Coronial recommendations: Fatal facts

A summary of cases and recommendations made between April and June 2018

Edition 57
DISCLAIMER

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ACKNOWLEDGMENTS

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CORONERS’ RECOMMENDATIONS

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

The National 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 April and June 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

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Case summary

A middle aged male died due to a vehicle incident in which they were a motorcyclist.

The adult lost control of their motorcycle and was later found lying beside the road by passers by. They were conveyed to hospital where their condition deteriorated and they later passed away

Coronial findings

The coroner found that the death was unintentional.

The coroner found that there were shortcomings in the reporting of the death to the Coroners Court by the treating hospital.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the ACT Government amendment section 43 of the *Health Act 1993* to avoid a repetition of this conduct.

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Coronial recommendations: Fatal facts

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

A middle aged male died from exposure and dehydration preceded by alcohol withdrawal. They had a long history of chronic alcoholism.

Prior to their death, the adult had been voluntarily admitted to hospital where they left unnoticed by hospital staff. Despite a police search, they were unable to be located following their departure from hospital.

They were found deceased a long time later in bushland.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that there were errors in the key decisions made regarding locating the adult once they had left hospital, which ultimately resulted in the adult not being located early enough to prevent their death.

Coronial recommendations

The coroner made the following recommendations related to this case:

- The Australian Federal Police and [hospital] continue the reviews that are already ongoing with regard to the circumstances of [the adult’s] death having particular regard to the evidence in this matter and [police officer’s] recommendations.
- Both agencies consider the recommendations contained in [...] the immediate family’s statement and submissions to the coroner to see if any of those recommendations might further inform future institutional changes.

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Coronial recommendations: Fatal facts

Case number | ACT.2016.126
Primary category | Drugs and alcohol
Additional categories | Law enforcement
Fatal facts edition | 57 – cases closed between April and June 2018

Case summary
An adult male died from complications following methadone toxicity.
The adult was a prisoner at the time of their death and was receiving methadone as part of the prison’s methadone program. They were found unresponsive in their cell and were unable to be revived.

Coronial findings
The coroner found that the death was unintentional.
The coroner found that the adult was naïve to the use of opioids. During their initial review period in prison, the adult answered questions in a manner that eluded to them being opioid-dependent in order to receive methadone. The coroner found that the adult’s placement in the methadone programme was appropriate in the circumstances and did not affect the quality of care, treatment or supervision contributing to death.

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

- The Australian Capital Territory (ACT) Government should review the then existing practices and to remove inconsistencies in policies and procedures relied upon by correctional services officers so as to ensure prisoner safety and welfare checks through musters and headcounts which require eye contact and facial recognition to be complied with. The extent of compliance with those procedures, given their purpose is to ensure the safety and well-being of a detainee, should be evaluated and tested periodically to ensure they are effective and practical and minimise complacency through their routine application.
- The ACT Government should consider the viability or effectiveness that a daily structured compulsory physical education and training session might have on a prisoner focusing on the prisoner’s well-being and rehabilitation coupled with drug rehabilitation counselling. Any consideration of such a course would need, I acknowledge, to be
factored into current alcohol and drug support programs within the [prison] and the various sentencing periods for detainees.

- The ACT Government should ensure that minimising the infiltration of illicit substances into custodial facilities remains at the forefront of screening technology.
- ACT Health should consider obtaining either by consent from a prisoner or through reliance on legislation, a prisoner’s medical records and all relevant reports from alcohol and drug perspective created prior to incarceration for incorporating into a detainee electronic medical file for the purposes of an [prison] induction or prior to any assessment for access to pharmacotherapy treatment.
- The ACT Standard Operating Procedure’s (SOP) should be reviewed and the focus should be on prescribing individualised treatment setting out the parameters for commencement doses of Methadone for instance be anywhere from 5 to 20 mg with the ability to increase daily on medical review only.
- The SOP should be reviewed to ensure that those who have only recently commenced on the Methadone program not be allowed to self-prescribe increases for a set period of time to ensure they are in a physiological sense, capable of accommodating the increased amount of Methadone. Further and in the alternative, the ACT Government should consider whether not it is even appropriate to allow such increases to occur for a Schedule 8 drug.
- ACT Justice Health Services to consider whether or not adopting the National Guidelines to replace the ACT Opioid Maintenance Treatment Guidelines and incorporating random urinalysis or blood tests where there is no objective medical history of opioid dependence prior to placement on to the Methadone Maintenance Program.
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 summary

A female infant died shortly after their birth.

The infant was born with no reported complications. A short time after birth, their condition deteriorated and they were transferred to a special care unit. The infant’s health declined rapidly. Despite attempts to resuscitate the infant, they were unable to be revived.

Coronial findings

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

The cause of the infant’s death was undetermined following a post-mortem examination. The coroner later found that the death was due to hypoxia resulting from hypertension.

The coroner found that improvements could be made to neonatal post-mortem examination practices.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the NSW Minister for Health:

- I recommend that consideration be given to the introduction of a policy applicable to NSW Health Pathology requiring that the post-mortem examination of all reportable neonatal deaths be performed jointly by a forensic pathologist and a perinatal and paediatric anatomical pathologist in a forensic facility.

- In the event that Recommendation 1 is unable to be implemented due to reasonable workforce, and other, limitations, I recommend that consideration be given to the introduction of a policy applicable to NSW Health Pathology requiring that the post-mortem examination of all reportable, non-suspicious, non-traumatic neonatal deaths occurring in NSW hospitals be performed by a perinatal and paediatric pathologist. I further recommend that, depending on the geographic location where the death occurred, that the post-mortem examination be performed at The Children’s Hospital at Westmead, Sydney Children’s Hospital at Randwick, or John Hunter Children’s Hospital.
In the event that Recommendation 1 is unable to be implemented due to reasonable workforce limitations, I recommend that consideration be given to the development and implementation of structured guidelines, applicable to NSW Health Pathology, to facilitate consultation between forensic pathologists from the Department of Forensic Medicine and perinatal and paediatric pathologists from paediatric pathology units at The Children's Hospital at Westmead, Sydney Children's Hospital at Randwick, or John Hunter Children's Hospital regarding post-mortem examination of all reportable neonatal deaths. I further recommend that such guidelines should provide for any such consultation to be appropriately documented, and for any resulting autopsy report to be jointly authored by the case forensic pathologist and consulting perinatal and paediatric pathologist.
Coronial recommendations: Fatal facts

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Case summary

A male child died due to complications of a virus.

The child had recently been holidaying overseas with family and began experiencing a fever and cough upon their return home. They attended medical centres on two occasions, and both times were prescribed with antibiotics.

The child was later admitted to hospital where their condition deteriorated. The child went into cardiorespiratory arrest and, 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 nurses treating the child at the time of their collapse spent too long focusing on the child’s monitoring equipment, rather than checking their physical condition. As a result, there was an unacceptably long period between the child’s collapse and the nurses calling for a medical review.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the [local health district]

- I recommend that a component of the training for nursing staff address the phenomenon of “fixation errors”, particularly as it relates to assessment of results of monitoring equipment.

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Coronial recommendations: Fatal facts

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Case summary

A female infant died due to a brain injury a short time after their birth.

The infant began to experience breathing difficulties shortly after their birth. Despite attempts at resuscitation, the infant was unable to be revived.

Coronial findings

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

The coroner found that improvements could be made to neonatal post-mortem examination practices.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the NSW Minister for Health:

• I recommend that consideration be given to the introduction of a policy applicable to NSW Health Pathology requiring that the post-mortem examination of all reportable neonatal deaths be performed jointly by a forensic pathologist and a perinatal and paediatric anatomical pathologist in a forensic facility.

• In the event that Recommendation 1 is unable to be implemented due to reasonable workforce, and other, limitations, I recommend that consideration be given to the introduction of a policy applicable to NSW Health Pathology requiring that the post-mortem examination of all reportable, non-suspicious, non-traumatic neonatal deaths occurring in NSW hospitals be performed by a perinatal and paediatric pathologist. I further recommend that, depending on the geographic location where the death occurred, that the post-mortem examination be performed at The Children’s Hospital at Westmead, Sydney Children’s Hospital at Randwick, or John Hunter Children’s Hospital.

• In the event that Recommendation 1 is unable to be implemented due to reasonable workforce limitations, I recommend that consideration be given to the introduction of an annual training program, applicable to NSW Health Pathology, for Department of
Forensic Medicine forensic pathologists in relation to the identification and potential significance of squames when performing neonatal post-mortem examinations.

- In the event that Recommendation 1 is unable to be implemented due to reasonable workforce limitations, I recommend that consideration be given to the development and implementation of structured guidelines, applicable to NSW Health Pathology, to facilitate consultation between forensic pathologists from the Department of Forensic Medicine and perinatal and paediatric pathologists from paediatric pathology units at The Children's Hospital at Westmead, Sydney Children's Hospital at Randwick, or John Hunter Children's Hospital regarding post-mortem examination of all reportable neonatal deaths. I further recommend that such guidelines should provide for any such consultation to be appropriately documented, and for any resulting autopsy report to be jointly authored by the case forensic pathologist and consulting perinatal and paediatric pathologist.
Coronial recommendations: Fatal facts

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Case summary

An older male took their own life by hanging.

The adult had been diagnosed with bipolar affective disorder and had a history of non-compliance with medication. The adult was subject to a community treatment order (CTO) made while they resided in another state.

The adult was found near their home by a passer-by. Emergency services were called 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 CTO had not been implemented when the adult moved to New South Wales.

The coroner found that the adult’s death highlighted deficiencies in the law and procedures relating to care and treatment of transferred patients subject to CTOs.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the NSW Ministry of Health:
- That the Minister consider reviewing the provisions concerning the interstate application of mental health laws contained in Chapter 8 parts 1, 2 and 3 of the Mental Health Act 2007 (the NSW Act) in the light of counterpart provisions in the Mental Health Act 2014 (Vic) with a view to proposing any legislative amendments that may be necessary or desirable to ensure that where a mental health patient (whether or not involuntarily detained or subject to an inpatient treatment order) is referred or transferred by a mental health facility in another state to a declared mental health facility in NSW (the receiving facility) and that patient is subject to a community treatment order (CTO) in that other state:
the CTO shall take effect as a CTO made under the NSW Act which Act shall apply accordingly, except as provided by the regulations;

any documents that are relevant to the referred or transferred person are obtained by the receiving facility from the interstate mental health facility, and;

the provisions of s56(3) of the NSW Act do not apply to a person subject to an interstate CTO that takes effect hereunder unless the authorised medical officer of the receiving facility or the Tribunal otherwise orders.

That in any consideration of the revision of the Intergovernmental Memorandum of Agreement between NSW and Victoria dated 9 September 2011, the parties consider preparing or developing or authorising appropriate guidelines to accompany any revised agreement with respect to the relocation of mental health patients subject to a CTO from one jurisdiction to the other.

To the [local health district]:

That the Chief Executive Officer consider reviewing existing policies and clinical practices relating to the care, treatment and management of mental health patients in community health care agencies, and that new policies or guidelines that may be necessary or desirable be formulated to ensure:

that all clinical staff involved in receiving a patient subject to an interstate CTO upon transfer from an interstate mental health facility (transferee) are fully aware of the procedures for authorising and arranging receipt of the transferee;

that relevant staff fully consider the care and treatment information provided by the interstate mental health facility and any other health professional concerning the transferee to inform the assessment of the care and treatment needs of the transferee and the formulation of any ongoing management plan for the transferee;

that such staff be provided with all the information and training necessary to consult effectively with any general practitioner or other health professional involved in the treatment or proposed treatment of a transferee to ensure that there is a clear understanding of the treatment that the transferee requires and of any tasks that the general practitioner or health practitioner must undertake.
Coronial recommendations: Fatal facts

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Case summary

An adult male died due to intentional drowning.

The adult had come into contact with police and mental health services on numerous occasions in relation to suicidal thoughts.

The adult was found at a cliff location by police, and negotiations to ensure the adult’s safety commenced. During this time, the adult approached the cliff edge and jumped into the water below. They were found deceased in the water a short time later.

Coronial findings

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

Coronial recommendations

The coroner made the following recommendations related to this case:

To the Director of Medical Services, [hospital]:

- I recommend that consideration be given to conducting a service delivery review to determine whether family members of mental health inpatients are provided with adequate information about the ways in which they may communicate information and concerns relating to a patient to clinical staff responsible for that patient's treatment and care. If such a review demonstrates that adequate information is not provided then I further recommend that consideration be given to the implementation of a robust and reliable system (including relevant staff training) that allows for such information to be provided.

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Coronial recommendations: Fatal facts

Case number: NSW.2015.1646
Primary category: Intentional self-harm
Additional categories: Law enforcement
Fatal facts edition: 57 – cases closed between April and June 2018

Case summary

An adult male took their own life by asphyxiation.

The adult was a prisoner at the time of their death. The adult’s cellmate returned to their cell later than usual, and found the deceased unresponsive. Staff responded immediately but found that the adult had passed away.

Coronial findings

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

The coroner found that it would have been advantageous for more questions to have been asked of the adult by staff in relation to self-harm.

Coronial recommendations

The coroner made the following recommendations related to this case:

To Justice Health:
- That the current template for the “Reception Screening Assessment” form, in circumstances where the patient answers “yes” to any of the 3 mandatory questions under the heading “Suicide risk assessment”, be amended to also mandate that the clinician record answers to the further clarifying questions set out under that mandatory question;
- That the current proposed clarification of the patient appointment priority rating categories from 1 – 5 on the “Patient Administration System” include clarification of the rating categories so far as they apply to patients requiring mental health assessments.

To the Commissioner for Corrective Services:
- That the current ongoing revision of the Operations Procedures Manual (or its replacement, as the case may be) include clarification to Corrective Services [CSNSW] officers on the interaction between (a) the safety and security requirements for officers opening cells in response to a cell alarm in maximum security centres and (b) the duties of a first responding officer in a potential death in custody situation.
• That consideration be given to amending the current CSNSW “Intake Screening Questionnaire”, to ensure that currently consolidated questions concerning self-harm and suicide (both current plans and previous acts/attempts) are separated into separate questions as follows:
  o Do you have any current plans to hurt yourself?
  o Do you have any current plans to end your life?
  o Have you ever previously tried to hurt yourself?
  o Have you ever previously tried to end your life?

• That consideration be given to amending the current consolidated question in the CSNSW “Reception Checklist” concerning “current thoughts of self-harm/suicide” to have two discrete questions, one addressing current thoughts of self-harm and one addressing current thoughts of suicide. (I note from the Commissioners submissions that this has already been revised).
Coronial recommendations: Fatal facts

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Case summary

An adult female took their own life by hanging. They had a long history of depression. The adult had recently been discharged from a mental health unit. They were found unresponsive by a family member after being uncontactable for a number of hours. Emergency services were called to the scene and ambulance paramedics confirmed that the adult had passed away.

Coronial findings

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

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend to the Chief Executive of the [local health district] that a policy be implemented to the effect that:

  With respect to patients discharged from Mental Health Units (including Emergency Mental Health Units) in circumstances in which a discharge summary will not be available to be sent so that it is received on the day of discharge by a patient’s GP [general practitioner] and

  o  where follow-up by a GP is recorded as part of that patient’s discharge plan or
  o  where medications commenced by that GP are to be discontinued

  a member of the medical or nursing staff of the hospital should attempt to contact that GP to provide relevant information about the patient’s presentation and discharge plan.

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Case summary

A middle aged male due to gunshot injuries sustained in police operation.

The adult was involved in a dispute at their workplace, during which they brandished a knife and threatened other employees. Police were called to the scene and entered into negotiations with the adult. Police repeatedly requested that the adult lay down their weapon. The adult advanced on police while holding the knife and was shot as a result.

Coronial findings

The coroner found that the death was due to legal intervention.

Coronial recommendations

The coroner made the following recommendations related to this case:

To The NSW Commissioner of Police
- That consideration be given to the greater integration of mental health informed training into tactical options training with an emphasis on specific de-escalation techniques practiced by role play exercises.

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Coronial recommendations: Fatal facts

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Case summary

An adult male took their own life in an incident involving a firearm.

The adult had recently experienced the breakdown of their relationship. They attended their former partner’s home, during which time they demonstrated intent to end their own life. The ex-partner left the home and police were contacted. A lengthy siege took place with police attempting to negotiate with the adult. Despite attempts to ensure the adult’s safety, they inflicted fatal injuries and were found deceased in the home.

Coronial findings

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

The coroner found that aspects of the incident could be used in the training of police negotiators and that this may be beneficial to the overall management of similar negotiation situations in future.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the NSW Commissioner of Police:

- I recommend that consideration be given to using the experience of [the deceased’s] family during the events of [the incident] (with appropriate anonymization, and conditional upon consent being provided by [the deceased’s] family) in an appropriate case study as part future training packages provided by the NSW Police Negotiation Unit to police negotiators to address the issues of adequate and appropriate information gathering from, and impartation of information to, family members of subject persons involved in a high-risk incident.

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Coronial recommendations: Fatal facts

Case number | NSW.2015.2697
Primary category | Adverse medical effects
Fatal facts edition | 57 – cases closed between April and June 2018

Case summary
An older female died due to sepsis as a result of complications from a surgical procedure.

The adult had recently undergone surgery for the insertion of an intragastric balloon. Following a procedure to inflate the balloon, the adult was sent home, where they became unwell. They attended hospital where it was found that they had suffered irreversible organ damage. Despite further surgery, the adult’s condition deteriorated, and they passed away.

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

The coroner found the complications were caused by stomach pressure due to severe and protracted vomiting, and that the pressure was exacerbated due to the intragastric balloon.

The coroner found that the post-procedural care provided to the adult was deficient in that:

• instructions provided to the adult about contacting their doctor lacked clarity and;
• a member of the clinical team should have contacted the adult due to their high-risk patient status.

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

To the Australian and New Zealand Metabolic and Obesity Surgery Society:
• That consideration be given to developing guidelines concerning intragastric balloon procedures covering patient selection and exclusion criteria, indications and contraindications, risks, and appropriate follow up care and advice.
• That consideration be given to compiling a data registry with details and outcomes for all bariatric patients, aimed at providing clinicians and prospective patients with evidence-based information to guide decisions about the various bariatric options.

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Coronial recommendations: Fatal facts

Case summary
An adult male died due to complications of aspiration.
The adult suffered from cystic fibrosis. They experienced a bowel obstruction. As a result, their condition deteriorated, and they passed away in hospital.

Coronial findings
The coroner found that the death was due to natural causes.
The coroner found that clinicians failed to diagnose the adult’s clinical deterioration.

Coronial recommendations
The coroner made the following recommendations related to this case:
To the Minister of Health
• I recommend the establishment of a specialised ward for the care and treatment of patients diagnosed with cystic fibrosis at [hospital].
Coronial recommendations: Fatal facts

Case number: NSW.2016.2487
Primary category: Natural cause death
Additional categories: Law enforcement
Fatal facts edition: 57 – cases closed between April and June 2018

Case summary
An older male died due to a heart condition.

The adult had an extensive medical history. They called emergency services on the day of the incident, however the operator was unable to hear the adult or ascertained the services they required. Police were dispatched to the adult’s home and arrived several hours after the call was placed. The adult was found unresponsive and was unable to be revived.

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

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

To the Commissioner of NSW Police Force, Commissioner of NSW Ambulance Service, and [telecommunications company]:

- I recommend tabling for consideration at the next National Emergency Communications Working Group (scheduled for [date]) the following agenda item:

  The development of a system that would allow the following information to be readily accessed by, or provided to, the relevant Emergency Services Operator (ESO), where this is permitted by privacy legislation:
  - the audio recording of Triple Zero calls that is captured by [telecommunications company];
  - a caller’s Triple Zero call history, as held by [telecommunications company]; and
  - a location’s previous Triple Zero call history, as held by each ESO.

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Case summary
A young male died due to a vehicle incident in which they were a motorcyclist. They were riding a miniature motorcycle in traffic with a pillion passenger. Neither were wearing helmets.

The riders came to the attention of police, who followed the motorcycle. The young person continued attempts to evade police before colliding with another vehicle. They were taken to hospital where they passed away.

The young person had previously been cautioned by police for riding a motorcycle unlicensed, uninsured and unregistered. They were anxious not to be caught doing so again, as they believed they would have to attend court.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the conduct of the police was non-compliant with the NSW Police Force’s Safe Driving Policy.

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

To the Commissioner of Police:
• That the NSW Commissioner of Police implement further training and educational initiatives aimed at developing a better understanding of the requirements of the Safe Driving Policy regarding pursuits amongst the employees of the NSW Police Force to whom the Safe Driving Policy applies and, furthermore, undertakes a full audit regarding the effectiveness of these training and educational initiatives.

To the NSW Minister for Roads, Maritime and Freight:
• That the NSW Minister for Roads, Maritime and Freight consider consulting all relevant stakeholders with a view to establishing a working party to review of the current
confiscation powers available to police under the *Road Transport Act 2013* (NSW) in relation to trail bikes and mini-motorcycles.
NORTHERN TERRITORY

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>NT.2013.262</th>
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</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Homicide and assault</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Law enforcement</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>57 – cases closed between April and June 2018</td>
</tr>
</tbody>
</table>

Case summary
An adult female died due to injuries sustained in an assault.
The adult was found deceased in suspicious circumstances.

Coronial findings
The coroner found that the death was due to assault.
The coroner found that the investigation into the adult’s death was of poor quality and took an excessively long time. The coroner also found that officers present at the scene of the incident failed to appreciate the evidence before them.

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

- That the Commissioner of Police do all things necessary to ensure that specimens and exhibits from Coronial investigations are not destroyed without the written consent of a coroner.
- That the Commissioner of Police do all things necessary to ensure that specimens and exhibits are not destroyed that relate to sexual offences or other serious offences going to the identity of the alleged offender.
- That the Commissioner of Police do all things necessary to ensure that those that investigate major offences have the appropriate skill, experience and resources to undertake the investigations to which they are tasked.
- That the Commissioner of Police do all things necessary to ensure that senior police undertake their roles in facilitating, supervising and providing governance in relation to all major investigations.

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>NT.2016.68</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Law enforcement</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Falls</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>57 – cases closed between April and June 2018</td>
</tr>
</tbody>
</table>

Case summary

An older adult male died from a head injury due to a fall.

The adult was intoxicated and was asleep in an acquaintance’s home. Police attended the home and requested that the adult leave the residence. While leaving, the adult stumbled and struck their head against a wall as they fell. They were conveyed to hospital where the passed away as a result of their injuries.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult’s death may have been preventable. While the adult was only in the care of police for a short period of time, the coroner found that the care provided by police was inadequate.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Commissioner of Police provide instruction and training to the police in relation to the limits of their powers under the *Police Administration Act* and the *Trespass Act* and the appropriate procedure to follow in similar circumstances.
- That the Commissioner of Police provide instruction and training to police in relation to their duty of care to persons being “moved on”.
- That the Commissioner of Police provide instruction and training to police so it is understood that persons in the control of police are categorised as being in police custody for the purposes of Police Custody Incident and Illness Reports and the reporting of deaths to the Coroner.

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>NT.2017.159</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Mental illness and health</td>
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<tr>
<td>Fatal facts edition</td>
<td>57 – cases closed between April and June 2018</td>
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</tbody>
</table>

Case summary

An adult female died from pulmonary embolism from a deep vein thrombosis.

The adult had a long history of mental health issues. They had been restrained on multiple occasions both in medical and police custody settings in the period leading up to their death.

The adult had been sedated and their condition deteriorated while in hospital. Despite attempts at resuscitation, they were unable to be revived.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the restraints used by various agencies in dealing with the adult, in conjunction with their already prevalent physical health issues, may have contributed to the formation of the deep vein thrombosis.

The coroner found that the care provided to the adult was adequate but should have involved the forensic mental health team at an earlier time.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the [health service] do all things necessary to ensure that the Forensic Mental Health Team provides appropriate service to Central Australia so as to enable early intervention for complex cases.
- That a multi-agency forum be established that includes a wide range of agencies (including Health, Ambulance, Police and Corrections) so as to enable a proactive and clear multi-agency response to complex cases.

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

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

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<thead>
<tr>
<th>Case number</th>
<th>QLD.2013.2396</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Electrocution</td>
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<tr>
<td>Additional categories</td>
<td>Work related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>57 – cases closed between April and June 2018</td>
</tr>
</tbody>
</table>

Case summary

An adult male died due to electrocution in a workplace incident.

The adult worked as a roofer and was installing guttering and fascia at a construction site. The adult sustained a fatal electrical shock due to a damaged light fitting coming into contact with a metal water pipe and the scaffolding they were holding.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the likelihood of the adult’s death would have been greatly reduced had a residual current device (RCD) been installed on the light fitting.

Coronial recommendations

The coroner made the following recommendations related to this case:

- The 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.
- The Office of Industrial Relations in conjunction with the Electrical Safety Office review the circumstances of this case and consider if there should be amendments to the *Demolition Work: Code of Practice 2013* and/or the *Managing electrical risks in the workplace Code of Practice 2013* that mandate:
  - An electrical isolation certificate be obtained by the principal contractor for any demolition or dismantling working in any building structure.
  - Further that any electrical isolation certificate should provide sufficient information (a plan may be one solution but there may be others) to identify the precise area that has been isolated, including any cabling and fittings which have been removed, and if there is any remaining cabling and fittings of the relevant area, as well as details of the method of isolation, including use of lockout and tag-out means and testing to prove de-energised protocols.
That a further electrical isolation certificate be mandatory where there is any extension of the scope of demolition and dismantling work.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>QLD.2015.652</th>
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</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Water related</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Leisure activity, Work related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>57 – cases closed between April and June 2018</td>
</tr>
</tbody>
</table>

Case summary

A young female died due to drowning in a diving incident.

The young person was a tourist who was taking part in a sailing a diving trip as part of a group. They had no prior diving experience.

The young person became separated from their dive group and was unable to be located. A search and rescue operation was carried out, during which the young person was found in deep water. They were brought to the surface, however attempts to revive them were unsuccessful.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the young person became separated from the group due to poor underwater visibility and a lack of adequate instructor supervision.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Office of Industrial Relations (WHSQ), within six months, review and consider for inclusion in the relevant Code of practice issues addressing:
  - Introductory Diver: Instructor ratios of a maximum of 2:1, and 1:1 if conditions are poor (such as current, visibility, or surface chop);
  - Review the term ‘resort dive’ to be renamed ‘introductory dive’;
  - The instructor to always be within arms-length of their resort divers, and to ‘link arms’ if conditions (whether visibility, current, or surface chop) are assessed as poor or very poor;
  - Dive instructors must do a dive site assessment, including:
    - Assessing visibility with a secchi disk and
    - Conducting an in-water (at depth) visual inspection for horizontal visibility, and to assess current, to determine if the site is suitable for introductory divers and to determine the Introductory Diver: Dive Instructor, ratio;
o That elementary dive skills including mask clearing, regulator clearing, regulator recovery, buddy breathing, BCD [buoyancy control device] inflate/deflate, and emergency weight belt dropping, are taught until the skill is competently demonstrated to the instructor, and that this is to occur in a controlled water environment such as a swimming pool;

o That diving groups are staggered, and that routes are determined in a way to avoid dive group interaction whilst underwater;

o That the dive instructors solely have the final decision on whether a dive proceeds, or is terminated, and that it not be the skipper, nor the tour operator (who may have commercial considerations influencing their judgement);

o That safety measures include that the ‘Surface Watch’ person has an emergency ‘grab bag’ which includes a weighted lost diver marker, and that dive instructors carry on their person (whilst conducting the dive) a suitable underwater marker system to indicate underwater the last known position that the separated driver was seen;

o That if swimming fins are used, then some style of ‘fin-safe’ style retainer strap is used with the swimming fins;

o Whether a policy should be implemented that if any diver becomes separated, that all divers in that group must immediately surface and inflate their BCD, even though it is an emergency ascent.

• That the Office of Industrial Relations (WHSQ), within six months, consider whether the relevant diving Code of practice needs to be mandated as the minimum standard for operations, rather than being “guidelines”.

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>QLD.2015.2030</th>
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<tr>
<td>Additional categories</td>
<td>Mental illness and health, Law enforcement</td>
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<tr>
<td>Fatal facts edition</td>
<td>57 – cases closed between April and June 2018</td>
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</table>

Case summary

An adult male took their own life by hanging. They were a prisoner at the time of their death.

The adult was seen by their treating psychiatrist and prison psychologists in the week before their death but were not assessed as being at risk of suicide. They had been made subject to an interim order for detention and faced extradition to another state at the conclusion of their term of imprisonment.

The adult was found unresponsive in their cell by prison staff and were unable to be revived.

Coronial findings

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

The coroner found that the adult took their life in the context of stress associated with a probable lengthy period of incarceration following their original release date and an ongoing mental illness.

The coroner found that while Queensland Corrective Services (QCS) Psychological Services staff were aware of application process being taken out in relation to the adult’s offending at the time, they should have been better informed about the key stages in that process to better understand the adult’s response to it. The coroner also found that collateral checks should have been undertaken to verify the adult’s claims that they were being supported by family and friends.

Coronial recommendations

The coroner made the following recommendations related to this case:

To Queensland Health and Queensland Corrective Services:

- Consider whether amendments are required to legislation to supplement the release of information (including documents) under the MOU [memorandum of understanding] on Confidential Information Disclosure to optimise the health care provided to persons in custody; and protect health practitioners from liability when sharing prisoner health information appropriately; and
Consider amendments to the Operating Guidelines under the MOU on Confidential Information Disclosure to provide more relevant contextual information in relation to the sharing of information in correctional settings.
Coronial recommendations: Fatal facts

**Case number**  
QLD.2016.615

**Primary category**  
Intentional self-harm

**Additional categories**  
Mental illness and health, Law enforcement

**Fatal facts edition**  
57 – cases closed between April and June 2018

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**Case summary**

A young male took their own life by hanging.

The young person was a prisoner at the time of their death. They had a history of mental illness, self-harm and substance abuse. They were found unresponsive in their cell during a muster. Resuscitation attempts were commenced, and the young person were conveyed to hospital, where they later passed away.

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**Coronial findings**

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

The coroner found there was a prolonged delay between the young person’s admission to the prison and their first appointment with a visiting medical officer.

The coroner also found that improvements could be made to information gathering for the purpose of informing coronial investigations into the deaths of prisoners.

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**Coronial recommendations**

The coroner made the following recommendations related to this case:

- That [hospital and health service] urgently consider additional resourcing of Offender Health Services within [prison] (both staffing and number of consultation rooms) to ensure prisoners are able to see a doctor:
  - within at least seven days after they have been triaged and identified as requiring a non-urgent medical consultation, and ideally within a few days
  - and/or within a timeframe that is commensurate with those timeframes experienced by members of the general public in the community.
- That Office of Chief Inspector, Queensland Health and all Hospital and Health Services who provide health services to prisoners jointly consider ways for ensuring that, where a prisoner dies and health services provided to that prisoner are relevant to the Office of Chief Inspector’s investigation into that death, there is a mechanism for gathering relevant Queensland Health and Hospital and Health Services information to inform that
investigation, including through interviews with Queensland Health and Hospital and Health Service staff.
Coronal recommendations: Fatal facts

Case number: QLD.2015.3338
Primary category: Aged care
Additional categories: Physical health
Fatal facts edition: 57 – cases closed between April and June 2018

Case summary

A middle aged male died due to choking on food.

The adult suffered from a degenerative condition and resided in an aged care facility.

The adult had been assessed as being vulnerable to swallowing difficulties, including choking. A care plan had been put in place to manage their risk of choking, including supervision while eating and the provision of a moist minced died.

The adult was provided with a meal of solid food and was left unsupervised with the door to their room closed. Staff found the adult deceased a few hours later.

Coronal findings

The coroner found that the death was unintentional.

The coroner found that the care plan was not strictly adhered to by staff due to the adult’s challenging behaviour. The food provided to the adult was not in accordance with the care plan that had been put in place.

Coronal recommendations

The coroner made the following recommendations related to this case:

- That choking deaths of persons in care with a disability be specifically acknowledged as a systemic issue, and strategies to manage, monitor, review and report on this particular issue should be built in to the NDIS [National Disability Insurance Scheme] quality assurance and reporting framework if this has not already occurred.
- That all staff involved in the provision of care to residential aged and disability care residents be informed of any material change to a resident’s care plan prior to the commencement of their next shift. Whether this be in the form of an oral handover or some other form of information sharing should be a matter for each organization to determine.
• That residential aged and disability care residents' care plans be subject to routine review at least three monthly and sooner if health or other personal circumstances have changed.

• That residential aged and disability care residents with conditions that affect their ability to swallow should undergo regular medical examinations, at intervals as recommended by a medical practitioner, to assess their respiratory health in order to identify and treat aspiration pneumonia.
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.2011.448</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Child and infant death</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>57 – cases closed between April and June 2018</td>
</tr>
</tbody>
</table>

Case summary
An infant female died due to accidental suffocation while co-sleeping with their parents.
The infant’s family was known to child protection services.

Coronial findings
The coroner found that the death was unintentional.
The coroner found that the infant should not have been in the care of their parents at time due to the high level of risk to them in that environment.

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

- That Child Protection Services provide training on an ongoing basis to its child safety officers in effectively identifying and responding to situations where it is identified that an infant under the age of 12 months may be at risk due to unsafe sleeping practices.
- That the Deputy Secretary, Child and Youth Services, provide the Chair of the working party for the Vulnerable Infants and Babies Strategy with this finding to assist in informing the development of the Tasmanian Strategic Framework for Vulnerable Infants and Babies.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>TAS.2016.355</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Child and infant death</td>
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<tr>
<td>Fatal facts edition</td>
<td>57 – cases closed between April and June 2018</td>
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</tbody>
</table>

Case summary

A male infant died due to complications of unsafe sleeping.

The infant was co-sleeping with their parent and a sibling. When their parent awoke, they found the infant unresponsive and contacted emergency services. Paramedics attended the scene and resuscitation was attempted; however, the infant was unable to be revived.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the practice of co-sleeping increased the risk of sudden unexpected death in infants and that continued messaging about the dangers of co-sleeping was failing to reach the community.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the parents or older siblings of infants under the age of 12 months are not to sleep in the same bed with their infants, but to always place them on their back in their own cot to sleep.

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>TAS.2014.343</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>57 – cases closed between April and June 2018</td>
</tr>
</tbody>
</table>

Case summary

A middle aged female died from complications associated with delayed treatment of a superior mesenteric artery thrombus.

The adult had a significant medical history. They contacted an ambulance due to being unwell and were conveyed to hospital. They were later conveyed to another hospital for treatment, where their condition continued to deteriorate. Their condition appeared to stabilise following surgery, however they became critically unwell and died a few days later.

Coronial findings

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

The coroner found that there was a very small window of opportunity for a surgical response to the adult’s condition.

The coroner found that there were delays in diagnosis, and that the hospital to which the adult was initially taken did not have the capacity to treat them as required. There were further delays in transporting the adult to an appropriate hospital for treatment, and a lack of urgency in the care provided.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That [hospital] carry out a review of the circumstances of [the adult’s] transfer which may identify shortcomings in the system and facilitate improvements.

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>
<th>TAS.2016.438</th>
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<td>Additional categories</td>
<td>Physical health</td>
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<tr>
<td>Fatal facts edition</td>
<td>57 – cases closed between April and June 2018</td>
</tr>
</tbody>
</table>

Case summary

An older male died from oxygen deprivation and carbon dioxide toxicity.

The adult used an oxygen concentrator to deliver oxygen directly to their nose due to suffering from emphysema caused by smoking. They had been appropriately trained in use of the concentrator and warned of the dangers of smoking near the device.

The adult began smoking at home while using the oxygen concentrator. As a result, the oxygen tubing ignited, causing the adult to inhale carbon monoxide. Emergency services were contacted and ambulance paramedics attended the scene; however the adult was unable to be revived.

Coronial findings

The coroner found that the death was unintentional.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That medical oxygen concentrators are only used strictly in accordance with manufacturer’s instructions and specifically never whilst smoking or exposed to an open flame.

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

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<thead>
<tr>
<th>Case number</th>
<th>VIC.2011.4321</th>
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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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<tr>
<td>Fatal facts edition</td>
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</table>

**Case summary**

An adult male died due to sudden unexpected death in epilepsy (SUDEP).

The adult had previously been involved in a transport incident after which they were diagnosed with an acquired brain injury and suffered epileptic seizures. They received compensation from the Transport Accident Commission (TAC) and a trustee service was appointed for their legal and financial affairs. A Personal Emergency Response (PER) unit was installed at the adult’s home. When the adult moved residences, the PER device was not included in their moving arrangements. The device was moved to the new address, but not reconnected.

The adult was located unresponsive in their room by their housemate. They were holding the PER device. The housemate attempted to make an emergency call using the PER pendant, then using the handset in another room, both times without success. Emergency services were then contacted by phone and attended the scene. The adult was confirmed to have passed away.

**Coronial findings**

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

The coroner found it unlikely that the adult would have been able to activate the PER device themselves, had it been connected.

The coroner noted a variety of issues in the management of the adult’s relocation and the installation of the PER device at their new residence.

**Coronial recommendations**

The coroner made the following recommendations related to this case:

- That [PER provider] contact all users with a device similar to [the deceased’s], clearly stating and warning that if the unit is disconnected from either the telephone line or the power source, the unit may cease to operate and advising that a [PER provider] technician is required for transfer of the unit.
• That [PER provider], when it writes to users with a similar device to [the deceased’s], provide stickers to be applied to units which clearly state they are not to be disconnected from either the telephone line or the power source, and if that occurs the unit may not operate. It should also advise to contact [PER provider] to transfer the unit.

• That all the [PER] literature provided to users for devices similar to [the deceased’s] include clear warnings about the consequences of disconnection to the telephone or power lines and the need for a [PER provider] technician to transfer the device. The [PER] user guide and information brochure should be updated to contain this essential information.

• That TAC [Transport Accident Commission] writes to all clients who are users of [PER] devices such as [the deceased’s], if it has not done so already, warning them about the dangers of disconnecting the device from the telephone or power supply and advising a technician is required to transfer the unit.

• That TAC when providing case management services (either internal or outsourced) for TAC clients include or require that a risk assessment is performed regarding the potential risks involved in the task requiring case management.

• That TAC implements a ‘hot note’ warning or flag on their electronic systems, such as that implemented by [disability support provider] and [trustee service], if it has not done so already, as an alert that a client has a Personal Emergency Response device.

• That TAC, [trustee service], and [disability support provider] conduct a review, if they have not done so already, to ensure that all clients with lifesaving equipment such as [the deceased’s] are recorded appropriately on their electronic systems so the equipment is identified as a risk requiring evaluation in the event of any change to the client’s circumstances, such as when moving address.
Coronial recommendations: Fatal facts

Case number: VIC.2015.3139
Primary category: Natural cause death
Additional categories: Child and infant death
Fatal facts edition: 57 – cases closed between April and June 2018

Case summary
A male infant died as a result of herpes simplex virus.

The infant was discharged home from hospital a few days after birth. They were taken to a general practitioner by their parent when they began showing signs of being unwell. A few days later, the infant was exhibiting difficulty breathing and was taken to hospital. They were discharged home as their respiratory complaint was believed to be benign.

An ambulance was called while the infant was being reviewed again by a general practitioner later that day. The infant became critically unwell in hospital and passed away despite extensive medical treatment.

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

The coroner found that the source of the infant’s herpes simplex virus was unknown. The coroner noted a lack of notetaking and delays in regard to the infant’s treatment.

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

That the Royal Australian College of General Practitioners:
• Use the death of [infant] as an educational case for members to demonstrate the importance of decision support tools such as clinical practice guidelines to outline the assessment of a neonate. In particular, the importance of assessing for lethargy, poor feeding, apnoea, grunting, colour, and tone, along with measuring rectal temperature, respiratory and heart rate;
• Continue education on the recognition of the sick neonate;
• Continue to educate its members as to the importance of comprehensive clinical notes that correctly reflect the information captured in consultations in accordance with its initiative Quality Health Records in Australian Healthcare.
• Reinforce that information captured in a consultation should be recorded in the patient health record at the time of the consultation or as soon as practicable afterwards.
That each of the Royal Australian College of General Practitioners, the Royal Australasian College of Physicians (Paediatrics and Child Health Division), and the Australian College for Emergency Medicine:

- Consider educational opportunities posed by the circumstances of this case, in particular in relation to the presentation of neonates with herpes simplex virus.

The Victorian Department of Health and Human Services:

- Continue to educate as to the importance of the recognition of the sick neonate, and comprehensive contemporaneous clinical notes.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2012.4444</th>
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<tr>
<td>Primary category</td>
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<td>Mental illness and health</td>
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<tr>
<td>Fatal facts edition</td>
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</table>

Case summary

A middle aged male took their own life by hanging.

The adult had been diagnosed with bipolar affective disorder, for which they had received electroconvulsive therapy (ECT) treatments. They were held as an involuntary hospital patient at the time of their death due to their declining mental health.

The adult was found unresponsive in their room at the hospital. They were resuscitated, but found to have sustained an irreversible brain injury, and later passed away.

Coronial findings

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

The coroner found that improvements could be made to protocols regarding dealing with mental health patients, including patient treatment and management of self-harm risks.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Office of the Chief Psychiatrist reviews all relevant research including its own data, and advises the mental health profession at large as to how patients who are suffering from bipolar affective disorder and are acutely depressed and who have shown themselves to be resistant to ECT [electroconvulsive therapy] over a prolonged period (and have objected to its ongoing use), should be assessed and managed in a hospital setting. Such advice should also deal with such other methods of management, which might be employed in such cases, this having regard the Mental Health Act 2014 and the Victorian Charter on Human Rights and Responsibilities Act 2006.

- That the Office of the Chief Psychiatrist amends the December 2015 guidelines on electroconvulsive therapy so as to provide greater direction to the mental health profession as to the type, frequency and as to the appropriate manner of calculation of the top end limit to the level of shock delivery, in all instances of delivery of ECT to mentally unwell patients. Direction in regard to the delivery of anaesthesia in connection with the condition under treatment, should also be part of such an amendment.
• That the Office of the Chief Psychiatrist reviews its approach to the bringing into psychiatric hospital units of any personal items of a potentially dangerous nature. Belts, cords and the like are clearly such items.

• That [healthcare provider] creates a new audit team to be responsible for assessment of risk concerning the existence of ligature points, within [ward, hospital], which team is to be answerable directly to the Chief Executive Officer [healthcare provider], and is to be chaired by an independent person who is possessed of appropriate training and experience in risk assessment in a hospital setting.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2015.4117</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Intentional self-harm</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Drugs and alcohol, Law enforcement</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>57 – cases closed between April and June 2018</td>
</tr>
</tbody>
</table>

Case summary
An adult female took their own life by drug toxicity. The adult suffered from multiple physical and mental health issues. They had recently come into contact with police and mental health services in relation to the importation of pentobarbitone with the intent to end their life. A postal stopper had been put in place to intercept international parcels addressed to the adult, due to the suspicion they might continue to import pentobarbitone.

The adult was interviewed by police on the day of their death in relation to the importation of pentobarbitone. Later that day, they were found unresponsive in their home. Attempts to resuscitate the adult were unsuccessful.

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

The coroner found that parcels addressed to the adult had recently been intercepted at a post office due to the postal stopper. An officer at the Department of Immigration and Border Protection tested the contents of the parcels, and subsequently released them. The officer was unaware of the reason the testing was required. As a result, an additional test that would have been capable of detecting pentobarbitone was not undertaken.

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

- That the Department of Immigration and Border Protection establish processes to ensure that when a mail stopper is issued, officers who examine items seized under the auspices of that mail stopper are aware of why it was issued. This would enable officers to focus their attention on known risks when examining items, and select tests and examination techniques that are appropriate to the risks.

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 summary

An older male died due to prescription drug toxicity.

The adult had recently been prescribed methotrexate by their general practitioner to treat their psoriasis. No blood tests were conducted prior to the prescription being provided. The dispensing pharmacist was concerned by the potentially dangerous daily dose prescribed, and called the general practitioner, who confirmed it to be the correct dose.

The adult’s condition deteriorated over the following days as they began to experience serious symptoms of toxicity to the drug. They were admitted to hospital 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 death was entirely preventable and that the methotrexate was inappropriately prescribed. The coroner found that treatment of psoriasis with methotrexate should never be initiated by a general practitioner and should never occur without first conducting blood tests to determine its safety.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Commonwealth Department of Human Services consider whether methotrexate should be designated an authority required medication, to reduce the risk of harm and death resulting from inappropriate prescribing.
- That [medicines providers] review their methotrexate prescribing advice for treatment of psoriasis, to ensure the advice reflects current clinical practice and evidence and is framed in such a way as to clearly mitigate the risk of inappropriate daily dosing as occurred in the death of [the deceased].
- That the Commonwealth Department of Health ensure that any Product Information for methotrexate made available by the Therapeutic Goods Administration, reflects current clinical practice and evidence and is framed in such a way as to clearly mitigate the risk of
inappropriate daily dosing for treatment of psoriasis as occurred in the death of [the deceased].

- That the Pharmacy Board of Australia and the Pharmaceutical Society of Australia consult with each other and any other professional body they deem relevant, as to what, if any, further guidance and support should be provided to pharmacists to enable and empower them to discharge their duty of care to patients in situations where they have a concern as to the safety and appropriateness of prescribed medication.

- That the Pharmaceutical Society of Australia review its Standard and guidelines for pharmacists performing clinical interventions and consider the circumstances in which a pharmacist might be encouraged to provide a copy of a Clinical Intervention Form to the patient and/or prescriber and/or another person.
Coronial recommendations: Fatal facts

Case number: VIC.2015.5857
Primary category: Adverse medical effects
Fatal facts edition: 57 – cases closed between April and June 2018

Case summary

A middle aged male died due to complications of chemotherapy treatment.

A Positron Emission Tomography (PET) scan suggested that the adult may have been suffering from toxicity to their chemotherapy treatment. Despite this, the adult received another dose of chemotherapy a couple of days later, as the haematologist who ordered the scan was unaware of the results. The adult was later found deceased in their residence.

Coronial findings

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

The coroner found that prompt and effective communication of the adult’s abnormal test results may have prevented their death.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Royal Australian and New Zealand College of Radiologists, the Australian Association of Nuclear Medicine Specialists and the Royal Australasian College of Physicians collaborate to develop a set of Standards dedicated to systems for the communication of imaging results. The Standards should be as explicit as possible in setting out the roles and responsibilities of diagnostician and referring doctor and the required manner of communication in different situations consistent with the conclusions and comments in this case.
- That [hospital] revise its current ONCOLOGY REFERRAL FORM FOR PET SCAN to include all information that may be relevant to the nuclear medicine physician performing the scan in determining the timeliness and manner of communication of the results.
- That [hospital] phase out fax transmission of imaging results as a matter of priority.

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Coronial recommendations: Fatal facts

Case summary

An older male died due to complications of a medical procedure.

The adult had an extensive medical history. The adult had recently undergone a colonoscopy, during which malformations were identified that required treatment. The adult underwent argon plasma coagulation (APC), during which they became uncomfortable and the procedure was stopped with a plan to continue a few days later.

The adult’s condition deteriorated in hospital and they underwent an emergency surgical procedure, which identified injuries to their bowel. Their condition continued to worsen, and they passed away a few days later.

Coronial findings

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

The coroner found that the adult’s injuries were sustained due to prolonged application of the APC. The gastroenterologist who performed the APC was appropriately experienced and had received training in the use of the electrosurgical system. However, this training did not include techniques.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Therapeutic Goods Administration review the circumstances of [the deceased’s] death.
- That the Therapeutic Goods Administration review the [health services] Governance and Risk Management Unit Investigation Report conclusions and recommendations.
- That the Therapeutic Goods Administration consider whether the manufacturer has met the relevant Australian Essential Principles in relation to the [electrosurgical system].

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Coronial recommendations: Fatal facts

Case number
The coroner held a joint investigation into the following deaths which resulted from the same incident: VIC.2015.1108, VIC.2015.1109

Primary category
Transport and traffic related

Fatal facts edition
57 – cases closed between April and June 2018

Case summary
A middle aged male and an adult female died due to a vehicle incident in which they were riding a motorcycle. The male was operating the motorcycle with the female as a pillion passenger. They were rounding a bend when the operator lost control of the motorcycle, causing it to cross onto the incorrect side of the road and collide with an oncoming vehicle. Emergency services were called to the scene, and both riders were declared deceased by paramedics.

Coronial findings
The coroner found that the death was unintentional. The coroner found that the motorcycle was travelling in excess of the advised speed limit at the time of the incident, and that this contributed to the collision. The coroner also found that a shove located on the bend contributed to the rider’s loss of control. Despite routine inspections of the area conducted in the period leading up to the incident, the shove had not been identified as a hazard or defect.

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

- That VicRoads enhances the training of its own inspectors and also requires its contractor to enhance the training of its inspectors to be more mindful of the needs of motorcycle riders and of their increased vulnerability to road imperfections when undertaking inspections.
- That VicRoads further promotes the use of its hotline amongst the motorcycling community and encourages motorcycle riders to use the hotline to report any road hazards, defects or imperfections that may endanger motorcycle riders in particular.

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.2016.3258</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>57 – cases closed between April and June 2018</td>
</tr>
</tbody>
</table>

### Case summary

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

The adult was struck by a truck at a pedestrian crossing. The truck was in the pedestrian crossing zone against a red light due to heavy traffic. Emergency services conveyed the adult to hospital, where they later passed away.

### Coronial findings

The coroner found that the death was unintentional.

The coroner found that the design of the truck cab resulting in the driver being unable to see the adult.

### Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the Australian Design Rules as administered by the Australian Government under the *Motor Vehicle Standards Act 1989* are amended to require that front warning sensors and side sensors are installed during manufacturing for all cab-over heavy vehicles with a Gross Vehicle Mass equal to or greater than 4.5 tonne.

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

Case number: VIC.2016.6026
Primary category: Transport and traffic related
Fatal facts edition: 57 – cases closed between April and June 2018

Case summary
An older female died due to a vehicle incident in which they were a passenger.

The adult was fatally injured when they vehicle in which they were travelling was struck by another vehicle towing a heavily laden trailer. The driver of the other vehicle had lost control, causing it to veer into the path of the adult’s vehicle.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the speed of the vehicle towing the trailer, the excessive weight being towed and the loading configuration of the trailer all contributed to the incident.

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

• That the Transport Accident Commission and VicRoads consider facilitating public awareness campaigns that highlight the dangers of towing an overloaded trailer.
• That the Transport Accident Commission and VicRoads consider any changes to driver licencing training that may include towing techniques.

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Coronial recommendations: Fatal facts

Case number: VIC.2016.3973
Primary category: Drugs and alcohol
Fatal facts edition: 57 – cases closed between April and June 2018

Case summary

An adult male died due to complications associated with diabetes and drug use.

The adult had a long history of drug use. The adult was made subject to a Community Corrections Order in the months prior to their death, and was required to attend a rehabilitation clinic.

The adult had recently been discharged from the clinic due to suspected illicit drug use and a suspected positive preliminary drug test. The sample taken from the adult was sent to pathology for further testing, and no illicit drugs were identified.

The adult was found unresponsive at a friend’s home where they were staying following discharge from the clinic. Paramedics attended and confirmed they had passed away.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult’s desire that their family not be informed of their discharge led to them staying at a residence in which medication and drug paraphernalia were available.

The coroner found that it may be advisable to delay discharging clients that returned positive preliminary drug tests until more reliable results had been received.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That in light of the circumstances of this case [rehabilitation centre] review the appropriateness of its policy to discharge clients who return a positive preliminary drug screen prior to the comprehensive pathology results.

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Coronial recommendations: Fatal facts

Case number | VIC.2017.4036
Primary category | Water related
Additional categories | Leisure activity
Fatal facts edition | 57 – cases closed between April and June 2018

Case summary
An adult male died due to a fishing incident.
The adult was reported missing when they did not attend work. They were known to have gone fishing on their kayak the day prior and their vehicle was located parked near a boat ramp.

Significant search operations were undertaken, during which the adult’s kayak was found at sea. However, the adult was never located.

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

It was noted during the investigation that there had been a large increase in the number of human powered vessel fatalities, and that additional safety measurements should be implemented.

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

- That Transport Safety Victoria liaise with the Department of Economic Development, Jobs, Transport and Resources with a view to seek amendment of the Maritime Safety Regulations 2012 (Vic), to require the compulsory carrying of an EPIRB [emergency position indicating radio beacon] or a Personal Locator Beacon (preferably with GPS [global positioning system] capability) for all human powered vessel activities, regardless of the classification of waterway or distance offshore.

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
WA.2013.186

Primary category
Work related

Fatal facts edition
57 – cases closed between April and June 2018

Case summary

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

The adult worked at a shipbuilding and repairing company. They were assisting in the unloading of a sea container packed with crates when one of the crates fell and struck the adult. The adult was trapped beneath the crate and was seriously injured. They were freed with the assistance of other employees and were conveyed to hospital, where they later passed away.

Coronial findings

The coroner found that the death was unintentional.

The coroner found there were a lack of guidelines or written protocols for the task being undertaken at the time of the incident.

Coronial recommendations

The coroner made the following recommendations related to this case:


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Coronial recommendations: Fatal facts

Case number | WA.2013.429
Primary category | Animal
Additional categories | Drugs and alcohol, Youth
Fatal facts edition | 57 – cases closed between April and June 2018

Case summary
A young male died due to injuries sustained in a crocodile attack.

The young person had an intellectual disability due to severe foetal alcohol syndrome and required a high level of care. They resided in a remote community. The young person went missing and their disappearance was reported to police. A large search operation was commenced, during which the young person was found deceased with severe injuries indicative of a crocodile attack.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the young person’s supervision, treatment and care was appropriate and of a reasonable standard, but that more could have been done to educate their carers about foetal alcohol syndrome so that they could learn ways to manage the young person’s behaviour. The coroner found that additional assessment could be implemented for children at risk of neurodevelopmental impairment as they grew older.

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

- I recommend that the WACHS [Western Australia Country Health Service] continues to provide universal screening of, and support for, pregnant women for alcohol use and all children identified through that screening as being at risk of neurodevelopmental impairment on the basis of antenatal exposure to alcohol and/or early life trauma be assessed by a paediatrician for developmental and behavioural impairments at age 12 months and in the year prior to school entry.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>WA.2014.2049</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Intentional self-harm</td>
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<tr>
<td>Additional categories</td>
<td>Mental illness and health, Law enforcement</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>57 – cases closed between April and June 2018</td>
</tr>
</tbody>
</table>

Case summary

An adult male took their own life by hanging.

The adult had a history of mental illness and was subject to a community treatment order at the time of their death.

The adult had been arrested and charged by police on the night of the incident, who had then taken them home. The adult was unable to be contacted the next morning, and was later found deceased at their home.

Coronial findings

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

The coroner found that police dealing with the adult had an incomplete understanding of the requirements of the Mental Health Act 1996 to justify taking the adult to hospital.

Coronial recommendations

The coroner made the following recommendations related to this case:

- The Commissioner of Police consider and, if appropriate, implement regular in-service training of operational police officers in relation to mental health related issues.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>WA.2015.1902</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Water related</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Child and infant death</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>57 – cases closed between April and June 2018</td>
</tr>
</tbody>
</table>

Case summary

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

The child was being cared for at a family day care held at the carer’s home. The child was unknowingly left outside unsupervised and was found floating face down in the swimming pool. The carer began performing resuscitation but was unable to locate their mobile phone to call emergency services. They ran to a neighbour for assistance, and ambulance paramedics were called to the scene before transporting the child to hospital. The child’s condition did not improve, and they later passed away.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that improvements could be made to the safety of family day care facilities where educators offered a care service from their home.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the Honorable Minister for Child Protection and Community Services give consideration to amending the relevant legislation in Western Australia to exclude homes with a swimming pool, outdoor spa or jacuzzi from being used to operate a family day care service where children under the age of five are admitted to care, which should come into effect immediately given the high level of risk of drowning.
- I recommend that the Honorable Minister for Child Protection and Community Services give consideration to amending the relevant legislation in Western Australia to exclude new family day educators from being approved to operate a family day care service from a home with a swimming pool, outdoor spa or jacuzzi.
- I recommend that the Honorable Minister for Child Protection and Community Services give consideration to amending the relevant legislation in Western Australia to require that where an existing family day educator operates a family day care service from a home with a swimming pool, outdoor spa or Jacuzzi (which will only be for children over
the age of 5 years) the approved provider must physically inspect the property monthly to ensure that the safety barrier to the water hazard is functioning effectively and there are no climbable hazards in proximity to the fencing. The need for direct supervision in proximity to the water hazard must also be reiterated to the educator during each inspection.

- I recommend that the Honorable Minister for Child Protection and Community Services give consideration to requiring all family day educators to have a fixed landline installed at their premises so that it is available to contact emergency services in the case of an emergency.
# 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>
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</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>
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</tbody>
</table>