one touch” prescribing;
- The effective use, if any, of font, format, sound, colour and placement for alerts; and
- Known literature and clinical guidelines on safe e-prescribing.

TrakCare Proficiency

That medical practitioner accreditation include a TrakCare assessment process whereby it is mandatory for a person separate from the user to confirm that the user is proficient to safely use the system;

That consideration be given to the most appropriate person to conduct the assessment and if the assessment would be more effective in person or on-line; and

That TrakCare proficiency for anaesthetists be assessed by the use of simulations or scenarios designed in consultation with the Anaesthetics Department.
Handover Practices

- That a staff seminar or seminars be held involving staff from nursing and the Anaesthetics Department about handover practices which would include simulations of handovers by staff, the provision of feedback and discussion of mechanisms to enhance the communication between nursing staff and anaesthetics staff;
- That an audit or audits be conducted in relation to safe handover practices at the Hospital with particular priority given to practices at PACU/Recovery;
- That there be a minimum number of audits conducted annually at appropriate intervals; and
- That the results of those audits be published on the Hospital intranet and be held by the Nursing Directorate.

Perioperative Management

- That, at least, representatives of the Anaesthetics Department and the nursing staff consider mechanisms to provide safe and effective perioperative management for patients, including:
  - Monitoring of patients taking high risk medications;
  - Postoperative review of patients by anaesthetists in PACU/Recovery and on the ward;
  - The introduction of a pain service; and
- Relevant existing clinical guidelines including Australian and New Zealand College of Anaesthetists guidelines, Clinical Excellence Commission guidelines and any known proposed upcoming reform.

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Coronial recommendations: Fatal facts

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<td>Fatal facts edition</td>
<td>56 – cases closed between January and March 2018</td>
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Case summary

An adult female died due to complications of epilepsy.

The adult lived in a group home and was under the care of a disability support worker. They had care plans in place to manage their epilepsy.

The adult suffered a lengthy seizure, following which they became unresponsive. Attempts to revive the adult were unsuccessful.

Coronial findings

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

The coroner found that the care home staff did not follow the assigned care plan in relation to management of the adult’s epilepsy. Training provided to staff at the care home in relation to epilepsy seizures was less than optimal.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the Chief Executive Officer of the National Disability Insurance Agency:

- I recommend that a copy of these findings be provided to the Chief Executive Officer of the National Disability Insurance Agency so that consideration can be given to:
  - the identified shortcomings in the supported living services provided to [the deceased], and the lessons learned and improvements made as a result of her death; and
  - the adoption of a multidisciplinary team approach to the drafting and implementation of appropriate Epilepsy Management Plans by supported living (group accommodation) disability service providers in the [region].

To the Managing Director of the [disability services provider]:

- I recommend that a copy of these findings be provided to the Managing Director of the [disability services provider] so that consideration can be given to:
- the identified shortcomings in the supported living services provided to [the deceased], and the lessons learned and improvements made as a result of her death; and
- the adoption of a multidisciplinary team approach to the drafting and implementation of appropriate Epilepsy Management Plans by supported living (group accommodation) disability service providers in the [region].
NORTHERN TERRITORY

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

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<thead>
<tr>
<th>Case number</th>
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<tr>
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<td>Transport and traffic related</td>
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<td>Fatal facts edition</td>
<td>56 – cases closed between January and March 2018</td>
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Case summary

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

The adult was riding their motorcycle along a section of road undergoing roadworks. The adult suffered fatal injuries when their motorcycle collided with a temporary barrier.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult was under the influence of drugs and alcohol at the time of the collision, which would have impacted their manner of riding, level of observation and reaction times.

In addition, the temporary traffic management devices in place at the scene were found to be substandard and unsafe.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that DIPL [Department of Infrastructure, Planning and Logistics] establish the proposed panel of experts to audit compliance of implementation of Traffic Control Diagrams and compliance with Australian Standards at major or high risk roadworks.
- I recommend that the government consider legislating to require compliance with the Australian Standards when using traffic control devices and provide an offence for failure to do so.

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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>
<td>56 – cases closed between January and March 2018</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 and had recently been transferred to a different section of the prison.

The adult had recently become concerned about perceived allegations made against them. They were found unresponsive in their cell by a roommate. Despite attempts at resuscitation, the adult was unable to be revived.

Coronial findings

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

The coroner found that the reason for the adult's transfer to a different section of the prison had not been recorded.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend the Commissioner of the Northern Territory Correctional Services ensure that the reasons for the transfer of prisoners within the Correctional Precinct are recorded.

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Coronial recommendations: Fatal facts

<table>
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<td>Law enforcement, Indigenous</td>
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<tr>
<td>Fatal facts edition</td>
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Case summary

An adult male died due to a heart condition complicated by an unspecified connective tissue disease.

The adult was a prisoner at the time of their death. They had been unwell in the years leading up to their death, with suggestions they may have had an autoimmune disease.

The adult began exhibiting a variety of symptoms while in prison. They became sufficiently unwell to be transported to hospital, where they became critically ill. The adult’s condition deteriorated, and they were unable to be revived.

Coronial findings

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

The coroner found that there were no systems in place to inform the hospital that the adult was in prison. As a result, there was no follow up in relation to their suspected autoimmune disease while they were imprisoned.

The coroner found that the prison failed to notify the adult’s family of their critical illness and transportation to hospital. In addition, there was no indigenous interpreter available in the prison or hospital.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the Commissioner of Correctional Services ensure that appropriate processes and procedures are in place to advise the families of prisoners whenever a prisoner is under medical care and at significant risk of dying.
- I recommend that the Department of Health ensure that the processes and procedures for accessing the Shared Electronic Health Record are appropriate and that the records are being accessed in appropriate cases.
I recommend the [health service] develop a system wide training program on the requirements of patient monitoring, track and trigger charts and methodologies in escalating care.

I recommend that the [health service] take all reasonable steps to ensure access to interpreters for indigenous patients where there is a need due to language or cultural barriers.
QUEENSLAND

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>QLD.2012.4448</th>
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</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Electrocution</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Work related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>56 – cases closed between January and March 2018</td>
</tr>
</tbody>
</table>

Case summary

A young adult male died due to a workplace incident.

The young person was an apprentice electrician. They were installing data cables in the ceiling of a worksite on the day of the incident. The young person was fatally electrocuted when the gang nail plate they were using penetrated a cable that energised a nearby air-conditioning unit.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the Electrical Safety Office, which carried out an inspection following the death, missed a number of opportunities to investigate hazards present at the scene of the incident.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend ESO [Electrical Safety Office] reconsider the various options for the extension of the requirement for the mandatory fitting of residual current devices (including cost benefit analysis), and a draft discussion paper be circulated to key stakeholders and the public for consultation prior to finalisation of its policy position or advice to State Government.

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>
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<td>Law enforcement</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>56 – cases closed between January and March 2018</td>
</tr>
</tbody>
</table>

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

The adult worked as a truck driver. While driving, their truck suffered a mechanical failure, causing the vehicle to leave the road and collide with a tree. The adult suffered serious injuries as a result and was conveyed to hospital. They passed away while undergoing surgery for their injuries.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the vehicle’s suspension failed due to being heavily worn from travelling on rough country roads.

The coroner found that the adult died due to a combination of their injuries and deep vein thrombosis contributed to by their immobility following the collision.

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

- I recommend that the National Heavy Vehicle Regulator and Department of Transport and Main Roads consider if there should be enhanced education and guidelines to ensure persons performing heavy vehicle inspections are aware of the risks involved in not having clean components when they perform a visual check.
- I recommend that in the process of revising the current MOU [memorandum of understanding] between QPS [Queensland Police Service] and WHSQ [Workplace Health and Safety Queensland] that this includes a process for the notification of heavy vehicle incidents to the NHVR [National Heavy Vehicle Regulator].

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>
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<tr>
<td>Fatal facts edition</td>
<td>56 – cases closed between January and March 2018</td>
</tr>
</tbody>
</table>

Case summary

A young male took their own life by hanging.

The young person suffered from schizoaffective disorder and had a long history of mental illness. They were an inpatient at a mental health facility. The young person was found deceased in their room.

Coronial findings

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

The coroner found that the circumstances of the young person’s death gave rise to questions about missed opportunities to better manage the risk of inpatient suicide.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend Queensland Mental Health centralise within the State a body, with oversight from the Office of Chief Psychiatrist, tasked with the function of reviewing and reporting to Hospital and Health Services on lessons learnt and other opportunities for improvement through internal and external investigations (including RCA [root cause analysis] reports, Health Service Investigation Reports, Health Ombudsman Reports, Coronial findings and recommendations) as well as like reports from other States.
- I recommend that the Office of the Chief Psychiatrist commission an independent, external audit and review of the extent to which each relevant Hospital and Health Service has implemented the Ligature and Environmental Guidelines as well as the effectiveness of that implementation. The results of that audit and review be shared with each Hospital and Health Service as well as any opportunities for improvement.

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

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<tr>
<th>Case number</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Law enforcement</td>
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<tr>
<td>Fatal facts edition</td>
<td>56 – cases closed between January and March 2018</td>
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</tbody>
</table>

Case summary
An adult male died following a physical restraint incident.

The adult had been voluntarily conveyed to hospital due to anxiety symptoms. Security guards were called to escort the adult from an area of the hospital that they entered without authorisation. The adult became aggressive and a struggle ensued. Security guards restrained the adult and police were called to the scene. Upon handover to police, the adult was unresponsive. Despite attempts at resuscitation, they were unable to be revived.

Coronial findings
The coroner found that the death was due to legal intervention. The adult died due to the combined effect of drugs and being restrained in a prone position.

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

- I recommend that a review be conducted in order to establish clear lines of communication and authority between [area] Protective Services and the line managers within individual hospitals within that health district to ensure that mandatory training in occupational violence prevention is undertaken, particularly by those on emergency response teams, within the timeframes specified.
- I recommend that, consistent with Queensland Police Service policy, hospital and health service officers who are members of emergency response teams who fail to demonstrate competence in restrictive practices training are not to be deployed to perform such practices.
- I recommend that the [area] Hospital and Health Service consider adopting aspects of the Queensland Police Service’s practical training in relation to the physiological impacts of positional asphyxia to reinforce the risks of prone restraint to those engaged in this practice.

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

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>The coroner held a joint investigation into the following deaths which resulted from the same incident: TAS.2013.363, TAS.2013.364</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
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</tr>
<tr>
<td>Additional categories</td>
<td>Homicide and assault, Intentional self-harm</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>56 – cases closed between January and March 2018</td>
</tr>
</tbody>
</table>

Case summary

A middle aged female and middle aged male died due to injuries inflicted by the male.

The pair were married, and the male had previously behaved violently toward their spouse. The male had a history of mental health issues. The male had attended their general practitioner several times in the weeks leading up to the incident due to their deteriorating mental state and emerging psychosis. They later attended a local hospital for assistance.

The female died when they were fatally assaulted by male, who then took their own life.

Coronial findings

The coroner found that the female’s death was due to assault and the male’s death was due to intentional self-harm.

The coroner found that the adult was suffering from psychotic delusions at the time of the incident. The coroner found that the medical care provided to the adult from the medical practitioners and the hospital was satisfactory. However, there were deficiencies in the completion of important hospital documentation.

Coronial recommendations

The coroner made the following recommendations related to these cases:

- I recommend that the [hospital] review its procedures relating to ensuring satisfactory completion of all documentation relating to the reasons for decision-making under the Mental Health Act 2013, particularly those decisions affecting a patient’s rights and liberty;
- I recommend that the [hospital] review its procedures for the timely provision of critical clinical information to the receiving hospital and treating practitioners in the case of transfer of mental health patients from the [hospital] to another hospital;
I recommend that the [hospital] review its procedures regarding the timely provision of discharge summaries to the patient’s treating practitioners in the case of mental health patients.
Coronial recommendations: Fatal facts

<table>
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<tr>
<th>Case number</th>
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<tbody>
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<td>Additional categories</td>
<td>Law enforcement, Drugs and alcohol</td>
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<tr>
<td>Fatal facts edition</td>
<td>56 – cases closed between January and March 2018</td>
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</table>

Case summary
An older female took their own life by drug overdose.

The adult had a history of serious mental illness, including suicide ideation and attempts. Police had attended the adult’s home on numerous occasions in response to concerns for their welfare.

The adult contacted a counsellor via a rural outreach service on the day of their death and indicated that they had consumed large amounts of alcohol and medication. The counsellor contacted the Police Radio Dispatch Service (RDS), and the RDS operator arranged for police to attend the adult’s home. Upon arrival, police found the adult in poor condition, and an ambulance was requested. Ambulance personnel commenced resuscitation efforts, but the adult was unable to be revived.

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

The coroner found that the RDS operator ought to have requested ambulance attendance at the same time police were dispatched to the scene, and that the consequent delay in the arrival of ambulance personnel was unnecessary.

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

- That Tasmania Police review the applicable RDS [Radio Dispatch Service] policies and procedures dealing with the circumstances in which an ambulance is to be dispatched to reported suicide attempts.

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

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

Case number: VIC.2011.3208
Primary category: Adverse medical effects
Fatal facts edition: 56 – cases closed between January and March 2018

Case summary
An older male died due to complications following a surgery.

The adult had been taking anticoagulant medication and was advised to transition to a different medication prior to surgery. A clinical plan for reintroducing the original medication following the adult’s surgery was made. The adult’s International Normalised Ratio (INR) remained low in the days after surgery and they were readmitted to hospital for an adverse clotting incident, where they later passed away.

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

The coroner found that the medical practitioner’s plan of transition therapy with the adult’s medications was appropriate, however accounts of the instructions given to the adult were inconsistent and these may not have been understood.

The coroner found that ineffective communication between the adult and medical practitioners contributed to poor compliance with the therapy and the adverse incident that lead to the adult’s death.

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

- That the Royal Australasian College of General Practitioners reminds its member of the need to identify information clinically relevant to a patient's anticoagulation therapy and ensure that such information is communicated in a timely manner to the pathology laboratory or other medical practitioner monitoring the patient's anticoagulation therapy and INR [International Normalised Ratio] levels.

- That the Royal Australasian College of General Practitioners considers recommending to its members, that patients on anticoagulation therapy be reviewed by a haematologist at regular intervals.

- That the Royal Australasian College of Physicians-Haematologists considers recommending to its members that they proactively seek from the general practitioners
of their long-term anticoagulation therapy patients, an annual update of information that is clinically relevant to optimal anticoagulation therapy management, including indications for anticoagulation therapy, adverse clotting events, planned surgery, prescribed medications and other changes to the patient’s circumstances.

- That the Royal College of Pathologists of Australasia considers recommending to its members that they proactively seek from the general practitioners of their long-term anticoagulation therapy patients, an annual update of information that is clinically relevant to optimal anticoagulation therapy management, including indications for anticoagulation therapy, adverse clotting events, planned surgery, prescribed medications and other changes to the patient’s circumstances.

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Coronial recommendations: Fatal facts

Case number: VIC.2016.3717
Primary category: Adverse medical effects
Additional categories: Drugs and alcohol
Fatal facts edition: 56 – cases closed between January and March 2018

Case summary
An older female died due to a muscular tissue condition in the context of cancer and renal impairment.

The adult had been taking a cholesterol-lowering medication for a number of years. During the most recent pharmacy visit to receive this medication, a different medication was incorrectly dispensed to the adult’s partner for their use. The adult later attended hospital with declining physical health. Despite medical efforts the adult’s condition deteriorated and they passed away a few days after admission.

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

The coroner found that the ingestion of the incorrect medication was a contributing factor in the adult’s death. The coroner also found that the adult’s death was contributed to by their age, existing co-morbidities and development of other complications in hospital.

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

- In the interests of contributing to a reduction of preventable deaths, I recommend that the [pharmacy] institute a policy whereby, when issues that concern dispensed medication are raised by a customer, the concern is referred to the pharmacist for review.
- I further recommend that the National Council of the Pharmacy Guild of Australia review the circumstances of [the adult’s] death, for the purposes of education, awareness and the creation of robust dispensing policies and guidelines.

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Coronial recommendations: Fatal facts

Case summary

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

The adult was driving along a road as a council tip truck was approaching from the opposite direction. It was raining and the road was wet. The adult indicated for a turn and the tip truck began to brake, causing the rear of the truck to slide out and collide with the adult’s car. The adult died of their injuries at the scene.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the tip truck’s exhaust break could lock the rear wheels or cause a loss of control when used in wet or slippery conditions when the truck was unladen, as happened during the incident.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That [city council] educate all employees who operate [truck manufacturer] trucks in the course of their employment about the potential consequences of operating the exhaust brake when the truck is unladen or in slippery and wet conditions.

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Coronial recommendations: Fatal facts

<table>
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<tr>
<th>Case number</th>
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<tr>
<td>Primary category</td>
<td>Transport and traffic related</td>
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<tr>
<td>Fatal facts edition</td>
<td>56 – cases closed between January and March 2018</td>
</tr>
</tbody>
</table>

Case summary

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

The adult was driving when they entered an intersection against a stop sign. Their vehicle was struck by an oncoming vehicle and collided with a fence. The adult passed away at the scene due to their injuries.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult failed to slow or stop their vehicle at the intersection.

Investigating police suggested the following improvements to the intersection’s design:

- That a speed limit sign be posted approximately 200 metres from the intersection, in both directions, with a reduced speed limit for drivers travelling through the intersection.
- That tree lines immediately south-east of the intersection be removed to improve the line of sight of drivers approaching the intersection.
- That a review be conducted into the structure of the intersection, particularly the need to have the intersection raised as a result of the drain running parallel to the road.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that [local council] review the design and layout of the intersection of [road] and [road] in light of the circumstances of this collision and the improvements suggested [by police].
Coronial recommendations: Fatal facts

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<tr>
<th>Case number</th>
<th>VIC.2016.5099</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Transport and traffic related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>56 – cases closed between January and March 2018</td>
</tr>
</tbody>
</table>

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

The adult’s vehicle entered an intersection in the path of an oncoming truck. Despite taking evasive action, the truck driver was unable to avoid a collision. The adult was unable to be revived and passed away at the scene.

Coronial findings
The coroner found that the death was unintentional.

Investigating police made several suggested improvements to the intersection. At the time of inquest, the coroner noted that the speed limit in the area had not been reduced, nor any changes made to a turning lane at the intersection.

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

- I recommend the [local council] examines the traffic patterns at the [intersection], [suburb], to determine the need for a reduction in the speed limit and lengthening the westbound left hand turn lane on [road].
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2015.3239</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Animal</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Work related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>56 – cases closed between January and March 2018</td>
</tr>
</tbody>
</table>

Case summary

An adult female died after a fall from a horse.

The adult worked at a racecourse and was riding one of the horses around the track. The horse was spooked, causing the adult to fall. The adult held onto the reins for a few metres before falling to the ground. The horse stepped on the adult causing significant injuries from which they could not be revived.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult had not undergone formal training in trackwork, and that formal training was not required for track riding employment. The coroner also found that there was no training provided to track riders and jockeys on safe ways to fall from a horse and there were deficiencies in ensuring employees had appropriate personal protective equipment.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That [racing authority] consider the feasibility of compulsory fall safety training for individuals engaged in track work with racehorses.

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>
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<tr>
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</tr>
<tr>
<td>Fatal facts edition</td>
<td>56 – cases closed between January and March 2018</td>
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</table>

Case summary
A middle aged female took their own life by hanging.

The adult had a history of depression and previous suicide attempts. The adult had been admitted to a medical clinic for treatment of their depression and was due to start a new treatment. Noises were heard coming from the adult's room in the night and upon entry staff discovered the adult unresponsive. They were taken 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 adult had been assessed by the clinic as being at low risk of self-harm for the duration of their stay. The coroner found that due to the low risk assessment the clinic did not consider the need to remove potential ligatures from the adult's environment and that their policies focused more on hanging points than ligatures.

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

- I recommend that the [medical clinic] draft a policy for the removal of potential ligatures from all inpatients with due regard to the comments set out above.

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Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2016.180</th>
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<tbody>
<tr>
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<td>Intentional self-harm</td>
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</tr>
<tr>
<td>Fatal facts edition</td>
<td>56 – cases closed between January and March 2018</td>
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</table>

Case summary

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

The adult was a disability support pensioner who lived in a supported residential service and had a history of mental illness and suicide attempts. The adult had presented to the emergency department several days before their death following an intentional overdose and was discharged the following day. Follow-ups were arranged by the critical assessment treatment team but the adult refused to engage with these contacts.

The adult was reported missing from the supported residential service on the day of the incident and was later located deceased.

Coronial findings

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

The coroner found that the assessment of the adult’s ongoing risks was left to the supported residential service staff instead of the crisis assessment treatment team, without appreciation of the role and level of expertise among these staff. The coroner found that the management of the adult following their presentation to the emergency department may have contributed to their death.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Department of Health and Human Services, in conjunction with Supported Residential Services, Mental Health Services, Mental Health Community Support Services and Consumer Representation, develop a guide that improves the safety of SRS [Supported Residential Services] residents with an acute deterioration in mental state with associated acute risks who are engaged with acute or continuing care teams, rehabilitation-recovery focused or other community mental health services. The guide should address the following, namely:
- SRS staff are provided with a current safety plan for the resident during a period of deterioration;
- SRS residents are, wherever possible, engaged in the development of the safety plan developed for a particular episode of deterioration;
- Refusal by a SRS resident to engage in the development of a safety plan does not preclude the engaged mental health service from completing a safety plan for a specific episode of deterioration with a view to engaging with the resident when s/he is willing;
- The elements to be included in a safety plan, including clear details and advice for SRS staff about when and whom to contact in particular circumstances;
- The response the SRS may reasonably expect from the engaged mental health service(s);
- Reflect the staffing levels and limits of SRS staff skills; and
- Include a requirement that at the resolution of an acute deterioration of mental state and cessation of any associated acute risks (as assessed by the engaged mental health service), that the SRS resident and the SRS staff are informed that the safety plan is no longer current.
Coronial recommendations: Fatal facts

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<th>Case number</th>
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<td>Fatal facts edition</td>
<td>56 – cases closed between January and March 2018</td>
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</table>

Case summary

An adult female died due to self-inflicted injuries.

The adult had a history of mental health issues, relationship issues and previous suicide attempts. The adult was taken to hospital after a suicide attempt and asked for their electronic device to be returned after it was removed on admission. The following morning the adult was found deceased in their hospital bathroom.

Coronial findings

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

The coroner found that the hospital’s search of the adult’s possessions on admission was inadequate as it had not included removing covers from electronic devices to check for concealed items. The coroner found that other mental health service guidelines for performing searches did not make specific references to electronic devices.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the Chief Psychiatrist, as an interim measure, issue a revised guideline in relation to search policy of compulsory patients in high dependency units, to the effect that as part of a search, electronic devices [...] be subject to thorough examination.
Coronial recommendations: Fatal facts

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

Case summary

A young male took their own life by inhalation of a substance.

The young person suffered from a disease for which they had undergone multiple surgeries. They were diagnosed with depression for which they were prescribed medication.

The young person’s housemate found them deceased in their room with inhalation apparatus at the scene after not seeing them for a couple of days. Ambulance paramedics attended and confirmed the young person had passed away.

Coronial findings

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

Concerns were raised during the coronial investigation regarding the prescribing of an antidepressant drug to the young person. The coroner was unable to determine the role, if any, of the antidepressant prescribed.

Coronial recommendations

The coroner made the following recommendations related to this case:

- With a view to improving public health and safety in relation to the prescribing of antidepressants to children, adolescents and young people; I recommend that The Chief Psychiatrist instigate and perform a supervisory type role in respect of research, with the aim of updating clinical guidelines for the prescription of antidepressant medication to children, adolescents and young people.
- And, in performing this supervisory type role, I recommend that The Chief Psychiatrist ensure that the aforementioned research contemplates children, adolescents and young people as distinct cohorts.
- And, in light of the Office of The Chief Psychiatrist’s duty to provide clinical leadership, and continual improvement of public mental health services per the Mental Health Act 2014 (Vic), I recommend that The Chief Psychiatrist perform this supervisory type role with a view to providing current and clear clinical guidelines to all medical practitioners.
who prescribe antidepressant medication to children adolescents and young people, including general practitioners.
Coronial recommendations: Fatal facts

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<tr>
<th>Case number</th>
<th>VIC.2016.5309</th>
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<td>Leisure activity, Sports related</td>
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<tr>
<td>Fatal facts edition</td>
<td>56 – cases closed between January and March 2018</td>
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Case summary

A middle aged male died due to drowning.

The adult was taking part in an organised ocean paddling session. The proposed paddle was only suitable for experienced paddlers due to the weather conditions.

During the course of the paddle, the adult fell into the water. Their leg rope detached from the paddle ski, which was washed away. The adult used their mobile phone to contact a fellow paddler, who had arrived on shore ahead of them. The adult was located a few hours later by emergency services and brought ashore. Despite resuscitation attempts, they were unable to be revived.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the weather conditions made the paddling course challenging. The leg rope used by the adult was not designed for use with their model of paddle ski.

The coroner found that a timelier search and rescue operation may have been possible had emergency services been contacted sooner or had a personal locator beacon or emergency position indicating radio beacon been activated.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the Department of Economic Development, Jobs, Transport and Resources consider reviewing current regulatory safety requirements for operators of human-powered recreational vessels by requiring operators to carry and/or fix Emergency Position Indicating Radio Beacons and/or Personal Locator Beacons (preferably those with GPS [global positioning system] capability) onto their Personal Flotation Devices (with no limitations as to distance from the coast). This has the
potential to significantly increase the timeliness of notifications to emergency services, and any subsequent search and rescue operation.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2016.5999</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Weather related</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Natural cause death, Leisure activity</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>56 – cases closed between January and March 2018</td>
</tr>
</tbody>
</table>

Case summary

A young male died due to the effects of heat.

The young person was taking part in a school camp at the time of the incident. They were participating in a rural hiking expedition in hot weather.

During the hike, the young person appeared fatigued, tired and confused. They collapsed, became delusional and agitated, and were breathing rapidly. A support vehicle was contacted, and an evacuation was requested. Paramedics met the support vehicle, following which the young person went into cardiac arrest. Despite attempts at resuscitation, they were unable to be revived.

Coronial findings

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

The coroner found that given the remote location, lack of readily available medical facilities and lack of temperature monitoring, there was a threat to the health and safety of all persons involved in the expedition.

The coroner found that the young person was suffering from an infection that may also have contributed to their heat-related illness.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That [school] consider holding the [camp] experience during periods of lower/milder heat and not during peak summer conditions.
- That the 'Student Preparation' booklets be updated to reflect the dangers of heat stroke, heat exhaustion and dehydration and ways in which to manage these conditions. Students and parents should be thoroughly briefed on these dangers prior to the camp and the students reminded of them during the course of the camp.
• Parents/guardians should also be fully advised of the risks of the expedition prior to signing a consent form.

• That staff utilise communication equipment to check on current weather forecasts prior to each day’s activities and periodically throughout the day, and amend the activities accordingly.

• That [school] adopt immediate procedures that provide more accurate guidelines for heat stress management during such activities. In particular, [school] may consider the Sports Medicine Australia Guidelines on Hot Weather [...] which relate to sporting activities in times of high heat and humidity. Bushwalking whilst carrying heavy packs in harsh climactic conditions may be considered strenuous activity, particularly for participants who are inexperienced in such conditions. The guidelines recommend that in temperatures of 31-35 degrees Celsius with relative humidity exceeding 50%, the risk of heat illness is high to very high and duration or the activity should be limited to less than 60 minutes per session. For temperatures 36 degrees and above with humidity of 30% and above, the risk of heat illness is extreme and the activity should be postponed to a cooler condition (or cooler part of the day) or postponed to another day.
Coronial recommendations: Fatal facts

Case summary
An adult male took their own life by inhalation of a substance.

The adult had a history of major depressive disorder, anxiety and post-traumatic stress disorder (PTSD) following service in the Australian Defence Force. They separated from their spouse a few months prior to their death.

The adult was found deceased in their vehicle on the side of the road.

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

The coroner found that there would be great benefit in the sharing of information regarding suicide deaths of current and former serving Australian Defence Force members between relevant organisations.

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

- That the Australian Institute of Health and Welfare engage with the Coroners Court of Victoria to explore whether there are opportunities to share data on Victorian suicides among current and former serving Australian Defence Force members, to inform the design and implementation of suicide prevention initiatives.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2016.6209</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Adverse medical effects</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Drugs and alcohol, Physical health</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>56 – cases closed between January and March 2018</td>
</tr>
</tbody>
</table>

Case summary

A middle aged female died due to prescription drug toxicity associated with a genetic condition.

The adult had a long medical history including multiple medical conditions. The adult underwent a kidney transplant over a year prior to their death. Several months later, the adult was admitted to hospital while travelling overseas due to ongoing issues stemming from the transplant. They were prescribed azathioprine, which they continued taking upon their return to Australia following discussion with a consultant nephrologist.

Later blood tests showed a dramatic change in the adult’s blood components and they were admitted to hospital. The adult’s condition continued to deteriorate, and 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 adult had a genetic susceptibility that made them extremely sensitive to the effects of azathioprine. Prior to the adult’s death, the hospital did not have a policy to perform testing on patients for genetic susceptibility when prescribing azathioprine.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That TPMT [thiopurine methyltransferase] genotyping for the common alleles should be mandatory for patients prior to the commencement of thiopurine containing medications.

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.2016.3413</th>
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</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Natural cause death</td>
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<tr>
<td>Additional categories</td>
<td>Child and infant death</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>56 – cases closed between January and March 2018</td>
</tr>
</tbody>
</table>

Case summary

A female infant died due to complications arising from their birth.

The infant was born with the umbilical cord wrapped around their neck and was transferred to a neonatal resuscitation device to be stabilised. The infant remained in intensive care until they passed away a few days later.

Coronial findings

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

The coroner found that efforts to care for the infant by the hospital were appropriate and in accordance with clinical practice guidelines. The coroner found that the placenta had been inadvertently discarded after delivery instead of being submitted for histological testing.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That [hospital] develop a clinical guideline describing the clinical scenarios that require placentas be sent for histopathological examination.

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.2017.2080</th>
</tr>
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<tr>
<td>Primary category</td>
<td>Natural cause death</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Youth</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>56 – cases closed between January and March 2018</td>
</tr>
</tbody>
</table>

Case summary

A young female died due to effects of meningococcal. They were otherwise in good health prior to their death.

The young person complained to their parent of feeling unwell and was later taken to hospital via ambulance. They were administered multiple medications, and a few hours later were transferred to intensive care. Their condition deteriorated, and despite multiple attempts to treat the young person, they passed away in hospital.

Coronial findings

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

The coroner noted that the Victorian Government ran a free school-based meningococcal vaccination program during the year of the young person’s death. The young person did not receive the vaccination at school, or via a general practitioner or the local council immunisation service, despite being eligible.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Victorian Department of Health and Human Services consider reinstituting access to free meningococcal ACWY vaccination for young people aged 15 to 19 years inclusive, whether in the secondary school setting or otherwise.
- That the Royal Australian College of General Practitioners inform its members of the need to ensure that patients ages between 15 and 19 years (including those who turned 19 years in 2017) have received the meningococcal ACWY vaccine (if clinically appropriate) or are otherwise advised of the availability of the vaccine and the costs and benefits of immunisation against meningococcal disease.

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.
WESTERN AUSTRALIA

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

**Case number**
The coroner held a joint investigation into the following deaths which resulted from the same incident: WA.2015.650, WA.2015.681

**Primary category**
Water related

**Additional categories**
Leisure activity

**Fatal facts edition**
56 – cases closed between January and March 2018

**Case summary**
Two adult males died due to drowning in a rock fishing incident.

The adults were rock fishing when they were swept off the rocks and into the ocean by a wave. They were not wearing life jackets.

Ocean conditions were rough, with large swells at the time of the incident.

**Coronial findings**
The coroner found that the death was unintentional.

The coroner found that the area was known to be dangerous and remote, which hindered any assistance required for rescue activities. The body responsible for the maintenance of the area had emphasised the dangers associated with the area by way of worded and pictorial signage in numerous locations.

**Coronial recommendations**
The coroner made the following recommendations related to these cases:

- Regulations be implemented which make it a requirement rock fishermen wear life jackets when fishing from rocks subject to wave action and spray on the WA coast;  
  - Those life jackets to comply with Australian Standards 4758.1:2015 and self-inflate on impact with water, have a minimum level of 150N, are made of retro reflective material, are abrasion resistant and incorporate a light and whistle; and  
  - Rock fishermen carry a personal emergency positioning indicator rescue beacon (EPIRB)
- Approaches be made to [telecommunications company] to install a mobile phone tower on [island], after suitable survey, to assist communication in alerting responders to, and coordinating, emergencies.
• A marine VHF [very high frequency] repeater be installed and maintained on [island] by DFES [Department of Fire and Emergency Services] established on channel 80 with separate infrastructure from the police repeater.

• There be collaboration in developing reliable communication plans utilising internationally approved frequencies/channel allocations for marine search and rescue operations in line with the International Telecommunications Union (ITU) and the Australian Communications and Media Authority (ACMA) Standards.

• The regulation and management of drones for emergency search and rescue operations be clarified and training and certification of competent pilots be promoted within search and rescue groups.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>WA.2016.651</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>56 – cases closed between January and March 2018</td>
</tr>
</tbody>
</table>

Case summary

An adult male died due to drowning in a rock fishing incident.

While rock fishing at a beach, the adult fell from the rocks into the water. They were not wearing a life jacket. The anchor rope attaching the adult to the rocks broke, and they were carried out into deeper water. Emergency services were contacted and the adult’s body was recovered from the water the following day.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that had the adult been wearing a life jacket, they likely would have survived and been successfully rescued.

Coronial recommendations

The coroner made the following recommendations related to this case:

- Regulations be implemented which make it a requirement rock fishermen wear life jackets when fishing from rocks subject to wave action and spray on the WA coast;
  - Those life jackets to comply with Australian Standards 4758.1:2015 and self-inflate on impact with water, have a minimum level of 150N, are made of retro reflective material, are abrasion resistant and incorporate a light and whistle; and
  - Rock fishermen carry a personal emergency positioning indicator rescue beacon (EPIRB).
- Approaches be made to [telecommunications company] to install a mobile phone tower on [island], after suitable survey, to assist communication in alerting responders to, and coordinating, emergencies.
- A marine VHF [very high frequency] repeater be installed and maintained on [island] by DFES [Department of Fire and Emergency Services] established on channel 80 with separate infrastructure from the police repeater.
• There be collaboration in developing reliable communication plans utilising internationally approved frequencies/channel allocations for marine search and rescue operations in line with the International Telecommunications Union (ITU) and the Australian Communications and Media Authority (ACMA) Standards.
• The regulation and management of drones for emergency search and rescue operations be clarified and training and certification of competent pilots be promoted within search and rescue groups.
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.2015.1306, WA.2015.1631, WA.2015.1632</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Water related</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Work-related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>56 – cases closed between January and March 2018</td>
</tr>
</tbody>
</table>

Case summary

Two adult males and a middle aged male died due to drowning in a boating incident.

The group worked in the fishing industry and were undertaking a trawling trip on a boat owned by the middle aged male. Their boat did not arrive at its destination as scheduled, and a search was undertaken. The boat was found submerged at sea and one of the occupants was found deceased inside. The bodies of the other occupants were never recovered, and they were determined to have died at sea.

Coronial findings

The coroner found that the deaths were unintentional.

The coroner found that the boat capsized due to combination of a lack of stability after the owner made several modifications to the boat and the squalling weather overnight.

The boat owner made significant modifications to the boat and did not disclose the full extent of these during the vessel survey process. The surveyor failed to notice the extent of the modifications.

Coronial recommendations

The coroner made the following recommendations related to these cases:

- I recommend that Australian Maritime Safety Authority (AMSA), as the National Regulator of the National Law, should give consideration to establishing a transitional approach to ending the grandfathering of safety standards for existing vessels. Compliance with current standards in regard to vessel operations and safety equipment should be given priority.
- I recommend that AMSA, as the National Regulator of the National Law, should give guidance to accredited surveyors to remind them of the importance of independently
verifying key information when assessing a vessel’s stability, given the critical importance of the stability of a vessel in allowing a vessel to operate safely.

- I recommend that Fisheries [the Department of Fisheries] give guidance to its staff that, in addition to the regulatory aspect to the Vessel Monitoring System (VMS), there is an important secondary safety aspect that they have a responsibility to facilitate as part of their duties. Staff should prioritise communicating with a vessel that has issued an Automatic Communication Locator (ALC) alert that cannot be resolved and if the relevant staff are unsuccessful in contacting the vessel or ascertaining its whereabouts within 4 hours of becoming aware of the alert, they should notify Water Police of the relevant circumstances and provide any relevant information that is available from the VMS to aid police in determining whether, and where, a search should be commenced. In addition, I recommend that, moving forward, Fisheries should consider ways in which the VMS can be monitored 24 hours a day, 7 days a week, and if a practical means can be found, they should be resourced accordingly.

- I recommend that AMSA, as the National Regulator of the National Law, should give strong consideration to making changes to the current regulatory requirements concerning Emergency Positioning Indicating Radio Beacons [EPIRBs] to include mandatory requirements for the carriage on both new and existing vessels of float free EPIRBs that deploy automatically when immersed in water, where these are appropriate.

- I recommend that AMSA, as the National Regulator of the National Law, working in conjunction with Worksafe in Western Australia, should promote and encourage the wearing of life jackets while working on commercial fishing vessels, noting that commercial fishing vessels are workplaces and there is a need to improve the safety culture on these vessels.
## 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>