Coronial recommendations: Fatal facts

A summary of cases and recommendations made between July and September 2018

Edition 58
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CORONERS’ RECOMMENDATIONS

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

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

_Coronal recommendations: Fatal facts_ includes case summaries and recommendations for cases closed between July and September 2018.

NEW SOUTH WALES

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

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Case summary

A middle aged male died as a result of an assault by persons unknown.

The adult had a history of drug use and incarceration. They were discovered deceased in the entrance of residential units with severe injuries.

Coronial findings

The coroner found that the death was due to assault.

The coroner found that the adult was assaulted at their residence by persons unknown, before making their way to a second premises where they succumbed to their injuries. The coroner found that there was insufficient evidence to identify the persons responsible for the adult’s death.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend the death of [the deceased] be referred to the Unsolved Homicide Unit, Homicide Squad NSW Police Force for further investigation.

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.
Coronal recommendations: Fatal facts

Case number | NSW.2013.1743
Primary category | Natural cause death
Additional categories | Adverse medical effects, Older persons
Fatal facts edition | 58 – cases closed between July and September 2018

Case summary

An older male died of complications of a heart attack following a fall.

The adult suffered a fall in public and was transported to hospital with a fractured hip. Prior to surgery, an electrocardiogram (ECG) was performed which the doctor interpreted as normal. The adult was transferred to a second hospital where a second ECG was undertaken that indicated the adult had suffered a heart attack.

The adult was scheduled for surgery the following day. The medical team reviewed the first ECG from the previous day and determined the adult was fit for surgery. The surgery proceeded without complication but the adult was noted to be confused and delirious in recovery. They had ongoing delirium in the following days and were transferred to an acute aged care unit, where they became unresponsive. Resuscitation attempts were made but the adult was declared deceased shortly afterwards.

Coronial findings

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

Following expert opinions at inquest, the coroner found that the first ECG was abnormal but not uncommon for a patient of the adult’s age. The coroner could not find any evidence that the adult’s fall was cardiac-related.

The coroner found that as the first ECG was abnormal but non-specific, there were no other clinical steps taken that should have been prior to the planned surgery date. The coroner found that surgery was appropriate in the circumstances.

The coroner was unable to determine the origin of the second ECG or whether the results were ever brought to the attention of a clinician. It was noted that had the second ECG been available to the adult’s medical team, the adult would have had their care immediately transferred to a cardiology service.

Coronial recommendations

The coroner made the following recommendations related to this case:
I recommend that consideration be given to incorporating the contents of the [date] memorandum from the Directors of Clinical Services and Nursing relating to proper processes for the performance of, filing of, and attendance on, an ECG into a policy directive, protocol, or guideline to provide for a greater degree of reliability, visibility and training in clinical practice.

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

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Case summary

An adult male died of peritonitis while in custody on remand.

The adult was arrested several days prior to their death and was taken to a remand centre. They underwent a medical assessment on arrival and were noted to have a history of drug and alcohol abuse and were exhibiting withdrawal symptoms. They underwent a review by drug and alcohol workers and were discharged to their cell.

The adult reported back pain, sweating and goose bumps which caused them ongoing distress for a couple of days. They were witnessed having a fit in their cell on the cell cameras and medical personnel attended. The adult was unresponsive and was transferred to hospital. Life support measures were withdrawn, and they passed away later that day.

Coronial findings

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

The coroner found that the nurse who reviewed the adult following their complaints of back pain, sweating and goose bumps attributed these to drug withdrawal, and referred the adult to a drug and alcohol nurse in response. Expert evidence at inquest presented differing views on whether the back pain should have alerted nursing staff to a different diagnosis. As such, the coroner found that there was no basis to conclude that the initial review conducted by the nurse was inappropriate or inadequate in any way.

The coroner found that nursing staff had instructed corrective officers to look for signs and symptoms in relation to drug withdrawal, but that these instructions were ineffectual. The coroner found that this was because the adult’s Health Problem Notification Form (HPNF) had not been read by any of the corrective officers on shift on the night of the incident. The coroner found that the observations of the adult in their cell were inadequate.

The coroner found that no feature of the adult’s presentation or history suggested they had peritonitis, and therefore found that their care and treatment at the hospital was reasonable and appropriate.
Coronial recommendations

The coroner made the following recommendations related to this case:

To the Commissioner for Corrective Services NSW:

- That consideration be given to amending the Custodial Operations Policy and Procedures (COPP) to provide that information contained in a Health Problem Notification Form (HPNF) relating to an inmate, particularly information that relates to the type of observation required, how frequently such observations are to be performed, and by whom the observation will be attended, be reproduced in a form and placed in a location that is readily accessible and visible by Corrective Services NSW (CSNSW) staff rotating between shifts.

- That consideration be given to amending the COPP to provide that part of the responsibilities of a CSNSW Officer in Charge is to ensure that CSNSW staff under their supervision, who are rotating between shifts, are aware of:
  - information contained in a HPNF relating to an inmate, particularly information that relates to the type of observation required, how frequently such observations are to be performed, and by whom the observations will be attended; and
  - information provided by a Justice Health & Forensic Mental Health Network (Justice Health) clinical staff member, following the clinical assessment of an inmate, in relation to any ongoing health concern that the inmate may have.

- That consideration be given to collaboration with Justice Health in order to devise appropriate and regular education and training programs delivered by Justice Health clinical staff to ensure that CSNSW staff are aware of:
  - the importance of the contents of a HPNF in relation to an inmate’s good health;
  - how to correctly understand instructions contained in a HPNF which relate to observing an inmate’s signs; and
  - how to effectively carry out instructions contained in a HPNF which relate to ensuring that inmate’s good health, particularly those instructions which relate to the type of observation required, how frequently the observation should be made, and by whom the observation will be attended.

- That consideration be given to conducting a review of local procedures at the [remand centre] in order to determine whether:
  - appropriate directions are provided by senior CSNSW staff to other CSNSW staff; and
  - whether appropriate monitoring equipment exists; to allow for instructions contained in a HPNF which relate to observing an inmate are able to be followed and implemented effectively in order to ensure that inmate’s good health.

- That consideration be given to amending the COPP to provide that in response to a cell call alarm relating to an inmate with a health care issue previously identified by Justice Health clinical staff:
  - responding CSNSW staff should attend the cell in the company of a Justice Health clinical staff member in order to ascertain that the inmate is in good health;
o in the event that a Justice Health clinical staff member is unable to attend the cell, responding CSNSW staff should approach the task of ascertaining whether the inmate is in good health with a high index of suspicion; and
o in the event that a Justice Health clinical staff member is unable to attend the cell, responding CSNSW staff are to advise the Justice Health Nurse Unit Manager or Nurse in Charge as soon as possible after the cell attendance of the results of speaking directly to, and visually inspecting, the inmate.

To the Chief Executive, Justice Health & Forensic Mental Health Network (Justice Health):

• That consideration be given to the circumstances of [the deceased’s] death (with appropriate anonymization, and conditional upon consent being provided by [the deceased’s] family and following appropriate consultation with them) being used as a case study as part of training provided to Justice Health clinical staff in relation to treatment of inmates presenting with drug withdrawal-like symptoms.

• That consideration be given to collaboration with Corrective Services NSW (CSNSW) in order to devise appropriate and regular education and training programs delivered by Justice Health clinical staff to ensure that CSNSW staff are aware of:
  o the importance of the contents of a HPNF in relation to an inmate’s good health;
  o how to correctly understand instructions contained in a HPNF which relate to observing an inmate’s signs; and
  o how to effectively carry out instructions contained in a HPNF which relate to ensuring that inmate’s good health, particularly those instructions which relate to the type of observation required, how frequently the observation should be made, and by whom the observation will be attended.

• That consideration be given to requiring that following the clinical assessment of an inmate by a Justice Health clinical staff member, and where the inmate is deemed to have an ongoing health concern, the Justice Health clinical staff member is to provide a verbal and written handover to the first available CSNSW Officer in Charge (OIC) of the area where the inmate is housed in order to ensure that the inmate’s health concerns are adequately and appropriately managed.

• That consideration be to amending Policy 1.231 Health Problem Notification Form (Adult) to provide that in the event of a request from CSNSW staff relating to responding to a cell call alarm initiated by an inmate with a health care issue previously identified by Justice Health clinical staff, a Justice Health clinical staff member is to accompany CSNSW responding staff to the cell in order to assist in ascertaining that the inmate is in good health.

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Coronial recommendations: Fatal facts

Case number | NSW.2015.169
Primary category | Child and infant death
Additional categories | Physical health
Fatal facts edition | 58 – cases closed between July and September 2018

Case summary

A female child died as a result of accidental hanging while in respite care at hospital.

The child had profound physical and cognitive disabilities and required a high level of full-time care. The child commenced respite periods in a care facility that provided a high level of care for children in similar circumstances. The child’s patient risk profile noted that they were prone to wriggling in their cot, but they were not noted as a fall risk.

The child transitioned to a bed to match their sleeping arrangements at home. They were admitted for several weeks of respite care. During a nightly check, the child was discovered to have fallen from their bed and were hanging by their neck by their t-shirt that was hooked to a part of the bed. Resuscitation attempts were made but the child died soon afterwards.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that critical information regarding the child’s sleeping arrangements at home were lost in the hospital system, resulting in an unsafe sleeping environment for the child. The coroner found that the bed was not adapted in an appropriate way for the child’s needs given their age, physical stature, mobility and medical conditions.

The coroner found that the child’s admission form incorrectly noted them as being “completely immobile”. The child was able to move and was known to move around in bed frequently. The bars on the edge of the bed were not designed as fall prevention, and the child was small enough to fall between the gap in the bars at the top of the bed.

The coroner found that no risk assessment was conducted when the child was moved from a cot to a bed. The coroner found that the facility failed to implement proper systems for risk assessment, bed selection and the training of staff for a child patient with profound disabilities.

Coronial recommendations

The coroner made the following recommendations related to this case:
To the Minister for Health:

- It is recommended that a group of appropriately qualified experts, in consultation with organisations that represent or care for children with physical and neurological disabilities develop a standard, guideline or other type of publication, which is directed to improving the safety of beds used by children with physical and/or neurological disabilities including:
  - How to conduct a thorough assessment, taking into account characteristics such as any movement disorder and bed mobility to determine the risk of entrapment, entanglement, fall or injury to a child. That such assessment occur prior to a child with a physical and/or neurological disability being placed in any bed. The assessment of bed accessories or equipment, and strategies to eliminate or appropriately minimise risks.
  - Recommended appropriate training in relation to the matters listed [...] above.
  - Recommended proper review procedures or re-evaluation of the matters listed [...] above.
  - Any other matter that the group considers appropriate to ensure bed safety.
Coronial recommendations: Fatal facts

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Case summary

A young female died in the course of a police operation.

The young person was diagnosed with Attention Deficit Disorder as a child, and later was diagnosed with Asperger’s Syndrome. They attended a psychiatrist several weeks prior to their death, who cast doubt on the diagnosis of Asperger’s and was of the view the young person suffered from a major depressive disorder.

The young person left their home carrying a large kitchen knife on the day of the incident. They were witnessed behaving strangely by a member of the public who contacted police. Before police arrived, the young person encountered other members of the public who noted they were not aggressive or threatening but considered the situation to be unpredictable, and also called police.

When police arrived, they ordered the young person to drop the knife. Police attempted to incapacitate them using a taser and capsicum spray, both of which were unsuccessful. The young person did not respond to repeated orders to drop the knife and advanced on a police officer. The officer shot the young person as a result. They were transported to hospital where they were declared deceased shortly afterwards.

Coronial findings

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

The fatal incident occurred within minutes of police arriving. The coroner was unable to determine whether the young person intended to harm the police officer they were advancing upon. The coroner found that the police officer had reason to believe that they were in danger at the time they fired their weapon.

The coroner found that while the officers involved did not breach police policies or procedures in their interaction with the young person, their response was not appropriate. The coroner found that alternate communication skills could have been used to attempt to disarm them, rather than the immediate use of weapons. The coroner found that further
training was needed for police officers in relation to responding to persons with mental health issues.

The coroner found that the young person was likely suffering a psychotic episode due to undiagnosed schizophrenia at the time of the incident. Their lack of response to police officers’ presence and their unusual behaviour indicated a significant psychotic episode. The coroner found that despite all reports from the public noting that the young person was exhibiting behaviour consistent with disturbed mental health, the responding police officers did not consider this in their decisions about how to interact with the young person on arrival.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the NSW Commissioner of Police:

• Consideration be given to the Mental Health Intervention Team (MHIT) and Weapons and Tactics Policy and Review (WTPR) establishing and documenting a joint review of training packages for defensive tactics training where mental health is likely to be a relevant factor.

• 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.

• Consideration be given to requiring all present Operational Safety instructors to complete the four day MHIT training. This should be undertaken as soon as practicable, while ensuring the availability of Operational Safety instructors to meet ongoing accreditation requirements.

• Consideration be given to the MHIT and WTPR jointly pursuing a program of:
  o reviewing international learning with respect to first responder interactions with persons in mental health crisis and
  o designing defensive tactics training that seeks to embody the learning obtained from the review.

• Consideration be given to requiring that all police radio and Triple 000 operators undertake training by the MHIT in skills which will better equip them to recognise signs of mental health disturbance in reports from police and civilians.

• Consideration be given to developing criteria by reference to which police radio operators may identify an incident as possibly involving a person in mental health crisis.

• Consideration be given to developing and implementing a system to dispatch four day MHIT accredited officers as first responders in cases which meet criteria indicating possible mental health crisis.

• Consideration be given to developing a mandatory training package for all police officers other than commissioned officers, and specifically including Local Area Commanders, to ensure understanding of the protocol for responding four day accredited MHIT officers.
• Consideration be given to reviewing the four day MHIT program to include more experiential learning, in the form of role play exercises.
• Consideration be given to offering MHIT booster training on a one to three year basis.
Coronial recommendations: Fatal facts

Case summary

An adult male died due to drug toxicity.

The adult had a long history of drug and alcohol dependence and was a voluntary inpatient at a hospital drug withdrawal facility. They sought treatment a couple of days before their death, which coincided with a public holiday weekend. They were classed as high risk due to alcohol withdrawal and the likely combination of withdrawal medications they would require.

The adult was administered diazepam, and soon began self-reporting severe opioid withdrawal symptoms. Nursing staff rang the on-call medical consultant for advice and were told to begin buprenorphine for opioid withdrawal treatment.

Nursing staff administered an initial dose to the adult and noted that the adult’s pupils were pinpoint. A second dose was administered shortly afterwards, and a third dose the following day. The adult was discovered unresponsive in their room by nursing staff. Despite resuscitation attempts, they passed away later that day.

Coronial findings

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

The coroner found that due to the public holiday weekend, staffing was limited, and the on-call doctor was servicing several health districts in the area.

The coroner found that pinpoint pupils were a sign of opioid toxicity, and this coupled with the adult’s stabilising withdrawal symptoms indicated that further doses of buprenorphine were excessive. The coroner found that the adult was administered nearly twice the amount of buprenorphine recommended for the first 24 hours of withdrawal treatment.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the Chief Executive Officer, [location] Health District:
• That in determining whether to admit a patient with complex needs to [facility], consideration be given to admitting the patient earlier rather than later in the week, so as to allow maximum medical coverage.

• That consideration be given to a review by a group of addiction medication specialists convened by the Local Health District, of the Department of Human Services (DHS) Medication Guidelines for Inpatient Detoxification in light of the NSW Clinical Guidelines: Treatment of Opioid Dependence (2018), with respect to the prescription and administration of buprenorphine. Areas for review should include appropriate dosing guidelines, guidance about the effects of buprenorphine when administered with other sedating drugs, and clarification of the terms ‘PRN’ ['as needed'] and ‘breakthrough' doses and when these are appropriate.

• That consideration be given to further training for nurses working in [facility] with respect to the following:
  o The DHS Medication Guidelines for Inpatient Detoxification
  o The NSW 2018 Clinical Guidelines: Treatment of Opioid Dependence
  o Clinical management and monitoring of sedation in inpatients including the co-administration of benzodiazepines and buprenorphine
  o Clinical judgment in PRN administration of buprenorphine and breakthrough doses
  o The steps to be taken where a patient is found unexpectedly to be intoxicated.

• That a copy of the DHS Medication Guidelines for Inpatient Detoxification be available at the Nurses’ Station at [facility].

• That [facility] consider introducing a sedation chart to observations kept for patients who are administered buprenorphine and/or benzodiazepines.
Coronial recommendations: Fatal facts

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Case summary

An adult female died due to prescription drug overdose. The adult had a substantial medical history and had received a wide range of medication. They resided in a household where drug use was frequent and household members becoming unconscious was not uncommon.

The adult was witnessed taking medication on the day of the incident and was soon noted to be in a slumped position. Family members were not concerned. The adult’s partner attempted to wake them but was unsuccessful. A few hours later, the adult was still unable to be roused and emergency services were contacted. They were found to be deceased.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that if the adult had received more immediate medical attention, they would have survived the overdose, and that there was a lack of appreciation for the danger they faced when they were initially unable to be roused.

The coroner found that the adult had obtained multiple prescription medications from different doctors, and had the prescriptions filled at different pharmacies. None of the adult’s doctors considered them to be a typical drug user, as their prescription requests were compelling given their medical history.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the Minister for Health:

- I recommend that urgent consideration is given to raising the priority for the introduction of Real Time Prescription Monitoring (RTPM) in NSW. I recommend that the Ministry plan and publish a timetable for the scheme’s commencement.

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Coronial recommendations: Fatal facts

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Case summary

An adult male was reported missing by their family. Their remains were found in bushland a few years after they were reported missing.

Coronial findings

The coroner found that the death was due to assault.

The coroner found that the adult may have been involved in criminal activity prior to their death.

The coroner was unable to determine how the adult died but concluded that the death was not accidental.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the death of [the deceased] be referred to the Unsolved Homicide Unit of the NSW Police Homicide Squad for further investigation.
Coronial recommendations: Fatal facts

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Case summary

A young male died due to self-inflicted injuries. They were a prisoner at the time of their death.

The young person had a history of drug and alcohol abuse and had been diagnosed with several psychological disorders. They had been housed in a high-risk management area of a prison for several years prior to their death.

The young person activated their cell alarm (known as the ‘knock-up’) on the night of the incident and informed the answering officer that they had injured themselves. The officer did not understand what the young person was saying but called roving officers to check on them. The young person called a second time. The officer misheard them and considered their request was not urgent and could wait until the morning. Roving officers briefly observed the cell door without observing the cell itself and left without checking on the young person’s welfare. After the roving officers left, the floor outside the young person’s cell became wet. During the night several officers walked over the wet area without paying attention to it or checking on the young person’s welfare.

During head count the following morning, officers discovered the young person unresponsive with obvious injuries. They were declared deceased on arrival of medical staff.

Coronial findings

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

The coroner found that had the young person received medical attention in the few hours following their knock-up call, it is likely they would have achieved a complete recovery.

The coroner found that the response by both the knock-up call officer and roving officers was inadequate. In addition, the roving officers neither noticed or reported the water flowing from the young person’s cell during the night. Had had they more closely inspected the area, this may have led to further investigation of the cell.

The coroner found that although the young person was at risk of self-harm, there was no clear requirements for correctional officers to restrict access to sharp objects.
The coroner found that placing the young person in isolation precipitated, amplified and perpetuated their mental illness. Consideration was not given to transferring the young person for mental health treatment due to high demand for, and low supply of, mental health beds for correctional inmates.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the Minister for Corrections, the Minister for Health, Justice Health and Commissioner of Corrective Services NSW (CSNSW):

- That CSNSW and Justice Health, undertake a review to determine whether the number of beds available for the treatment of mentally ill patients is adequate for the demand for such beds by those in the NSW correctional system and whether additional beds may be provided for those who are mentally ill and in need of various levels of mental health care. This review should include inpatient, step-down and low acuity beds Statewide.

To Corrective Services New South Wales (CSNSW):

**Knock-Up System**

- That steps be undertaken to improve the audio-quality of the Knock-up System at the [high risk management area].
- That the Local Operating Procedures at the [high risk management area] be amended to require a Corrective Service Officer, in the Control Room or elsewhere, who receives an unclear knock-up call to reverse knock-up the caller to clarify the reason for the knock-up.
- That a Corrective Services Officer who receives a knock up call records the call, the action taken (if any) and the officers involved.
- That all Corrective Services Officers at the [high risk management area] be provided with regular training on COPP and Local Operating Procedures including new Local Operating Procedure HRM/002.

**Rovers**

- That Rovers on C and B Watch enter the [high risk management area] deck and open the hatch to the external door of each cell to conduct a visual check on the welfare of the inmate at least once per Watch. That additional security support for the Rovers be provided, if necessary, in order to do so.
- That Rovers on C and B Watch inspect the rear yards of cells at the [high risk management area] on their rounds and report anything unusual to the Night Senior, including the escape of blood or water from cells.

**Access to Razors**

- That CSNSW formally consult with a Justice Health Mental Health Nurse as to whether an inmate at the [high risk management area] should have access to razors, other sharps or
obvious ligatures where the inmate has recently engaged in or threatened self-harm or suicide or has been supervised by a Risk Intervention Team (RIT).

**Family Visits**
- That CSNSW streamline the process for approving visits for inmates in the [high risk management area].

To Justice Health & Forensic Mental Health Network ("Justice Health") and CSNSW:
- That CSNSW ensure that Justice Health are provided with:
  - real time information about inmates in isolation at the [high risk management area];
  - appropriate access to inmates kept in isolation at the [high risk management area] by Justice Health staff; and
  - access to telehealth facilities. and, on that basis, Justice Health are to amend Justice Health Policy 1.360 Segregated Custody to apply to those kept in isolation at the [high risk management area] and who have a mental illness, whether or not the patient is in segregation.

To Justice Health:
- Where the treating psychiatrist has concluded that isolation or segregation is adversely affecting the mental illness of a patient at the [high risk management area] the treating clinician, by way of a formal notification process, brings to the attention of the General Manager of the [high risk management area] the effect of isolation on an inmate’s mental health.
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 passenger.

The adult was fatally injured when a tree fell onto the vehicle in which they were travelling. The driver was obeying the road rules and was unable to take evasive action before the tree struck the vehicle. The adult died at the scene.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that there was a violent storm on the day of the incident and the wind was very severe. Several other trees in the area fell as a result of the wind.

The coroner found that the system in place by the local council was inadequate to identify trees which were a potential hazard.

Coronial recommendations

The coroner made the following recommendations related to this case:

I recommend to the Mayor and Councillors of [local council] that:

- [Local council] adopt, and continue to implement, an appropriate tree management plan incorporating the principal features of Council’s Draft Street and Park Tree Management Plan, identified by its issue date [...], suitably amended to provide for the frequency of assessment of trees to be based on risk and for persons performing those risk assessments to be qualified to at least Australian Qualification Framework Level 5 and to hold a Tree Risk Assessment Qualification or similar.

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 | NSW.2016.896
Primary category | Transport and traffic related
Additional categories | Law enforcement, Work related
Fatal facts edition | 58 – cases closed between July and September 2018

Case summary
An adult male died due to a vehicle incident during a police operation.

The adult worked as a police officer and was dispatched to intercept a vehicle being pursued by other police vehicles. After some time, they reported over the police radio that they were not able to travel to the vehicle’s location in time to intercept it.

The other police vehicles involved in the pursuit lost sight of the vehicle, and the police members terminated their individual involvement in the pursuit via police radio (VKG). This was misinterpreted by the dispatcher as a termination of the pursuit as a whole.

A second pursuit began when the vehicle was sighted again. The police members who initiated the second pursuit did not seek or obtain permission to do so. The adult was called upon to intercept the vehicle on the road ahead. They were driving at speed to reach the location when they failed to negotiate a bend and collided with a tree. They suffered fatal injuries and died at the scene.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that some police vehicles involved in the first pursuit did not have proper authorisation to be involved. The police member in charge of the pursuit noted that had they been aware of the unauthorised police vehicles at the time, they would have called off the pursuit earlier.

The coroner found that there was some ambiguity around the use and definition of “termination” as it relates to pursuits. The coroner opined that if it had been clearly established that the first pursuit had been terminated, and if there had been consideration as to whether approval ought to be given for the re-initiation of the pursuit, the second pursuit may not have taken place.

The adult’s global positioning system (GPS) location was not available in their vehicle for communication officers to monitor the pursuits on screen. The coroner found that the lack of information provided and requested about the adult’s location was contrary to procedures.
The coroner noted that the police service expressed an intention to improve training on location communication and police safety, and therefore did not make a recommendation in this regard.

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 reviewing the current version of the NSW Police Force Safe Driving Policy to ensure that it provides:
  - an unequivocal definition of the term “termination” as it relates to pursuits;
  - clear indication as to whether, and in what circumstances, losing sight of a pursued vehicle amounts to termination of a pursuit; and
  - for consistency in language and instructions to police officers in relation to when a pursuit is terminated.

- I recommend that consideration be given to the establishment of a standard VKG broadcast at the termination of a pursuit to:
  - confirm the termination of the pursuit;
  - direct involved police officers to cease pursuing and stop following a pursued vehicle, and to return to driving at the legal speed limit; and
  - remind involved police officers of the requirement for approval to be given before a pursuit is re-initiated.

- I further recommend that the establishment of such a standard VKG broadcast to be incorporated into relevant training packages provided to both VKG Shift Coordinators and VKG dispatchers.
Coronial recommendations: Fatal facts

Case number | NSW.2016.4157
Primary category | Fire related
Additional categories | Child and infant death, Domestic incident
Fatal facts edition | 58 – cases closed between July and September 2018

Case summary
A female child died as a result of injuries sustained in a house fire.

The child resided with their family in a rental property. They were diagnosed with autism and did not always recognise danger. The day before the fire, the family celebrated a birthday and had candles on a cake. The child enjoyed the process of blowing the candles out.

The family awoke to the smell of smoke on the day of the incident and discovered the house was alight. The family escaped the house and the child’s parent re-entered the house to locate and rescue the child. They recovered the child who had suffered severe injuries. The child was transported to hospital where they succumbed to their injuries a few weeks later.

Coronial findings
The coroner found that the death was unintentional.

On inspection of the property, candles and matches were found in the kitchen. The coroner noted that the family had put the candles and matches in a cupboard and tied the handles, but that it was still possible to open the cupboard enough for a child’s hand to fit inside.

The coroner found that the smoke alarms in the house were not operational at the time. The estate agents were aware that the smoke alarms were not working but did not inform the owner of the property or seek to rectify this.

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

Minister of Innovation and Better Regulation:
• That consideration is given to an amendment to schedule 1 of the Residential Tenancy Regulations in relation to the Standard Form Agreement to include a provision requiring landlords to replace batteries in smoke alarms at either the commencement of each new lease (or at a minimum annually) if the respective smoke alarm does not have a non-removable battery attached to it.
• That consideration is given to introducing a system where a Certificate of Compliance is included as part of the residential tenancy agreement for all residential dwellings certifying that the rental property has a valid smoke alarm(s) which comply with the current regulatory requirements. The Certificate of Compliance is to be certified by an appropriately qualified person in fire protection services and such certificate should certify the smoke alarm:
  o has been properly installed in the correct location
  o has been tested and cleaned in accordance with the manufacturer's instructions
  o is working effectively
  o contains an attachment with a diagram of the location of each smoke alarm inside the rental property.

• That consideration is given to introducing an amendment to the definition of “urgent repairs” in s62 of the Residential Tenancy Act to specifically include a ‘smoke alarm that is not working’.

• That consideration is given to developing a Fire Fact Sheet for tenants and landlords which specifically and clearly outlines the responsibilities of both parties in relation to the maintenance of any smoke alarm. Without limiting such information, it is recommended that the fact sheet include relevant information on the following areas:
  o explanations regarding how and when to test, clean and change batteries
  o information containing photographs of different smoke alarm models and the different type of smoke alarm technologies which are currently on the market
  o who a tenant should contact in the event a smoke alarm is suspected or found not to be working
  o what to do in the event a smoke alarm is activated, including what procedures might be adopted in the event of a fire
  o who is responsible for fixing or replacing a smoke alarm
  o the time frame and powers of entry for which a landlord should correct or rectify any fault
  o who to contact in the event of a fire or in the event a landlord has not rectified a fault within a reasonable time frame.

• That urgent consideration is given to finding strategies to improve the education of real estate agents in relation to fire safety. Consideration should be given to the introduction of a mandatory CPD [continuing professional development] training obligation requiring all real estate agents and property managers to cover the topic of ‘risk management’ which would incorporate relevant information on the importance of smoke alarms and the current legislative requirements. The training should include case examples. I further recommend that the facts of this coronial investigation be included in the content of any material on this topic area.

• That consideration is given, in consultation with the relevant stakeholders, to making an amendment to the Property, Stock and Business Agents (Qualifications) Order 2009 to
introduce a competency of “risk management” for persons seeking a career or qualification in property services or property management within NSW.

Real Estate Institute:
- That the Institute immediately contact all members and disseminate information regarding the findings of this inquest for purpose of advising and educating members in relation to the importance of smoke alarms being thoroughly checked during periodical inspections.

Ministers for Innovation and Better Regulation, Planning and Environment, Local Government & Emergency Services (responsible for FRNSW):
- That consideration is given to establishing and auspicing an inter-governmental committee or working party with representatives from all relevant departments or organisations with the objective of developing a co-ordinated approach to increasing public awareness of and compliance with fire prevention strategies in NSW.
- That the committee develop a document/brochure similar to that proposed in [above recommendation] which can be utilised by Local Councils and disseminated when required throughout their municipalities.
- That the committee conduct an analysis and review of factors relevant to non-compliance in the community with a view to developing strategies which could be jointly or independently implemented to improve awareness and compliance with the legislation governing smoke alarms in all residential dwellings.

Minister for Police & Emergency Services:
- That the Minister give consideration for an award to be provided to [the deceased’s parent] for their enormous bravery and selflessness in returning inside their home, prior to the arrival of FRNSW and successfully retrieving [the deceased] from a significant fire.

Minister for Planning:
- That consideration is given to amending the Environmental Planning and Assessment Regulation 2000 to commence the staged introduction of changes to the current law in relation to all existing “residential buildings”. The new requirements should provide that smoke alarms are installed:
  - In every bedroom and where bedrooms are served by a hallway, in that hallway, and all living or entertaining rooms
  - In the case where there is more than one alarm required that they shall be interconnected by hard wiring or wireless signal.
  - That all battery operated smoke alarms in existing dwellings be powered by a 10 year non removable battery or similar technology which does not require ongoing regular replacement.
Australian Building Codes Board (ACBC):
- That the ABCB support and introduce amendments to the National Construction Code and Building Code of Australia in relation to new buildings in line with the recommendation set out at [the recommendation to the Minister for Planning].
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>The coroner held a joint investigation into the following deaths which resulted from similar incidents: NSW.2017.1708, NSW.2016.2040, NSW.2016.4129</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>Location, Law enforcement</td>
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<td>Fatal facts edition</td>
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Case summary – NSW.2017.1708

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

The adult had a history of depression and a suicide attempt several years earlier. They had a recent history of driving offences which were a source of stress for them. After the adult’s friends were unable to contact them, a search commenced. Their vehicle was located near a known suicide location. Their body was located in the ocean the following day.

Case summary – NSW.2016.2040

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

The adult had a recent history of depression, mania and suicidal ideation. The adult did not return home at the expected time on the day of the incident and their family contacted police. Phone triangulation led police to a cliff where the adult’s body was observed on the rocks below.

Case summary – NSW.2016.4129

An adult male died as a result of a deliberate fall from a cliff.

The adult had a history of depression, mania and suicidal ideation. Several months prior to their death they were scheduled under the Mental Health Act and spent time in a psychiatric unit.

The adult told their family they were going out to run errands on the day of the incident. The family became concerned when the adult did not return, and a search commenced. Phone triangulation led police to a cliff where the adult’s body was observed on the rocks below.

Coronial findings

The coroner found that the deaths were due to intentional self-harm.
The coroner found that the geographical area where the deaths occurred posed problems to police in relation to phone triangulation. The coroner also noted that police did not receive adequate training to conduct negotiations with potential suicidal persons.

The coroner noted that National Parks and Wildlife were already drafting a plan to implement suicide prevention strategies in another known suicide location and found that the location of these deaths would benefit from similar prevention strategies.

Coronial recommendations

The coroner made the following recommendations related to these cases:

NSW Police:

- That the NSW Police Force works to develop a short training course focused on the skills required for de-escalating situations where a person is threatening self-harm by jumping from a height. The course should be designed for, and offered to, first-response officers in those commands with the highest incidence of suicide by jumping from heights.
- That the NSW Police Force continue to engage with the telecommunication industry to improve the access of police to technology that will allow reliable and real time tracking of people thought to be threatening self-harm on [location].

National Parks and Wildlife Service (NPWS):

- That the National Parks and Wildlife Service consult with appropriate experts to ensure that suicide prevention strategies are incorporated into the [location] Concept Plan before the plan is finalised and implementation begins. Suicide prevention strategies considered should include the following:
  - Restricting access to potential jumping sites through use of appropriate barriers or structural design.
  - Encouraging help-seeking. For example, through the use of signs with numbers for support services, the installation of phones that link directly to support services, or the use of Near-Field Technology.
  - Increasing the likelihood of intervention by third parties. For example, by increasing the likelihood that other people will be present, or the installation of CCTV [closed-circuit television] cameras at likely jump sites. Consideration should also be given to numbering signs around the park so that if a by-stander is reporting a person that appears to be considering self-harm they can easily communicate their location within the park.

[Location] Council:

- That the [location] Council, Community Safety Committee, support and assist the [location] Police Area Command in lobbying [telecommunications companies] to install a telephone tower or other appropriate technology on the [location] to improve the ability to track the mobile phones of people threatening self-harm on the [location].
• That the [location] Council continues to auspice and support the Community Safety Committee.

• That the [location] Council, Community Safety Committee work with all relevant stakeholders, including the NPWS, Police Local Area Command and Lifeline to determine suitable places on the [location] to trial Near Field Technology.

Catholic Archdiocese of [location]:

• That the Catholic Archdiocese of [location], consider the implementation of suicide prevention strategies around the cliff tops at [location]. The Catholic Archdiocese should be guided by the [location] Council, Community Safety Committee. Strategies considered should include:
  o Restricting access to potential jumping sites through use of appropriate barriers or structural design,
  o Encouraging help-seeking. For example, through the use of signs with numbers for support services, the installation of phones that link directly to support services, or the use of Near-Field Technology,
  o Increasing the likelihood of intervention by third parties. For example, by increasing the likelihood that other people will be present, or the installation of CCTV cameras at likely jump sites.

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: NSW.2017.2808
Primary category: Mental illness and health
Additional categories: Indigenous
Fatal facts edition: 58 – cases closed between July and September 2018

Case summary
An indigenous adult female died after absconding from their mental health unit. They were an involuntary patient at the time of their death.

The adult was suffering from paranoid schizophrenia. After absconding they walked into desert scrubland and their body was never recovered.

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

The coroner found that the death was unintentionally caused by misadventure.

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

To the [location] Health District:
- That funding is requested for an additional Aboriginal Health Liaison Officer to be rostered to work on the weekends and to be on call overnight, for Aboriginal mental health patients at [hospital].
- That consideration is given to the implementation of a system to ensure Aboriginal Mental Health Inpatients, who do not have leave, be granted personal access to an Aboriginal Mental Health Worker or an Aboriginal Health Liaison Officer.

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NORTHERN TERRITORY

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

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<thead>
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<th>Case number</th>
<th>NT.2016.217</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, Work related</td>
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<tr>
<td>Fatal facts edition</td>
<td>58 – cases closed between July and September 2018</td>
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</table>

Case summary

A middle aged female took their own life by hanging.

The adult was employed within a state government department. They had ongoing significant mental health issues that appeared to be impacting their working environment. The adult’s manager was aware of the situation and temporarily demoted the adult to relieve some of the workload. The adult was given little prior warning about the meeting in which their demotion was discussed.

Some days after the demotion, the adult did not attend work due to anxiety. The following day the manager humiliated the adult in front of their work colleagues. The adult was discovered deceased in their home a couple of days later.

Coronial findings

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

The coroner found that the manager was trying to reduce the adult’s anxiety by giving them little warning about the meeting discussing their demotion. The coroner found that due to the short time frame, the adult was not made aware that they could bring a support person into the meeting with them.

The coroner found that the public humiliation was likely a critical event for the adult in the context of their fear of losing their job.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Chief Executive Officer of the [department] do all things required to ensure the managers and HR [human resources] personnel within the Department are aware of their responsibility toward employees and in particular to refrain from bullying behaviour;
- That the Chief Executive Officer of the [department] continue the training of all managers and HR personnel to ensure a sound understanding of the appropriate supportive
behaviours and accommodation of persons suffering impairment (as defined in the Anti-Discrimination Act);

- That the [health service] ensure that the Mental Health Services keep proper patient notes and undertake all appropriate communication with stakeholders such as families, General Practitioners and other treating professionals.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>NT.2017.81</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Adverse medical effects</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>58 – cases closed between July and September 2018</td>
</tr>
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</table>

Case summary
An older male died of septic shock due to a perforated bowel.

The adult was admitted to hospital with abdominal pain and a hiatus hernia, for which they underwent surgery. After they were discharged, the adult continued to experience abdominal pain and re-presented to hospital. They were thought to have intra-abdominal sepsis and underwent further surgery to identify the source.

The surgery identified multiple injuries to the bowel. The adult remained critically ill and underwent several further surgeries over the following days. Their injuries were found to be incompatible with survival and they passed away the next day.

The death was not reported to the coroner until several years later.

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

The coroner found that the adult waited a couple of days after re-presenting to hospital. An expert opinion at inquest noted that the adult’s deterioration was clear at this point and they should have been taken into surgery earlier. The coroner found that the adult’s level of pain was overlooked and that appropriate diagnosis was delayed.

The coroner found that the adult’s family had no explanation about the adult’s death except via the death certificate. The communication with the family was poor, and they had to wait several years to find out why the death occurred.

The coroner found that the death should have been reported at the time, as it was unexpected until the final hours of the adult’s life.

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

- I recommend that [health service] ensure that medical staff have all necessary induction and training in relation to appropriate communication with patients and families about symptoms, pain, prognosis, risk of procedures and limits of care.
• I recommend that [health service] speak to families after the death of a loved one and ensure that the family have been afforded proper communication, open disclosure and their reasonable needs are being met.

• I recommend that [health service] ensure that all deaths of patients that are reportable pursuant to the Coroners Act are reported in accordance with the law.
Coronial recommendations: Fatal facts

Case number | NT.2017.110
Primary category | Adverse medical effects
Additional categories | Physical health
Fatal facts edition | 58 – cases closed between July and September 2018

Case summary
An older male died due to sepsis while in hospital.

The adult attended hospital and was found to have Stage 4 colorectal cancer and obstruction of the bile duct. They underwent operations to cannulate the bile duct, but these were unsuccessful. A visiting interventionalist radiologist positioned a biliary wall stent. The adult complained of pain around the stent insertion site and their condition began to deteriorate. A gas filled collection was identified but a procedure was not performed to drain the collection as there was insufficient time that day. The procedure was booked for the following day, but the adult deteriorated and died soon after the initial procedure was postponed.

The most junior doctor on the adult’s treating team, an intern, was tasked with explaining the adult’s sudden deterioration and death to family members.

The death was not reported to the coroner as a staff member had advised that they had spoken to the coroner and that the death was not reportable.

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

The coroner found that the adult was in pain and did not receive treatment for many hours, despite informing doctors of their serious symptoms. There was a lack of urgency in making a diagnosis after the adult developed sepsis.

The coroner found that there was a failure to communicate appropriately with the adult and their family. There was no discussion about the limits of care with the adult until the final hours of their life, and no such conversation took place with the adult’s family. The adult relied on their family for support and assistance, that this was not recognised by clinicians, and the family was therefore excluded from the crucial stages towards the end of the adult’s life. The coroner found that the risks of the procedures the adult underwent were not properly communicated to the family.
There was no evidence of any staff member attempting to contact the Coroner’s Office at the time of the adult’s death. The death was unexpected and from an injury from a recent procedure, and therefore reportable.

The coroner found that the adult was left untreated to die in pain. The hospital denied the communication issues and no institutional changes had been made since the death.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that [health service] require the consultants providing care and treatment to the patients of the [health service] to fulfil their obligations in leading teams, communicating with other treating professionals, communicating with families, and ensuring that any adverse events are appropriately recorded and reported.
- I recommend that [health service] ensure that medical staff have all necessary training and induction in relation to communicating appropriately with patients and families about symptoms, pain, prognosis, risk of procedures and limits of care.
- I recommend [health service] speak to families after the death of a loved one and ensure that the family have been afforded proper communication, open disclosure and their reasonable needs are being met.
- I recommend that [health service] ensure sufficient governance and audit in relation to RiskMan [risk management system] and M&M [Surgical Morbidity and Mortality] meetings to ensure they are operating as intended.
- I recommend that [health service] ensure that all deaths of patients reportable pursuant to the Coroners Act are reported in accordance with the law.
QUEENSLAND

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

Case number | QLD.2014.3197
---|---
Primary category | Adverse medical effects
Additional categories | Law enforcement
Fatal facts edition | 58 – cases closed between July and September 2018

Case summary

A young male died as a result of sepsis while detained as a refugee in a regional processing centre. The young person developed an infection while in detention. They were administered antibiotics but continued to deteriorate. They were transported to a hospital, however there was a lengthy delay in intubating and ventilating them and they went into cardiac arrest. The young person was transported to a second 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 preventable, and that the compounding effects of multiple errors caused the death. This included the failure to ensure the regional processing centre had antibiotics available for treatment, the failure to adequately detect and report a severely deteriorating patient, inadequate clinical care, and ineffective processes for patient transfer.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Department of Home Affairs develop and implement a written policy relating to the process for medical transfers requiring Australian Government approval which has, as an overriding consideration, the health and well-being of persons transferred to regional processing countries. Under that policy the approval process for medical transfers should be led by persons located in regional processing countries with clinical training in emergency medicine.
- That:
  - When an onsite clinician contacts the International SOS Assistance desk to request the medical transfer of a patient, there should be a set form, or check list, which the International SOS clinician is required to complete, including information such as:
    - An accurate picture of the clinical condition of the patient including full observations from the previous 4-6 hours, medication regimes, the effectiveness of those regimes, and physical presentation of the patient;
- An accurate reflection of the advice provided to the onsite clinician by International SOS;
- An accurate reflection of the timeframe within which the onsite clinician requires the patient to be transferred, including any flight options or transfer options that are known to the onsite clinician.

- The set form or checklist, as completed by the International SOS clinician, should form the basis of, or become an attachment to, the Request for Medical Movement (RMM) made to the International Health and Medical Services (IHMS) Assistance desk and sent to the Department of Immigration and Border Protection (DIBP).

- That clinics providing medical services to asylum seekers in regional processing countries be accredited to a level equivalent to the Royal Australian College of General Practitioners Standards for health services in Australian immigration detention centres.

- That the Department of Home Affairs and IHMS (and other service providers) collaborate, in conjunction with the Royal Australian College of General Practitioners, to ensure the implementation of a standard clinical audit tool at all regional processing country clinics.

- Consistent with the outcomes of the 2015 review of the [regional processing centre] clinic conducted by the DIBP, I recommend that as part of clinical audit processes, the Department of Home Affairs allocate sufficient and extended time to observe the clinical practices and processes at clinics providing health care to persons transferred to offshore processing countries. This will entail a medical record or inventory audit, as well as physically sitting in on medical consultations. On at least an annual basis, clinical audits should be undertaken in conjunction with the Royal Australian College of General Practitioners.

- That the Department of Home Affairs ensure that critical care units are established in close proximity to the centres where persons who have been transferred to regional processing countries are required to live, consistent with the Standards for the Provision of Quality Emergency Medical Care developed by the Australasian College for Emergency Medicine.

- That the critical and intensive care capacity of the [hospital] be benchmarked against relevant Australian standards developed by the College of Intensive Care Medicine and the Australasian College for Emergency Medicine.

- That the Commonwealth Attorney-General establish and fund a statutory framework to ensure the independent judicial investigation of the deaths of asylum seekers transferred by the Australian Government to regional processing countries. This may require that deceased persons are transferred back to Australia to ensure appropriate post-mortem examinations can be carried out. Amendments to contractual arrangements to require service providers to co-operate with such investigations would also be required.

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

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<th>Case number</th>
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<td>Additional categories</td>
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</tr>
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<td>Fatal facts edition</td>
<td>58 – cases closed between July and September 2018</td>
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Case summary

An older male died as a result of injuries they sustained in a deliberate fall from a height. They were a prisoner at the time of their death.

The adult attempted suicide several months prior to their death by jumping from a height at the correctional centre. As a result, they suffered cognitive impairment and required advanced medical care and full nursing care for daily activities.

The adult was noted to have poor blood oxygen levels due to aspiration. The medical staff present did not take action at that time, and the adult was later discovered unresponsive. Prison staff requested for an ambulance transfer, but the adult passed away prior to ambulance arrival.

Coronial findings

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

The coroner found that the adult’s medical condition resulting from the suicide attempt placed them at risk of an aspiration event. The coroner found that the medical staff should have provided oxygen to the adult once their oxygen levels were noted. It was unclear if provision of oxygen at this time would have resulted in a different outcome.

The coroner found that there was a delay in calling a Code Blue as the nurse who discovered the adult unresponsive had never been in a similar situation.

The coroner found that there was confusion around the procedure to call an ambulance that resulted in a delayed response from emergency services.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that [prison provider], in conjunction with Queensland Corrective Services, conduct a review of the process for calling for ambulance attendance at the [correctional...
centre], and the priority given to those requests. Consideration should be given to authorising clinical staff to directly request urgent ambulance assistance.

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

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<th>Case number</th>
<th>QLD.2015.3815</th>
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<td>Additional categories</td>
<td>Work related</td>
</tr>
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<td>Fatal facts edition</td>
<td>58 – cases closed between July and September 2018</td>
</tr>
</tbody>
</table>

Case summary

A middle aged female took their own life by drug overdose.

The adult was a healthcare worker who worked for correctional services. They were preparing to be a witness in a coronial investigation into the death of a prisoner at the time of their death. The adult was under the impression that they were being singled out for scrutiny and voiced concerns over the upcoming inquest.

The adult was discovered deceased in a hotel room. A number of notes were located outlining their decision.

Coronial findings

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

The coroner found that the adult had been given appropriate support by their workplace in relation to the upcoming inquest.

Coronial recommendations

The coroner made the following recommendations related to this case:

- It is recommended that the Queensland Government facilitate and fund a program that provides counselling for families as well as witnesses or others who may be involved in and impacted by a coronial investigation and/or inquest, similar to the program currently being facilitated by the Office of Industrial Relations.
Coronial recommendations: Fatal facts

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<tr>
<th>Case number</th>
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<tr>
<td>Additional categories</td>
<td>Adverse medical effects</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>58 – cases closed between July and September 2018</td>
</tr>
</tbody>
</table>

Case summary

A female infant died from an infection due to meconium aspiration following birth trauma and head injury as a result of a fall. The infant was born in hospital and had a very low Apgar score. Whilst being transferred to another room, the nurse slipped, and the infant was dropped onto the floor, resulting in fatal injuries.

Coronial findings

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

The coroner determined that the infant was likely without oxygen for three minutes and with resuscitation the priority, the administration of antibiotics was overlooked. The coroner also found that:

- there was inappropriate care and missed opportunities both within the pre-natal care of the mother and the labour period
- appropriate resuscitation equipment was not available in birthing suite
- manual ventilation was not administered
- there was a lack of diligence in checking of medical equipment.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That resuscitation tables never use an adapter, and that proprietary brand resuscitation masks only be used on that brand’s resuscitation table;
- That a bassinet and trolley be available in each birthing suite, and the baby is only to be transported from a room by the use of a bassinet and trolley;
- That expectant mothers be informed about the incidence and issues relating to GBS [Group B streptococcus infection], and encouraged to have screening conducted, if they choose.

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 | QLD.2016.1393
Primary category | Natural cause death
Additional categories | Law enforcement
Fatal facts edition | 58 – cases closed between July and September 2018

Case summary

An adult male died as a result of pneumonia.

The adult was a prisoner in a correctional facility and had been seen by nursing staff due to prolonged flu-like symptoms. They were prescribed pain relief and antibiotics, however, were not seen by a doctor and declined to attend the medical clinic.

The adult was found unresponsive in their cell and was unable to be revived.

Coronial findings

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

The coroner found it likely that the adult deteriorated rapidly due to infection and other medical conditions.

Of note were inadequate documentation, lack of review by a doctor and the missed opportunity to arrange a more urgent medical review and further clinical investigation.

Coronial recommendations

The coroner made the following recommendations related to this case:

- It is recommended that the review currently underway by a working group of QH [Queensland Health] and QCS [Queensland Corrective Services] examining the existing MOU [Memorandum of Understanding] and Operating Guidelines and referred to in two recent inquests also include consideration of the circumstances of [the deceased’s] death and relevant coronial findings.
- It is recommended that where a Hospital and Health Service conducts a RCA [root cause analysis] in relation to the death of a prisoner who was receiving a health service, and concerns/opportunities for improvement are identified in relation to QCS policies and practices, the health service (for instance in this case [hospital and health service]) liaises with QCS to jointly review and take appropriate action (which may involve further investigation and/or development of recommendations) and ensure there is a
mechanism for gathering relevant QCS information to inform that investigation, including through interviews with QCS staff.

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

<table>
<thead>
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<th>Case number</th>
<th>QLD.2016.2655</th>
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<tbody>
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<td>Law enforcement</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>58 – cases closed between July and September 2018</td>
</tr>
</tbody>
</table>

Case summary
An adult female died from liver failure due to cirrhosis and hepatitis C infection.

The adult was a prisoner in a correctional facility and had been admitted to hospital. As most of their conditions could not be treated, the adult was referred to palliative care. However, they chose to return to the correctional facility to await results of an exceptional circumstances parole.

The adult was found unresponsive in their cell and was confirmed to have passed away.

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

The coroner found that the adult likely died from respiratory arrest due to airways compromise in a prone position, in the context of an altered level of consciousness and respiratory depression from their medical conditions, effects of medications being taken and opioid toxicity.

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

- That the Queensland Government comprehensively review the current model for the provision of palliative care to prisoners with a view to improving how and where palliative care is delivered, including the provision of a range of post-release supported accommodation options for infirm prisoners eligible for parole, including exceptional circumstances parole.
- That Queensland Corrective Services develop a formal policy in relation to the selection, training and management of prisoner carers, including a requirement that prisoner carers be trained in the provision of basic first aid.
- That the Queensland Government ensure that the Parole Board Queensland has access to any medical, psychiatric and psychological reports that are tendered during sentencing proceedings. This may be facilitated by requiring that such reports are the subject of a court order that a copy of relevant reports be provided to Queensland Corrective Services.

Services, as well as enhanced information sharing between Queensland Corrective Services and Queensland Health at the time the parole application is being prepared.

- That Queensland Corrective Services and the Parole Board Queensland prepare guidelines to assist doctors to address relevant considerations when preparing reports in relation to exceptional circumstances parole applications. The guidelines should also clarify the level of expertise required of the authors of such reports. Consideration should also be given to obtaining advice from the Clinical Forensic Medicine Unit in these matters.

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

<table>
<thead>
<tr>
<th>Case number</th>
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<tr>
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<td>Additional categories</td>
<td>Sports related, Leisure activity</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>58 – cases closed between July and September 2018</td>
</tr>
</tbody>
</table>

Case summary

An adult male died from carbon monoxide poisoning causing unconsciousness underwater and drowning.

The adult was a master diver and one of a group of divers on a chartered vessel. During a dive, the adult indicated intent to surface to their dive partner. During ascent the adult was separated from their dive partner. They did not surface and were located on the sea bed.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the compressed air in the cylinder was contaminated with carbon monoxide. As the adult ascended, oxygen levels decreased and the carbon monoxide effects continued. The adult became severely impaired, incapacitated and subsequently drowned. The source of the contamination was the electrically powered air compressor used to fill the cylinder.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the legislation relating to recreational diving (Safety in Recreational Water Activities Act 2011 and the Work Health Safety Act and Regulations together with the Recreational Diving, Recreational Technical Diving and Snorkelling Code of Practice 2011) be reviewed.
- Dive vessels’ capacity to immediately respond to a diver/swimmer drifting on the surface be reviewed. The review should have regard to the availability of a tender and the capacity of the vessel to pull anchor immediately without stranding remaining divers underwater without a line to return to.
- The Police Dive Squad be equipped with suitable initial testing device/capability of air quality, prior to formal testing.

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.
SOUTH AUSTRALIA

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

<table>
<thead>
<tr>
<th>Case number</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Homicide and assault</td>
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<tr>
<td>Additional categories</td>
<td>Aged care, Mental illness and heath, Older persons</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>58 – cases closed between July and September 2018</td>
</tr>
</tbody>
</table>

Case summary

An older adult male died due to injuries sustained in an assault.

The adult was a resident of an aged mental health facility. As a result of prior behaviour, the adult was detained in the ‘ward of last resort’ on approval of their state appointed guardian several years prior to death.

The adult appeared to have been fatally assaulted in their room at the facility by another resident. The only account of events leading to the death was provided by another adult, who also suffered dementia. As a result, the exact events leading to death were unconfirmed.

There was a recent history of two prior assaults on the adult by the perpetrator in the period leading up to their death.

Coronial findings

The coroner found that the death was due to assault.

The coroner noted that the management of the deceased and other residents was suboptimal in that:

- there was a very poor standard of care provided by the facility
- the needs of deceased and perpetrator were not met
- steps were not taken to ensure the perpetrator could not encounter deceased
- the continued detention of the deceased within the facility was inappropriate.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that this State adopt a register of resident to resident aggression in the aged care sector to be supported by a system of mandatory reporting of such incidents, and that it apply regardless of the residents’ cognitive status.
- I further recommend that the Minister for Health raise with his counterparts the proposition that such registers should be duplicated across the other States and...
Territories, or better still that there be the adoption of a National register at the Commonwealth Government level.
TASMANIA

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

Case number | TAS.2010.289
---|---
Primary category | Older persons
Additional categories | Physical health
Fatal facts edition | 58 – cases closed between July and September 2018

Case summary

An older female died due to hypothermia.

The adult suffered from advanced dementia and resided with their child and the child’s family. The adult was put to bed in a large shipping container that was being converted into living premises. The shipping container was not insulated and there were large gaps surrounding the window and door frames, which had been poorly installed. During the night, the adult passed away due to hypothermia contributed to by their dementia, severe frailty and comorbidities. They were found deceased by the family the next morning, however their death was not reported for several hours.

Coronial findings

The coroner found that the death arose from circumstances of abuse.

The coroner found that the adult was subjected to elder abuse by their family and that there were a number of ‘red flag’ points signifying potential elder abuse in relation to organisations involved in the adult’s healthcare and financial affairs.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Tasmanian government undertakes a review of legislation to determine whether current components of legislation effectively and efficiently prevent or respond to abuse, neglect or exploitation of older persons; and in the event that they do not, commence a program of legislative reform to achieve that purpose.
- That the Tasmanian government develop, as a matter of priority, a renewed Elder Abuse Prevention Action Plan, such Plan to include:
  - A strategy to ascertain the prevalence of elder abuse in the Tasmanian community;
  - A strategy for responding to and preventing elder abuse in the Tasmanian community; and
  - Establishment of a steering committee or other mechanism to ensure efficient implementation of the Plan.
• That, in developing the Plan, the government undertakes an analysis of the applicability of the recommendations for preventing elder abuse contained in *Elder Abuse – A National Legal Response* (ALRC Report 131) and the *Legislative Council General Purpose Standing Committee No.2 – Enquiry into Elder Abuse in New South Wales*.

• That the Tasmanian government give consideration to the establishment of an independent body with specific responsibility for elder abuse by, inter alia, investigating complaints, researching and responding to the ill-treatment of older people, developing community education programs and by overseeing cases where there is a risk of elder abuse.

• Alternatively, that the Tasmanian government give consideration to enhancing the powers of, and appropriately resourcing, the Office of the Public Guardian so that the above functions can be effectively performed.

• That the government give consideration to resourcing and utilising Preventing Elder Abuse Tasmania (PEAT) as an appropriately qualified advisory group in respect of both law reform considerations and other prevention strategies.
Coronial recommendations: Fatal facts

**Case number**  
TAS.2014.313

**Primary category**  
Drugs and alcohol

**Fatal facts edition**  
58 – cases closed between July and September 2018

Case summary

An adult male died due to mixed drug toxicity.

The adult was a disability pensioner who had a history of serious mental health conditions. They also had a long history of drug-seeking behaviour and had continuously been engaged in ‘doctor shopping’ in attempts to obtain medication in excess of their prescriptions.

The adult was at their home with their neighbours present and was noted to ingest multiple prescription drugs. Shortly afterward, the adult became drowsy and began slurring their words. The neighbours left, and later returned to find the adult unresponsive. An ambulance was not called. A friend later found the adult cold and unresponsive, and called emergency services. Attending paramedics confirmed that the adult had passed away.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that there were issues in managing the supply of medications to the adult due to their drug-seeking behaviour and inability to responsibly manage their own medication intake.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Minister administering the *Poisons Regulations 2008* considers amending Regulation 70 to require any person prescribing drugs of a high abuse potential (such as benzodiazepines, z-drugs, pregabalin and quetiapine) to be specifically authorised by the Secretary (as defined in the *Poisons Act and Poisons Regulations*) to do so where the patient has been reported or diagnosed as drug dependent or drug seeking.
- That the real-time monitoring system currently used in Tasmania be reviewed with a view to including a requirement for dispensing pharmacists to record the dispensing of Schedule 4 drugs of a high abuse potential on the system at the time of dispensing.
- The creation within PSB [Pharmaceutical Services Branch] of a position of Outreach Clinical Educator or similar to provide outreach clinical support to prescribers and dispensers, the functions of that position to include education of prescribing doctors,
pharmacists and others regarding appropriate practice for prescribing of Schedule 8 and Schedule 4 drugs of a high abuse potential; and to encourage greater uptake and use of DORA [Drugs and Poisons Information System Online Remote Access] by doctors.

- PSB develop and implement a revised s59E application form which requires more comprehensive information to be provided by applicants seeking authority to prescribe under section 59E of the Poisons Act 1971. Specific emphasis should be on applicants providing evidence-based risk/benefit assessment of the requested Schedule 8 regimens.

- That the Minister responsible for administration of the Poisons Act 1971 review the current Act with a view to creating a new more contemporary Act in line with modern-day practices for the regulation, control, and prohibition of the importation, making, refining, preparation, sale, supply, use, possession, and prescription of certain substances and plants.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>TAS.2014.500</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Work related</td>
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<tr>
<td>Additional categories</td>
<td>Falls</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>58 – cases closed between July and September 2018</td>
</tr>
</tbody>
</table>

Case summary

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

The adult was working as a roof plumber at a construction site. The adult was working on a roof when they stood on a batten in an area where safety mesh had not been installed. The batten gave way, resulting in the adult falling to the ground below. Witnesses came to the adult’s aid and emergency services were contacted. They were conveyed to hospital where they passed away.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the incident would not have occurred had basic safety precautions been taken.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That a review be undertaken in relation to the adequacy of training and instruction delivered within the construction industry apprenticeships schemes for SWMS [Safe Work Method Statements], particularly for working at heights.

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.2015.469</th>
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<td>Work related</td>
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<td>Additional categories</td>
<td>Transport and traffic related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>58 – cases closed between July and September 2018</td>
</tr>
</tbody>
</table>

Case summary

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

The adult worked as a tractor driver, and was undertaking mowing work on a steep embankment on the day of the incident. The tractor deviated from its expected path and drove through tall grass and shrubbery. It drove down a hill, over an embankment and came to rest in a river. The tractor was noticed by a passer-by a few hours later. Despite attempts to rescue the adult, they were found to have passed away.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the crash occurred as a result of the adult losing consciousness, and that their death may have been prevented or their injuries lessened had they been wearing a seatbelt.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That seatbelts, where fitted, always be worn by tractor drivers in all circumstances.
- Where it is practicable to do so, three-point (shoulder sash) seatbelts, rather than lap seatbelts, should be fitted to all tractors.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>The coroner held a joint investigation into the following deaths which resulted from the same incident: TAS.2016.335, TAS.2016.336, TAS.2016.353, TAS.2016.372</th>
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<tbody>
<tr>
<td>Primary category</td>
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<td>Additional categories</td>
<td>Transport and traffic related</td>
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<tr>
<td>Fatal facts edition</td>
<td>58 – cases closed between July and September 2018</td>
</tr>
</tbody>
</table>

Case summary

Four adult males died as a result of a boating incident.

The adults embarked on a fishing trip on a boat that was partially owned by one of the adults. The group did not have much boating experience, and none of them, including the boat owner, held a boating licence or held any boating qualifications.

The weather and ocean conditions on the day of the incident were fine and calm. The group were seen heading out to sea by a witness who noted that the boat looked overloaded, and the person driving was not experienced.

The alarm was raised when a member of the group was unable to be contacted. A search commenced, and three of the four adults were discovered deceased the following day, along with some items from the boat. The fourth adult and the boat were never recovered.

Coronial findings

The coroner found that the deaths were unintentional.

At inquest, previous owners of the boat and individuals who had undertaken work on the boat gave evidence that the transom of the boat was made of plywood and was rotten. As the boat was never recovered, the coroner was unable to make a finding about the exact condition of the boat at the time of the incident. The coroner opined that the boat was likely less than entirely structurally sound at the time.

The coroner found that there was insufficient safety equipment aboard the boat. There were only three life jackets aboard, and one was suitable only for a child. The boat was not fitted with a marine radio or Emergency Position Indicating Radio Beacon (EPIRB). The coroner found that few, if any, people knew of the group’s plan for the day, posing further safety concerns. The coroner found that the boat owners did not consider the capacity of the boat having regard to its age and did not have it inspected before or after purchase.
The coroner was unable to determine the precise circumstances that led to the group being separated from the boat.

Coronial recommendations

The coroner made the following recommendations related to these cases:

- That all persons purchasing a second hand boat have it inspected before use by a suitably qualified person.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>TAS.2017.24</th>
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<tbody>
<tr>
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<td>Law enforcement</td>
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<td>Fatal facts edition</td>
<td>58 – cases closed between July and September 2018</td>
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</table>

Case summary

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

The adult had been riding their motorcycle with a group of interstate riders. Their fellow riders noticed them missing when they did not arrive at their intended destination. Fellow riders retraced their route and found the adult deceased where their motorcycle had crashed.

Coronial findings

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

The coroner found that no Crash Investigation Services officer attended the scene of the incident. In their absence, the coroner was unable to conclude whether speed or any other vehicles were contributory factors to the crash.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend an officer of Tasmania Police Crash Investigation Services attend all fatal motor vehicle or motorcycle crashes.
VICTORIA

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2010.4750</th>
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<tbody>
<tr>
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<td>Mental illness and health</td>
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<td>Additional categories</td>
<td>Transport and traffic related</td>
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<tr>
<td>Fatal facts edition</td>
<td>58 – cases closed between July and September 2018</td>
</tr>
</tbody>
</table>

Case summary

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

The adult had a history of mental health issues and had been admitted to psychiatric inpatient units on multiple occasions. They resided in a mental health unit at the time of their death.

The adult was on unescorted leave from the unit and was noted by staff to have been gone for a significant period. Efforts were made to locate the adult and police were notified. Meanwhile, the adult was struck by a vehicle at an intersection and attempts to resuscitate them were unsuccessful.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that improvements could be made to staff practices in relation to compliance, transfers, risk assessments, notetaking and training.

Coronial recommendations

The coroner made the following recommendations related to this case:

- There should be produced for the CCU [Community Care Unit] patients a clear policy as it relates to the expectations of staff and patients as to what is to occur in the event a patient leaves the grounds of [complex]. This policy should be not only provided in written form to the patient but a verbal explanation provided to them at the time of entry to the facility. The relatives and carers should also be informed where appropriate of the expectations of such a policy so they can assist in compliance.
- That at a minimum of 24 hours before the patient is moved from the SECU [Secure Extended Care Unit] to the CCU their next of kin or nominated carer is informed of what is to occur to allow them to provide input into the decision.
- That staff are provided with regular and refresher training on the how to conduct risk assessments to ensure uniformity in approach.
• That nursing staff be required to make comprehensive and contemporaneous patient notes prior to the conclusion of their shift.

• Training for all staff, not limited to psychiatrists, as to what is expected practice as dictated in the Chief Psychiatrists guidelines particularly as they relate to communication and engagement with relatives and carers.
Coronial recommendations: Fatal facts

Case number: VIC.2012.3445
Primary category: Natural cause death
Additional categories: Physical health
Fatal facts edition: 58 – cases closed between July and September 2018

Case summary
An adult female died due to complications of deep vein thrombosis during pregnancy.

The adult was obese and was in the early stages of pregnancy. They had recently been diagnosed with severe nausea and vomiting at a women’s hospital, and later represented with rib pain. They were provided with pain relief and discharged home; no further investigations were performed. The following day, the adult was in a critical condition and was transported to the women’s hospital. Their condition deteriorated and they were transferred to a nearby hospital, where they underwent surgery. They passed away a few hours later.

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

The coroner found that improvements could be made to the process of triaging patients to the two hospitals.

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

- I recommend that the Directors of Emergency Services at the [women’s hospital] and the [hospital] together with Ambulance Victoria under the guidance of the Secretary of the Department of Health and Human Services meet to consider the feasibility of a single triage point at the [hospital], this to determine whether a female patient should be triaged for admission to the [women’s hospital] or the [hospital].

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

<table>
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<tr>
<th>Case number</th>
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<td>Animal</td>
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<td>Additional categories</td>
<td>Work related</td>
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<tr>
<td>Fatal facts edition</td>
<td>58 – cases closed between July and September 2018</td>
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Case summary

An adult male died due to complications of a snake bite.

The adult worked as a gardener. While working along the banks of a river, they were bitten by a snake. The adult was provided with first aid and transported to hospital, where antivenom was administered. They were transported to another hospital, where their condition continued to deteriorate and additional antivenom was administered. Despite this, the adult passed away.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the Victorian Department of Health and Human Services (DHHS) clinical guidelines for snake bite management did not provide any suggestion or acknowledgement that more than one ampoule of antivenom may be required in some circumstances.

Coronial recommendations

The coroner made the following recommendations related to this case:

- In the course of this coronial investigation, I requested DHHS [Department of Health and Human Services] review the 2013 clinical guidelines, which it agreed to do so, and the 2017 clinical guidelines are largely unchanged. I recommend DHHS again review the 2017 Management of snake bite in emergency departments in Victoria clinical guidelines in light of this Finding.
- I recommend that the Australasian College for Emergency Medicine (ACEM) circulate this Finding to ACEM fellows to highlight the evidence, guidelines and potential issues in the management of snake bite.

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Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2015.27</th>
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<tr>
<td>Primary category</td>
<td>Animal</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>58 – cases closed between July and September 2018</td>
</tr>
</tbody>
</table>

Case summary

An older female died due to complications of a snake bite.

The adult was asleep in bed when they were bitten by a snake. The adult’s partner awoke to find them unwell with a snake in the room. They contacted emergency services and an ambulance conveyed the adult to hospital, where the site of the bite tested positive for tiger snake venom. Two vials of antivenom were administered. The adult’s condition deteriorated and they were administered a further vial of antivenom a few hours later. Despite attempts to resuscitate the adult, they were unable to be revived.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult’s treatment was appropriate and timely. The coroner found that the Victorian Department of Health and Human Services (DHHS) clinical guidelines for snake bite management did not provide any suggestion or acknowledgement that more than one ampoule of antivenom may be required in some circumstances.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the Australasian College for Emergency Medicine (ACEM) circulate this Finding to ACEM fellows to highlight the evidence, guidelines and potential issues in the management of snake bite.

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Coronial recommendations: Fatal facts

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<tr>
<th>Case number</th>
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<tr>
<td>Primary category</td>
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<td>Transport and traffic related, Leisure activity</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>58 – cases closed between July and September 2018</td>
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</table>

Case summary

An adult male died due to a motorcycling incident.

The adult was riding a motorcycle at a recreational motorcycle track. They were wearing full safety gear. Upon taking a jump on the track, the adult landed awkwardly and fell from their motorcycle. They suffered fatal injuries when they were struck by another motorcyclist.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the number and closeness of riders permitted on the track at any one time posed risks to riders’ safety.

Coronial recommendations

The coroner made the following recommendations related to this case:

That [motorcycle park] develops protocols or guidelines to be enforced by their officials at the track requiring separation of riders by requiring them to stagger their starts and/or otherwise maintain a safe distance from each other in order to minimise the risk of collision between riders and the risk that they may collide with each other and or come into contact with each other when one has already come to grief.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2015.4177</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Intentional self-harm</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Mental illness and health, Physical health</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>58 – cases closed between July and September 2018</td>
</tr>
</tbody>
</table>

Case summary

An older female took their own life by hanging.

The adult suffered a stroke in the months prior to their death, and family had noticed changes in the adult’s personality and behaviour. They continued to undergo rehabilitation therapy and had returned to living in their home.

The adult was told by their doctor in a recent appointment that they did not expect the adult’s condition to improve much more. The adult was found unresponsive at their home by their spouse. Emergency services were contacted and found the adult to be deceased upon their arrival.

Coronial findings

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

The coroner found there were deficiencies in the information provided to families and caregivers of stroke survivors, particularly with regards to the risk of depression developing when discharged home and the increased risk of suicide.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the Stroke Foundation:

- That the clinical guidelines include specific and timely education for family and caregivers of stroke survivors which recognises their risk for the development of depression, particularly in the year post recovery and the increased risk of self-harm following stroke. It should note that one in three stroke survivors is at risk of developing depression and stroke may double the risk of suicide even in the absence of a diagnosed depressive disorder.
- As half of stroke survivors are likely to experience a change in their mood or mental state, education should also include how family and caregivers can monitor how the stroke survivor is adapting to post-stroke living, what behaviours are attributable to the effects of the stroke and the type of red-flags that might indicate the need for referral, and
when and where to seek help. In addition and where relevant, this should include families and caregivers of stroke survivors with dysphasia being made aware (1) the high risk survivors have (60%) of developing depression, and (2) that if the stroke survivor had a prior history of depression and dysphasia, that these are two major risk factors for depression.
Coronal recommendations: Fatal facts

Case number | VIC.2015.4646
---|---
Primary category | Adverse medical effects
Additional categories | Physical health
Fatal facts edition | 58 – cases closed between July and September 2018

Case summary

A middle aged male died due to complications of home haemodialysis.

The adult suffered from end-stage renal failure and managed their condition at home using a haemodialysis machine. The adult was found unresponsive in their room by their spouse while attached to the haemodialysis machine. Resuscitation was attempted and emergency services were contacted.

Paramedics continued resuscitation efforts, but the adult was unable to be revived.

Coronal findings

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

The coroner found that the adult had implemented a shortcut with the lines attached to the haemodialysis machine, which was inconsistent with the training provided to them on how to use the machine. As a result, the adult lost a sufficient quantity of blood to cause their death.

Coronal recommendations

The coroner made the following recommendations related to this case:

- I recommend that Safer Care Victoria review the safety of haemodialysis machines used by home haemodialysis patients supported by Victorian public health services, with a particular focus on failsafe mechanisms and ways to avoid potentially dangerous short cuts when used in the home setting.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2015.6557</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Misadventure</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>58 – cases closed between July and September 2018</td>
</tr>
</tbody>
</table>

Case summary

A young male died due to injuries sustained in an explosion.

The young person was driving a truck, transporting personal possessions. This included gas bottles, which were situated in a rear storage compartment of the truck. While the young person was driving, gas leaking from the partially open bottles caused an explosion, resulting in the young person sustaining fatal injuries.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that public safety would be significantly enhanced by amendment of the relevant Australian Standards mandating the use of safety valves to minimise the risk that a cylinder will be left inadvertently opened or partially opened, particularly during transportation from one place to another.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That Energy Safe Victoria consider implementation of a public awareness campaign about the need to ensure that LPG [liquefied petroleum gas] gas cylinders’ valves are closed whenever they are not in use, particularly when they are being transported, and that, wherever possible, they are transported in an open or vented vehicle compartment.
- That, in the alternative to [findings] above, the Victorian government consider legislating so as to require that all LPG cylinders intended for domestic use are fitted, as a minimum, with a safety valve that will not allow the flow of gas unless the cylinder is coupled to an appliance, and, optimally, that they are also fitted with a thermal fuse or other mechanism that will prevent the flow of gas in the face of extreme heat or fire.
Coronial recommendations: Fatal facts

Case number | VIC.2016.2744
---|---
Primary category | Drugs and alcohol
Fatal facts edition | 58 – cases closed between July and September 2018

Case summary

A young male died due to combined drug toxicity.

The young person had a history of illicit drug use. They were located unresponsive in their room by a family member. Attempts were made to resuscitate them and emergency services were contacted. The young person was unable to be revived.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that locally-specific responses to emerging harms from heroin use may require broader strategic coordination in order for lessons learned from interventions in one area to be shared and applied in a timely manner to other areas where they could positively impact the lives of people injecting drugs.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Secretary of the Department of Health and Human Services considers the circumstances of [the deceased’s] death in the context of continuing increases in heroin related harms and in relation to the latest data which supports the need for continued development of risk reducing strategies for people who inject drugs.

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
The coroner held a joint investigation into the following deaths which resulted from the same incident: VIC.2016.3236, VIC.2016.3237

Primary category
Mental illness and health

Additional categories
Homicide and assault, Intentional self-harm, Child and infant death

Fatal facts edition
58 – cases closed between July and September 2018

Case summary
An adult female and their male infant died following a fall from a balcony.

The adult had moved to Australia with their spouse the year prior to their death. The spouse’s parents travelled to Australia to support the family for a few months following the birth of the infant. The adult appeared to be distressed without familial support after the spouse’s parents left.

The adult was home alone with the infant on the day of the incident. Both the adult and the infant were found deceased following a witnessed fall from the balcony of their home.

Coronial findings
The coroner found that adult’s death was due to intentional self-harm and the infant’s death was due to assault.

The coroner found that the adult was suffering from post-natal depression, that they had minimal social contacts in Australia and were experiencing social isolation that exacerbated their post-natal depression. The coroner found that the adult’s council area’s Maternal and Child Health Service (MCHS) monitored mothers in circumstances where an indicator of vulnerability had been identified. However, the coroner noted that there was no particular factor listed relating to social isolation and reduced support, despite these factors being known, strong predictors of post-partum mental health issues.

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

- That the [council area] MCHS consider adding “lack of social support/isolation” to the list of risk factors contained in their Risk Assessment Guide.

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.2016.4627</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Transport and traffic related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>58 – cases closed between July and September 2018</td>
</tr>
</tbody>
</table>

Case summary

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

The adult was struck by a vehicle as they were crossing a road at an undesignated pedestrian crossing. Emergency services were contacted and the adult was conveyed to hospital via ambulance. Later that day, the adult was transferred to another hospital where they were found to have sustained serious injuries. They passed away the following day.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the area was subject to heavy pedestrian traffic and was an unsafe area for pedestrians to cross the road.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the [local council] conduct an assessment of the intersection of [roads], [suburb], with a view to modifying the intersection to increase pedestrian safety.

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.2016.4777</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Physical health</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>58 – cases closed between July and September 2018</td>
</tr>
</tbody>
</table>

Case summary
An older male died due to complications of choking in the context of multiple comorbidities.

The adult had recently undergone a diagnostic procedure in hospital following which they were transferred to a ward for reduced mobility and discharge planning.

While on the ward, the adult suffered a fall, during which they sustained a head injury requiring stitches. They were returned to their room later that day and were noted to be eating their 'soft ward diet' meal by a nurse. The nurse left the room and upon returning found the adult unresponsive. They did not recover and later passed away.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that there were unclear recommendations from the speech pathology unit regarding the adult’s required level of supervision.

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

- That [health service] create policy to define the levels of supervision required for patients during oral intake.
- That the development of such a policy be done in consultation with the [health service] Speech Pathology Leadership Team and nursing staff, with the aim of articulating the policy in clear, unequivocal language that is common to both disciplines.

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.2016.5551</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Transport and traffic related</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Older persons</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>58 – cases closed between July and September 2018</td>
</tr>
</tbody>
</table>

Case summary

An older female died due to a vehicle incident in which they were a driver.

The adult was driving their vehicle when they failed to negotiate a bend in the road. As a result, the vehicle travelled over an embankment and onto a footpath before colliding with a tree. Witnesses contacted emergency services and the adult was conveyed to hospital. They were found to have sustained multiple serious injuries, and later passed away.

Coronial findings

The coroner found that the death was unintentional.

The coroner noted that the adult was observed driving erratically prior to the collision. Their doctor considered them unfit to drive and expressed frustration with the lack of transparency in the assessment process facilitated by VicRoads.

The coroner found that the circumstances of the death could inform activities being undertaken by VicRoads and Transport for Victoria to improve the existing system within which concerns about fitness to drive could be reported.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That, in the course of their current review, VicRoads and Transport for Victoria consider a mechanism for providing feedback to reporting General Practitioners.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2017.1157</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Falls</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Location</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>58 – cases closed between July and September 2018</td>
</tr>
</tbody>
</table>

Case summary

An adult male died due to injuries sustained in a fall.

The adult suffered an unwitnessed fall from a cliff edge. Witnesses noted the adult’s car unattended at the location and later found the adult lying on rocks below the cliff. Emergency services were contacted and recovered the adult. It was clear they had passed away.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that signage at the location was in poor condition and was not located near to the carpark and the area of the walking track where the incident occurred.

Coronial recommendations

The coroner made the following recommendations related to this case:

- Parks Victoria replace the sign located along the walking track that leads from the carpark at [location] and ensure that it meets the relevant Australian Standards.
- Parks Victoria consider installing vertical signage at the carpark and further signage along the walking track to warn users of the dangers of standing near or approaching the cliff edge.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2017.2551</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Transport and traffic related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>58 – cases closed between July and September 2018</td>
</tr>
</tbody>
</table>

Case summary

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

The adult had alighted a bus and was crossing the road below the crest of a hill. They were struck by an oncoming vehicle when they walked into the vehicle’s lane. The driver was unable to avoid a collision. Emergency services were contacted and the adult was conveyed to hospital, where they were found to have sustained serious injuries. Despite extensive treatment, the adult's condition deteriorated and they later passed away.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the location of the bus stop prior to the crest of the hill was a key factor in the incident and that foliage in the area partially blocked a street light, limiting visibility.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That Public Transport Victoria consider and investigate relocating the bus stops on the east and west side of [street], near [street], to the top of the crest to improve visibility for pedestrians and drivers.
- That [local council] consider maintaining or removing any tree(s) in the immediate vicinity of the current or relocated bus stop at the intersection of [streets] in [suburb] to ensure drivers have visibility of pedestrians and overhead lighting is not affected.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2017.2644</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</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>58 – cases closed between July and September 2018</td>
</tr>
</tbody>
</table>

**Case summary**

An adult male took their own life by hanging.

The adult had a history of schizoaffective disorder, substance use disorder and drug-induced psychosis. They had previously been admitted to a mental health unit and were receiving community treatment while residing with family at the time of their death.

The adult called the Crisis Assessment and Treatment Team (CATT) the night before their death due to their deteriorating mental state, but CATT did not attend. They later went outside and were unable to be found by family, who assumed they had gone for a walk, which was common practice. The adult was found deceased in a park the following day.

**Coronial findings**

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

The coroner noted that the adult’s management was suboptimal in that:

- there was a complete failure by the health service to record the interaction with the adult
- a triage clinician failed to undertake an assessment sufficient to determine the appropriate urgency of the response.

**Coronial recommendations**

The coroner made the following recommendations related to this case:

- I recommend [health service], if it has not already done so, develop and implement a formal procedure/practice/protocol to the effect that if a call for assistance is put through to a CATT [Crisis Assessment and Treatment Team] clinician and for whatever reason is not answered, then the call is automatically re-directed back to the initial call taker so that an initial risk assessment can be undertaken.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2017.3607</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Domestic incident</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>58 – cases closed between July and September 2018</td>
</tr>
</tbody>
</table>

Case summary

A middle aged female died due to carbon monoxide poisoning.

The adult had invited people to their house, but appeared not to be at home when their guests arrived. After they were unable to be contacted the following day, family attended their home where they found the adult deceased.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult died due to carbon monoxide poisoning from an open flued gas (OFG) heater in their unit.

Following the death, investigations were carried out which determined that the majority of the units in the complex where the adult resided featured the same type of heater, all of which failed carbon monoxide spillage testing.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That [name], the Chief Executive Officer of Australian Gas Association and [name], the Chief Executive Officer of Energy Safe Victoria, collaborate to implement a strategy and a plan to phase out all OFG [open flued gas] heaters.
- That [name], the Secretary of Department of Environment Land Water and Planning, conduct a Regulatory Impact Statement to consider the implementation of a system of mandatory continuous professional development training for Type A Gas Appliance plumbers and fitters as a condition of being registered or licenced.
- That [name], the Chief Executive Officer of [manufacturer], as the manufacturer of the [OFG heater], publish an article in The Age and the Herald Sun warning the public, especially those that have this type of heater installed in their homes, about the necessity of regular servicing and maintenance. This is to ensure that it operates in a safe and efficient manner and does not expose residents to carbon monoxide poisoning under the conditions that have been identified in this Inquest.
That [name], the Chief Executive Officer of Energy Safe Victoria, publish an article in their quarterly newsletter about the importance of testing for carbon monoxide spillage and provide guidance as to the appropriate detection equipment to use to obtain the most accurate results and to ensure the safety of the users.
Coronial recommendations: Fatal facts

Case number | VIC.2017.6400
Primary category | Transport and traffic related
Fatal facts edition | 58 – cases closed between July and September 2018

Case summary
An adult female died due to a vehicle incident in which they were a pedestrian.

A truck driver was driving along a road in heavy traffic. They stopped, at which point the adult walked from between parked cars in front of the truck in an attempt to cross the road.

The truck drove forward and struck the adult. Emergency services were contacted and found that the adult had passed away at the scene.

Coronial findings
The coroner found that the death was unintentional.

The coroner noted that a recommendation was made following a previous investigation into a similar death that trucks and heavy vehicles should be fitted with sensors that alert drivers to objects in their forward blind-spots. The coroner repeated this recommendation.

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

- 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 cabover heavy vehicles with a Gross Vehicle Mass equal to or greater than 4.5 tonne.

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

Case number | WA.2015.174
Primary category | Child and infant death
Additional categories | Indigenous
Fatal facts edition | 58 – cases closed between July and September 2018

Case summary
A male infant died due to asphyxiation in an unsafe sleeping environment.

The infant was born prematurely and was transferred between several hospitals in the weeks following their birth. They were still being monitored in hospital at the time of their death, and their parent remained with them.

The infant was found co-sleeping with their parent a number of times throughout the night by staff, contrary to advice from a midwife, and was repeatedly replaced in their cot. The parent and infant were found co-sleeping again later, at which time a nurse noted that the infant was unresponsive. Despite attempts at resuscitation, they were unable to be revived.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that there was a need for the Western Australian Country Health Service to explore alternative safe sleeping options for indigenous mothers in the state in addition to continued to ensure staff educate parents about, and model in practice, the safe sleeping message.

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

• I recommend that the WACHS [Western Australia Country Health Service] give active consideration to implementing a culturally appropriate safe sleeping space tool, such as the Pepi-Pod, in regional WA Hospitals, following the lead set by New Zealand and the Queensland Government.

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

Case number | WA.2015.836
Primary category | Natural cause death
Additional categories | Mental illness and health, Physical health
Fatal facts edition | 58 – cases closed between July and September 2018

Case summary

A middle aged male died due to heart disease in the setting of multiple comorbidities.

The adult suffered severe psychosis. They had recently been made an involuntary patient due to their mental health issues.

During their admission, the adult experienced periods of breathlessness. They were believed to have suffered a dystonic reaction to their antipsychotic medication, and all antipsychotic medication was later withheld. The adult collapsed and was unable to be revived, despite attempts at resuscitation.

Coronial findings

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

The coroner was satisfied that the adult’s supervision, treatment and care was reasonable, and noted that the occurrence of dystonic laryngeal linguistic reactions to antipsychotic medications to the extent of a fatal outcome was extremely rare.

The coroner found that the adult’s death could be used as a learning exercise as to the potential for a fatal outcome with lingual laryngeal dystonic reactions.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That those caring for patients treated with antipsychotic medication be trained to record in the notes whether any noted breathing difficulty relates to inspiration or expiration. This may provide a diagnostic tool in recognising the potential for laryngeal dystonia and prompt medication and intensive breathing support prior to arrest.

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.2015.1231</th>
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</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Intentional self-harm</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Mental illness and health, Law enforcement</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>58 – cases closed between July and September 2018</td>
</tr>
</tbody>
</table>

Case summary

A middle aged male took their own life in an incident involving a firearm.

The adult had recently demonstrated that they were somewhat obsessive over personal concerns, and had been prescribed anxiety medication by their general practitioner, which they did not take.

The adult worked as a police officer, and was on duty at the time of the incident. They were travelling as part of a squad to an operation. When the squad stopped for a break, the adult self-inflicted fatal injuries.

Coronial findings

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

The coroner found that the adult was aware of the services of the WA Police Health and Welfare Division but chose to access their general practitioner for their concerns.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That WA Police Health and Welfare Division use the police intranet to emphasise to serving members that their families should be made aware of the availability of its services. The development of a family intranet would be beneficial provided there was a way to ensure families were made aware of available services.
# 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 incident</td>
<td>Fatal incident that occurred as a result of domestic injury or event.</td>
</tr>
<tr>
<td>Drugs and alcohol</td>
<td>Death where drugs or alcohol or both were a primary or secondary cause of death.</td>
</tr>
<tr>
<td>Electrocution</td>
<td>Cases where electrocution 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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<td>--------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Location</td>
<td>Cases where the location type of either the incident or the discovery of the body is of significance. Does not refer to geographic location.</td>
</tr>
<tr>
<td>Mental illness and health</td>
<td>Incidents where the existence of mental illness issues were involved in the circumstance on death, both diagnosed and anecdotal. Note: mental illness is included as a contributing factor to death at the discretion of the coroner.</td>
</tr>
<tr>
<td>Misadventure</td>
<td>Risk taking behaviour such as train-surfing.</td>
</tr>
<tr>
<td>Natural cause death</td>
<td>Cases where the death is due to natural causes.</td>
</tr>
<tr>
<td>Older persons</td>
<td>Cases where the agedness of a person was a factor in the death.</td>
</tr>
<tr>
<td>Physical health</td>
<td>Cases where the existing physical health of the person contributed but was not necessarily the cause of death.</td>
</tr>
<tr>
<td>Sports related</td>
<td>Cases where a sporting incident contributed to death.</td>
</tr>
<tr>
<td>Transport and traffic related</td>
<td>Cases involving road, water and air vehicle incidents, motorised or naturally powered. Also includes cases where pedestrians are impacted by transport vehicles.</td>
</tr>
<tr>
<td>Water related</td>
<td>Includes swimming, scuba, snorkelling, boating, fishing and all water-related activities in either a recreational or commercial context.</td>
</tr>
<tr>
<td>Weather related</td>
<td>Cases where the environmental conditions such as heatwave or storm conditions contributed to death.</td>
</tr>
<tr>
<td>Work related</td>
<td>Includes cases where work is related to the death.</td>
</tr>
<tr>
<td>Weapon</td>
<td>Cases where the involvement of a weapon is significant.</td>
</tr>
<tr>
<td>Youth</td>
<td>Cases where the youth of a person was a factor in the death.</td>
</tr>
</tbody>
</table>