Coronial recommendations: Fatal facts

A summary of cases and recommendations made between October and December 2018

Edition 59
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APPENDIX A: FATAL FACTS WEB TOOL CATEGORY TAGS 68
CORONERS’ RECOMMENDATIONS

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

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

Coronial recommendations: Fatal facts includes case summaries and recommendations for cases closed between October and December 2018.

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

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>ACT.2015.81</th>
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<td>Primary category</td>
<td>Adverse medical effects</td>
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<tr>
<td>Fatal facts edition</td>
<td>59 – cases closed between October and December 2018</td>
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Case summary

A middle aged male died due to complications associated with an intra-aortic balloon pump.

The adult had a history of heart disease. They were admitted to hospital for surgery, and an intra-aortic balloon pump was inserted pre-operatively. The balloon was later found to have ruptured and required replacement. The adult then underwent heart surgery, following which they appeared stable. However, their condition deteriorated, and 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 due to a rare but recognised complication of the procedure, and that the intra-aortic balloon used was too long for the adult.

Coronial recommendations

The coroner made the following recommendations related to this case:

- If it has not already done so [hospital] should implement all of the “Suggestions for Improvement” from its Clinical Review Committee reviews of [the deceased’s] death.
- [Hospital] should put in place procedures to ensure that operation reports are appropriately recorded and accessible on a patient’s file.
- The Cardiac Society of Australia and New Zealand, as the professional body for cardiologists and those working in the area of cardiology, should consider the development and promulgation of:
  - An alert to its members of the facts of [the deceased’s] case, noting that although the balloon used was in accordance with published algorithms, nevertheless it was too large in his case.
  - Guidelines or procedures, formalising the broadly accepted practices, as to the practice of insertion or operation of intra-aortic balloon pumps, and particularly the selection of appropriately sized balloons.

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NEW SOUTH WALES

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

Case number | NSW.2013.3934
---|---
Primary category | Law enforcement
Additional categories | Homicide and assault
Fatal facts edition | 59 – cases closed between October and December 2018

Case summary
An adult male disappeared and was reported missing to police.

Despite police investigations and proof of life checks, the adult’s whereabouts remained unknown.

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

The coroner found that the adult’s death was suspicious and was a suspected homicide.

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

To the NSW Commissioner of Police:
- I recommend that the death of [deceased] be referred to the Unsolved Homicide Unit of the NSW Police Homicide Squad to be dealt with in accordance with its procedures and protocols for review and potential re-investigation.
- I recommend that the NSW Police Force apply for and support the provision of a reward relating to information which leads to the recovery and return of [deceased]'s remains to their family.

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Coronial recommendations: Fatal facts

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<td>Fatal facts edition</td>
<td>59 – cases closed between October and December 2018</td>
</tr>
</tbody>
</table>

Case summary

A young male died as a result of a stab wound.

Coronial findings

The coroner found that the death was due to assault.

The coroner found that the young person had been assaulted by unknown persons.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the death of [deceased] be referred to the Unsolved Homicide Unit of the NSW Police Homicide Squad to be dealt with in accordance with its procedures and protocols for review and potential re-investigation.

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Coronial recommendations: Fatal facts

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</table>

Case summary

A middle aged male died as a result of a vehicle incident in which they were a driver.

The adult was employed as a truck driver and was transporting a load when they were pulled over by police. The police officer at the scene considered the load to be improperly secured and spoke with the driver accordingly. While the adult was attempting to secure the load of their vehicle, they lost their balance and fell backwards into a moving lane of traffic. The adult was struck by a passing vehicle and sustained fatal injuries as a result.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the police officer’s decision to stop the adult’s vehicle was appropriate. The coroner noted that there was an area further along the road that was used by highway patrol to stop traffic. The coroner did not find that the second location was safer than the location of the incident.

The coroner found that the manner and method used by the police officer for the stopping of the adult’s vehicle were appropriate and in accordance with the procedures utilised by the police force at the time.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the New South Wales Commissioner of Police

- I recommend the Commissioner consider inserting the following information in the Motor Vehicle Stopping Techniques and Procedures:
  - On Page 2: In addition to your own safety, and that of any colleague working with you, consideration needs to be given to the safety of any driver, or passenger should they leave the vehicle. Such persons may become upset simply because they have been stopped or by action you may take. They may move outside the “corridor of safety” you have created and place themselves at risk by being struck by passing traffic.
you have no specific power to direct these persons to a particular place (unless you have placed them under arrest for a specific offence) it is recommended you suggest that they either remain within the vehicle or stand on its nearside until the stop has been completed.

- On Page 3: In circumstances where it is envisaged that the driver of the vehicle you have decided to stop will be requested to exit the vehicle for example, to inspect or rectify an unsecured load, a stopping location off the roadway where possible, should be selected.
Coronial recommendations: Fatal facts

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<tr>
<td>Fatal facts edition</td>
<td>59 – cases closed between October and December 2018</td>
</tr>
</tbody>
</table>

Case summary

A female child died due to cardiorespiratory failure. VACTERL syndrome (vertebral defects, anal atresia, cardiac defects, tracheo-esophageal fistula, renal anomalies, and limb abnormalities) was a significant issue in their death.

The child was brought to a regional hospital as they were feeling generally unwell. After some time of not being seen, they returned home. The child re-presented the following day after the parent noticed further deterioration in their condition. The child was admitted onto the ward under a locum paediatric consultant and underwent some tests. They had increasing difficulty breathing and deteriorated over a couple of days.

The child was reviewed by the hospital’s paediatric registrar the following day who was immediately concerned by their condition and contacted the child’s general paediatrician. The paediatrician noted the urgency of establishing an airway. Doctors attempted to secure an airway prior to transporting the child to a major hospital but were unable to do so. The child was transported with a laryngeal mask only. On arrival at the major hospital, the child was in acute respiratory distress. They went into cardiac arrest and despite resuscitation attempts, they were unable to be revived.

Coronial findings

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

The coroner found that the child was well known to various doctors and nurses at the hospital and there would have been easy access to practitioners who normally cared for them. The coroner found that there was insufficient notice taken of the child’s deterioration between their two presentations to hospital.

The coroner found that the child had a difficult airway that made them a high-risk patient due to intubation difficulties. The Ear, Nose and Throat (ENT) team had successfully intubated the child in the past, but that at the time of the incident, there was no ENT team at the regional hospital. The coroner made no criticism of the doctors who were unable to establish an airway prior to transport.
The coroner noted that the child’s parent was concerned their voice was not heard during the child’s stay in hospital, despite being acutely aware of their child’s complex medical conditions. The coroner found that a program existed to enable a patient, family or carer to escalate concerns about the condition of themselves or a loved one (Recognise, Engage, Act, Call, Help (REACH)). The coroner was unable to determine the extent or success of the program, or how it was advertised or utilised within the hospital.

The coroner found that the child’s death was potentially preventable, had the seriousness of their condition been recognised earlier and transfer to a major hospital been arranged earlier.

Coronial recommendations

The coroner made the following recommendations related to this case:

To [location] Local Health District

- That the [location] Local Health District consider introducing a training programme to be undertaken by all paediatric nursing staff at [hospital] to ensure that paediatric nursing staff are aware of, and understand, the Hospital’s policy in relation to paediatric respiratory support as set out by [paediatrician] in their statement to the inquest, namely:
  - The Hospital has now introduced thresholds for maximum respiratory support to paediatric patients. This threshold is 6 litres per minute via Hudson mask, and 2 litres per kilogram (or a maximum of 25 litres) at 60% fraction of inspired oxygen (FiO2) via heated, humidified high-flow nasal cannula (HHFNCO2)
  - When this threshold is reached paediatric review is triggered, including consultation with tertiary referral hospital regarding advice and/or potential transfer of the patient.
  - All changes in oxygen therapy are now also required to be approved by the on-duty Paediatrician. Nursing staff can escalate respiratory support as required prior to discussing this with the Paediatrician, however the change must be subsequently approved by a Paediatrician.
  - All paediatric patients on respiratory (oxygen) support are now required to be on a minimum of hourly nursing observations. If an inpatient is identified as high acuity by the nurse-in-charge or Paediatrician, a discussion is triggered with the nurse-in-charge and the Director of Nursing regarding increased nursing observations. A sick patient identified as high acuity would be placed on 1:1 nursing automatically. Patients on 1:1 nursing or oxygen therapy are prioritised at handover with no interruptions.

- That the [location] Local Health District consider developing a local Clinical Emergency Response System (CERS) protocol and a local paediatric specific CERS protocol for the Hospital as required by clause 4 of NSW Health Policy PD2013_049 “Recognition and Management of Patients who are Clinically Deteriorating” (NSW Health Policy).

- That the [location] Local Health District ensure that the local CERS and the paediatric specific CERS protocol for the Hospital makes clear that when a Clinical Review is initiated in the Hospital that a “designated responder”, as defined in the local CERS or paediatric specific CERS protocol, cannot be the same person who initiated the Clinical Review.
• That the [location] Local Health District consider conducting a refresher training programme to be undertaken by all paediatric nursing staff at the Hospital to ensure that paediatric nursing staff are aware of, and adequately understand, the REACH program.
• That the [location] Local Health District give consideration to conducting an audit of how the REACH program is communicated to patients and their families upon admission to the Hospital and assess, as best one can, the effectiveness of the particular mode of communication. Further that consideration is given to raising awareness of the program through the purchase and display of posters in patient rooms.
Coronial recommendations: Fatal facts

<table>
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<td>Child and infant death</td>
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<tr>
<td>Fatal facts edition</td>
<td>59 – cases closed between October and December 2018</td>
</tr>
</tbody>
</table>

Case summary

A female child died due to multiple injuries.

The child was at a venue with family that featured an unfenced and accessible memorial headstone. The child was playing with other children on and around the memorial when the headstone dislodged from the base and fell onto the child. The child suffered fatal injuries as a result and died at the scene.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the memorial was constructed a couple of decades ago, but that no person had been tasked with checking the ongoing safety of the memorial after its construction.

The coroner found that the headstone collapsed because the manner of its fixing to the base was inadequate. The coroner found that the design and building of the memorial were not structurally adequate, and construction of the memorial did not comply with the relevant Australian Standard at the time.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the Minister for Planning and Environment (NSW):

- That the Department of Planning and Environment consider amending the development standards in clause 2.78 of the State Environmental Planning Policy (Exempt and Complying Development) 2008, known as the ‘Codes SEPP’, to provide that a development not comprise masonry construction higher than one metre from existing ground level.

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A middle aged female died as a result of an undetected cancer.

The adult had been experiencing health problems for several months without a confirmed diagnosis. They were admitted to hospital for day surgery to provide diagnostic certainty.

The adult underwent the surgery during which biopsies were taken of some abnormalities. The adult was admitted to the high dependency unit (HDU) overnight rather than discharged so further investigations could be performed. The following day, the adult collapsed and became unresponsive. Medical staff and paramedic crews attempted resuscitation but the adult could not be revived.

Coronial findings

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

The coroner found that the adult was admitted to the HDU in order to receive continuous monitoring overnight. The coroner found that the observations were lacking, and more regular observations should have taken place.

The coroner found that on arrival, the paramedics had difficulty gaining access to the HDU and locating the adult. Despite this, the coroner found that the adult was unlikely to have responded to resuscitation and the delay did not have any impact on the death. During resuscitation, medical staff had difficulty with ventilation, despite being trained in basic life support. The coroner found that the gap between competence and performance in basic life support should be bridged.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the General Manager, [hospital]:

- I recommend that consideration be given to the implementation of robust, reliable and repeatable procedures to ensure that Career Medical Officers are informed of all relevant and current clinical and operational policies prior to the commencement of their first shift.
- I recommend that consideration be given to the installation of appropriate signs and directions at access points and at the exit points of all elevators used by attending Ambulance Service of NSW personnel who have been called to assist with the care and treatment of a patient at [hospital], in order to allow such personnel to be able to independently determine the exact location of the patient.

- I recommend that consideration be given to investigating the feasibility of providing simulation-based training in relation to airway management and ventilation to nursing staff and, in the event that it is deemed feasible to do so, that further consideration be given to incorporating such training in Basic Life Support and Advanced Life Support training provided to nursing staff as part of ongoing competency assessment.
Coronial recommendations: Fatal facts

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<td>Fatal facts edition</td>
<td>59 – cases closed between October and December 2018</td>
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</tbody>
</table>

Case summary

An adult male died in hospital due to an undiagnosed aortic dissection. They had a family history of heart-related conditions.

The adult presented at hospital with chest pain. They underwent a computed topography (CT) scan and blood examinations that did not reveal any abnormal results. The adult was transferred to an unmonitored ward where they collapsed shortly afterwards. They did not recover and were declared deceased later that day.

Coronial findings

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

The coroner found that the adult's family had communicated the family history of heart conditions with hospital staff, but this information was not properly recorded and thus was not considered fully in any diagnostic decisions. The coroner found that an aortic dissection should have been considered and the adult should have been transferred to a larger hospital. The coroner found that the adult should not have been transferred to an unmonitored ward.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the [location] Local Health District:
- That all nursing and medical staff who perform duties at [hospital] Emergency Department are reminded as part of their induction and ongoing training of the importance of clinical use of the NSW Health Chest Pain Pathway. In addition, all staff are to receive training regarding their specific roles and responsibilities in the use of the Chest Pain Pathway. Audits are to be performed at [hospital] to ensure compliance with this recommendation.

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Coronial recommendations: Fatal facts

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<td>Fatal facts edition</td>
<td>59 – cases closed between October and December 2018</td>
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Case summary
An older female died as a result of a ruptured abdominal aortic aneurysm.

The adult lived in a rural community with limited medical facilities. They were diagnosed with an abdominal aortic aneurysm and underwent a preliminary procedure in a city hospital in preparation for a larger repair that would occur later. The procedure was completed without complication and the adult was discharged and returned home. They were unwell in the days following the procedure and were conveyed to the rural hospital via ambulance.

The doctor at the rural hospital diagnosed the adult with a ruptured aneurysm. Arrangements were made to transfer the adult to a larger hospital. Due to miscommunications, the adult was transferred to a regional hospital with limited surgical capabilities, where they deteriorated and passed away.

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

The coroner found that the rural doctor did not explicitly communicate their diagnosis of a ruptured aneurysm to the rural treating team or the medical transfer retrieval team, nor did they communicate the need for the adult to be transferred to a major hospital.

The coroner found that the retrieval team were informed the adult had either a ruptured aneurysm or sepsis, and the retrieval doctor used a Focused Assessment with Sonography in Trauma (FAST) scan to determine whether there was a bleed in the adult’s peritoneal cavity. The FAST scan correctly read negative for a bleed, as the blood was behind the peritoneal cavity, not within it. The retrieval doctor’s primary diagnosis preference was therefore given to sepsis, rather than a ruptured aneurysm.

The coroner found that the adult’s chances of survival would likely not have increased had they been correctly diagnosed by the retrieval team and transferred to a major hospital.

Coronial recommendations
The coroner made the following recommendations related to this case:
To the Chief Executive, Rural and Remote Medical Service (RaRMS):

• I recommend that consideration be given to the development of a written procedure or policy which provides for the means by which General Practitioners/Visiting Medical Officers (GPs/VMOs) are provided with the password to access the laptop provided for by RaRMS at the [location] Multi-Purpose Service. I further recommend that consideration be given by RaRMS to the development of a similar written procedure or policy in relation to any other hospital where it provides a computer to allow GPs/VMOs to remotely access GP records.

To the Chief Executive, [location] Local Heath District:

• I recommend to that [location] Local Heath District clinicians should be directed that when it is known that a patient who has presented in a serious condition at hospital has had a recent surgical procedure at another hospital, the clinician responsible for the patient’s care must make all reasonable efforts as soon as it is reasonably practical to contact the hospital at which the recent surgery was conducted to obtain full details of that surgery and the patient’s history.
• I recommend that a direction should be given to [location] Local Heath District clinicians, receiving emergency calls from other hospitals about possible patient transfers, that they should comprehensively document in the pre-arrival notes information provided to them by the transferring hospital, including all information as to the patient’s history and suspected diagnosis.

To the Chief Executive, Ambulance Service of New South Wales:

• I recommend to that the Aeromedical Control Centre should prepare a written policy requiring a State Retrieval Consultant to take a full handover from the referring clinician with care of a patient to be retrieved from a medical facility. This requirement does not prevent the State Retrieval Consultant’s supplementary discussions with other health practitioners at the facility.
• I recommend that the Aeromedical Control Centre provide express written guidance to State Retrieval Consultants that they must expressly inform the senior clinician with care of a patient and the most senior retrieving practitioner of: (a) their preferred diagnosis as well as any secondary diagnosis; and (b) the appropriate facility to which to transfer a patient as soon as forming a view about that matter.
• I recommend that consideration be given to revision of current Aeromedical Control Centre policy documentation, including work instructions, to clearly identify which officers bear the ultimate responsibility in relation to: (a) the clinical management of patients to be retrieved; and (b) and in the decision as to where to transfer patients to.
• I recommend that consideration be given to providing an express definition in any relevant Aeromedical Control Centre policy documentation, including work instructions, as to what is meant by requiring State Retrieval Consultants to provide active input in all actual or potential medical retrievals.
• I recommend that comprehensive training be provided to all relevant Aeromedical Control Centre staff in relation to any current policy documentation, including the revision of any such documentation that might be made in accordance with [the two recommendations above].

• I recommend that consideration be given to the introduction of an express written policy requiring a Consultant to Consultant handover at the change of each shift, and that comprehensive training be provided to all State Retrieval Consultants and Clinical Coordinators in relation to such a requirement.

• I recommend that consideration be given to informing the Royal Flying Doctor Service [area] of any applicable protocols, contained in internal NSW Ambulance documentation, relevant to the potential use of permissive hypertension in a medical retrieval setting where a patient has ruptured an aneurysm.

To the Chief Executive, Royal Flying Doctor Service [area]:

• I recommend that consideration be given to the need to provide explicit written guidance to clinicians regarding the potential use of permissive hypertension in a medical retrieval setting where a patient has ruptured an aneurysm.

To the Chief Executive, Ambulance Service of New South Wales:

• I recommend that consideration be given to the introduction of an express written policy requiring that, in all medical retrievals, a handover be provided by the Aeromedical Control Centre to the hospital to which a patient is being transferred to.

To the Chief Executive, [location] Local Heath District:

• I recommend that consideration be given to the issuing of a policy directive requiring receiving [location] Local Heath District clinicians to review a Patient Transfer Form where a critically ill patient has been received from another hospital. Where the patient has been received from the [location] Multi-Purpose Service the receiving clinician should also review the electronic notes of [location] Multi-Purpose Service.
Coronial recommendations: Fatal facts

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<td>Adverse medical effects</td>
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<td>Fatal facts edition</td>
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Case summary

An adult male died of complications of septicaemia.

The adult presented at hospital with an infection and was administered antibiotics. The infection appeared to be responding well to treatment, but the adult’s blood oxygen levels were abnormally low. They were transferred to the intensive care unit (ICU) with hypoxaemia. They were administered oxygen via a face mask but were frequently agitated and non-compliant with oxygen therapy.

The adult fell asleep and the ICU nurse attended another patient. The nurse returned to find the adult had removed their oxygen mask and was not receiving oxygen or respiratory support. They suffered significant brain damage as a result and died in hospital several days later.

Coronial findings

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

The coroner found that the adult was suffering a severe hypoxaemia lung condition and was so agitated that they were incapable of cooperating consistently with their essential oxygen support. The coroner found that this situation required a high level of surveillance. The adult was being nursed in ICU on a 1:2 ratio, meaning they were in the care of a nurse who was responsible for a second patient. The coroner found that on that day, proper management of their condition required constant surveillance in the form of 1:1 nursing.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the Executive Director of the [area] Local Health District:

- That consideration be given to releasing as a Policy Directive, the Guideline titled Nursing Workforce in ICU issued in November 2016.

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Coronial recommendations: Fatal facts

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Case summary
A middle aged male died when the light aircraft they were piloting crashed into the ocean. The aircraft and the adult’s body were not recovered.

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

The coroner found that the adult had a history of mental ill health that was known to their employer. They had been suspended from working as a pilot in the past by the Civil Aviation Safety Authority (CASA) due to their mental illness.

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

To the Civil Aviation Safety Authority (CASA):
- That CASA give consideration to seeking an amendment of the indemnity currently provided in regulation 67.140 of the *Civil Aviation Safety Regulations 1998* (CASR) to provide indemnification for a wider range of good faith reporting in relation medical fitness by a broader range of persons.
- That CASA undertake to liaise with the Commonwealth Minister for Human Services to determine whether there is basis upon which it can appropriately share Pharmaceutical Benefits Scheme (PBS) prescribing information and Medical Benefits Scheme (MBS) information relating to persons who apply for the issue of a medicate certificate under Part 67 of the CASR.

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

An older male and an older female died of environmental heat injury when they became lost in the bush.

The adults were international tourists who had recently arrived in Australia. They attended a tourist location for a scenic walk on a very hot day and accidentally left the marked track. They were unable to relocate the track and eventually succumbed to heat exhaustion. They were found deceased by rescue services in the days that followed.

Coronial findings

The coroner found that the deaths were unintentional.

The coroner found that the track marker was significantly obscured by long grass, and a fence and warning sign usually present near the track had been washed away in recent floods. The coroner noted that the track marking and signage had since been updated. The coroner noted that there was no mobile phone reception in the area.

Coronial recommendations

The coroner made the following recommendations related to these cases:

- I recommend that the Department of Tourism and Culture do all such things as may be necessary to advise visitors who may visit its parks in areas without telecommunication reception of the existence of GPS [global positioning system] applications and the use to which they might be put when visiting those areas.

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Coronial recommendations: Fatal facts

Case number | NT.2017.258
---|---
Primary category | Transport and traffic related
Additional categories | Work related
Fatal facts edition | 59 – cases closed between October and December 2018

Case summary
A middle aged female died due to a workplace incident.

The adult worked as a bus driver. While working, the adult parked and alighted from the bus, leaving the engine running. They closed the doors using a switch under the front of the vehicle. Shortly afterward, the bus began to move forward. The adult ran back and activated the switch, however, they fell and were struck by the bus in the process. Emergency services were contacted, however, the adult was found to have passed away.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that there were no Australian Standards for bus brake interlocks for doors, nor were there any specifications or guidelines in the Northern Territory. The coroner noted the following bus safety measures implemented in New South Wales (TS-155):

*The Door Safety System shall only release the Brake Door System, if no object has been detected, after:*

- *The doors have fully closed; and*
- *The handbrake is released; and*
- *A secondary activation of either of the footbrake or the engine accelerator is applied.*

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

- That the Department of Infrastructure, Planning and Logistics give consideration to requiring buses to incorporate the secondary fail-safe system as provided in NSW by TS-155.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>NT.2017.187</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</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>59 – cases closed between October and December 2018</td>
</tr>
</tbody>
</table>

Case summary

A young female took their own life by hanging.

The young person was a student and developed symptoms of anxiety leading up to assessments and work placements. They attended multiple health practitioners and were prescribed medication; however, their condition did not improve. They were found unresponsive by family in their home. Attending paramedics confirmed they had passed away.

Coronial findings

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

The coroner found there were a series of missed opportunities in the young person’s care.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the [mental health service] ensure that all clients are properly assessed before making a decision to refer their care and treatment to a General Practitioner.
- That the role of the [mental health service] in the care and treatment of clients is explicitly stated to the client and if applicable the client’s family or significant other person.
- That the [mental health service] have a specific procedure to ensure that where any responsibility is retained by the Service for care and treatment, or the monitoring of care and treatment, that there be a proper coordination with all relevant providers.
- That before the involvement of the [mental health service] ceases that it ensures that that all other relevant providers are contacted and copies of their last consultations obtained.
- That the Medical Board remind all General Practitioners of the care and attention required and the obligation to take a detailed history, undertake an appropriate assessment and take proper notes when dealing with clients presenting with mental health concerns.

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QUEENSLAND

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>QLD.2016.3147</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Transport and traffic related</td>
</tr>
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<td>Additional categories</td>
<td>Law enforcement</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>59 – cases closed between October and December 2018</td>
</tr>
</tbody>
</table>

Case summary

An older male died following a vehicle incident in which they were a driver.

The adult lost control of their motorcycle whilst taking evasive action to prevent a collision with another vehicle. The other vehicle had slowed suddenly when its driver interpreted a ‘slow down’ hand signal from a police officer as a direction to stop. The motorcycle clipped the vehicle, causing it to slide off the road and collide with a stationary police vehicle.

Coronial findings

The coroner found that the death was unintentional.

The coroner determined that the death resulted from a combination of factors, including the misunderstanding of the police hand signal, the sudden braking of the other vehicle and the adult’s inability to maintain control the motorcycle resulting in wheel locking.

The coroner concluded that the police officer acted in accordance with training and operational procedures.

Coronial recommendations

The coroner made the following recommendations related to this case:

- Queensland Police Service give consideration to inclusion in section 15.4.2 of the Operational Procedures Manual, of more specific guidance to the safe location of interception sites, including the need to have regard to the distances required for vehicles to stop safely when travelling at the speed limit for the relevant section of road.
- Council consider issues identified with respect to the segment of road involved, including the capacity for vehicles to avoid collisions with vehicles accessing the road from adjacent driveways.

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Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>QLD.2016.4802</th>
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<td>Primary category</td>
<td>Weapon</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Law enforcement</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>59 – cases closed between October and December 2018</td>
</tr>
</tbody>
</table>

Case summary

An older male died from a gunshot wound during a stand-off with police.

The adult was experiencing a number of personal, health and family issues. These caused the adult cumulative stress, resulting in them threatening self-harm with a rifle. Police responded to the incident and requested that the adult put the rifle down so that help could be provided. The adult refused these requests and pointed their rifle at police officers. As a result, they were fatally shot by police.

Coronial findings

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

The coroner determined that the incident investigation was thoroughly and professionally conducted, that the officers involved acted appropriately in firing their weapons and that the application of lethal force was appropriate in the circumstances.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the QPS (Queensland Police Service) review the Operational Procedures Manual in order to clarify the use of the term ‘deployment’ with respect to service rifles, including the point at which authorisation is required and the criteria necessary to justify such deployment.
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>
<th>SA.2014.2071</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Work related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>59 – cases closed between October and December 2018</td>
</tr>
</tbody>
</table>

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

The adult was working at a construction site and was using a scissor lift to conduct work from a height. They were found unresponsive atop the scissor lift, trapped between the scissor lift’s platform fence and the ceiling above. Emergency services were contacted and the adult was conveyed to hospital, where they later passed away.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the work method was unsafe as the primary safety feature to deal with entrapment, the safety lowering lever, was in a position rendered difficult to access by a rescuer.

The coroner found that there was no safe work method statement (SWMS) developed for the work being undertaken by the adult while using a scissor lift. Had there been one, the risks involved would have been properly assessed and an alternative method of undertaking the work would have been devised.

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

- That the Elevating Work Platforms document dated September 2016 should be distributed on an annual basis electronically and in hard copy to all relevant building industry participants in South Australia. In addition, electronic links to the information sheet should be displayed permanently on SafeWork SA’s webpage and be kept current. The associated minimum standard of training document should be brought into line to include references to clear lines of sight.
- That the question of standardising scissor lift controls be given far greater impetus at a State and National level and that it be elevated to the Council of Australian Governments (COAG) for the commissioning of a project to pursue the standardisation of controls in scissor lifts.
• That until the implementation of a system of effective standardisation of scissor lift control configuration across the country, that scissor lifts not be operated unless there is a person on the ground operating as a spotter who is available at all times to take steps to activate the emergency lowering mechanism should that be necessary.

• That SafeWork SA consider whether the balance in the WHS Act [Work Health and Safety Act 2012] and Regulations between safety being managed by risk assessment as opposed to express mandatory rules about what must occur in particular circumstances should be shifted in favour of more express mandatory rules and take that matter up with SafeWork Australia for consideration.

• That SafeWork SA should investigate, consider and report upon the world’s best practice engineering solutions to protect workers against the risk of crushing due to overhead surfaces, including the availability and design of secondary protective systems including operator protective alarms and operator protective structures and the options for reform to require that all scissor lifts in use in South Australia have a secondary protection system.

• That the Government provide, through the Legal Services Commission, funding to enable families to be legally representative in Inquests, for deaths in custody, and generally. I direct this recommendation to the Attorney-General.
TASMANIA

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>TAS.2013.53</th>
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</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Work related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>59 – cases closed between October and December 2018</td>
</tr>
</tbody>
</table>

Case summary
An adult male died due to injuries sustained in a workplace incident.
The adult worked in construction as a piling technician. The adult was seriously injured at a
worksite when they were struck by a pile that fell from the sling it was being carried in.
Emergency services were contacted, however the adult was unable to be revived.

Coronial findings
The coroner found that the death was unintentional.
The coroner found that basic principles of risk management at the worksite had been ignored.
The coroner found that had a sufficiently thorough risk assessment been conducted regarding
the driving of piles on the site, a safer method of work would have been employed.

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

- Those in the piling industry adopt safe work method practices that include documented
  safe work method statements which include:
  - An outline of the method to be adopted to pile;
  - An assessment of the risks involved, any hazards present, and measures to mitigate
    and control those risks and hazards;
  - An assessment of the use of any lifting gear, including slings;
  - The use of a register to record the owner of any lifting gear used on work sites during
    piling operations;
  - A requirement, conveyed to all workers involved in piling operations at any level, that
    work is to stop and to be reviewed — with such review documented — if there is a
    change to work method involving the adoption of a new method of piling utilising, for
    example, lifting gear such as a sling (particularly if the method changes from purely
    mechanical to involving interaction between machinery and workers).
- Consistent with Industry Standards, the safety plan for piling operators take into account
  the following further safe work practices:
  - Consulting with all employees about piling operations on site;
o Coordination between a principal contractor on site and any other contractor retained, particularly in the context of contractors retained to undertake specific work such as piling;

o Effective site management to take into account changes in work methods (and review of same);

o Effective hazard identification and risk management;

o The implementation of detailed safe work method statements that, as a minimum, set out the work method to be adopted in piling, and which allows for documented review and modification, with work stopped until such review and modification has taken place;

o Ensuring that all lifting gear used or brought onto site is compliant with relevant standards, and in particular, fit for purpose, and that maintenance records are reviewed prior to work commencing using such lifting gear to ensure compliance;

o Ensuring that the basis of administrative controls such as exclusion zones are understood by workers, and that appropriate supervision is undertaken to enforce such zones;

o Ensuring that principal contractors effectively and consistently liaise with all contractors on site to address safety concerns, particularly in circumstances where piling operations are taking place at sites involving loose ground, changing ground conditions, or where difficulties present when using methodologies involving the pre-augering of holes and standing of piles prior to piles being driven.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>TAS.2014.476</th>
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<tr>
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<td>Domestic incident, Law enforcement</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>59 – cases closed between October and December 2018</td>
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</table>

Case summary

A female infant died due to complications of unsafe sleeping.

The infant resided with their parents and sibling, and the family was known to Child Safety Services (CSS). The infant was sleeping in a bed with one of their parents. Both parents were drug-affected at the time. The infant was sleeping face down with their face obstructed by a pillow and bedding. They were found unresponsive the following morning and were unable to be revived.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that there were critical failures in CSS processes and decision-making which left the infant exposed to the high risks associated with their death. The coroner also found that there were lengthy delays in the provision of information by CSS for the coronial investigation.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that upon CSS [Child Safety Services] becoming aware of the death of a child where that child, his/her parents or siblings are known to CSS within 3 years prior to the date of the death, CSS advises the Coroner’s Office of the death and provides a brief summary of its past and current involvement with the child and family members.
- I recommend that CSS review its policy “Reporting the death of a child in care to the Coroner” with a view to including provisions to accord with the above recommendation.
- I recommend that Tasmania Police notify CSS of the death of any child the subject of a report to the Coroner so as to enable CSS to provide the details referred to in the above recommendation.
- I recommend that CYS [Child and Youth Services] and CSS provide to the Coroner a copy of any review undertaken by it or at its request in respect of a child whose death has been
reported to the Coroner as soon as that review is completed or within a period of 90 days, whichever is the earlier.

- I recommend that CSS provide training on an ongoing basis to its child safety officers in effectively identifying and responding to situations where it is identified that an infant under the age of 12 months may be at risk due to unsafe sleeping practices.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>TAS.2016.204</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Drugs and alcohol</td>
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<tr>
<td>Additional categories</td>
<td>Law enforcement</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>59 – cases closed between October and December 2018</td>
</tr>
</tbody>
</table>

Case summary

A middle aged male died due to combined drug toxicity.

The adult resided with their partner and suffered from longstanding back pain, for which they were prescribed opioid medication. The adult frequently administered their medication in a manner contrary to prescribing advice. The partner woke on the night of the incident to find the adult unresponsive. Emergency services were contacted and paramedics attempted resuscitation. The adult was unable to be revived. The partner noted that the adult had previously indicated they no longer wished to live and had appeared depressed in the weeks leading up to their death.

Coronial findings

The coroner was unable to determine the intent of the deceased.

The coroner found that police records raised suspicions that the adult was selling their medication and was using other substances not prescribed to them. The coroner found that had the police information been available to the Pharmaceutical Services Branch (PSB), the PSB may have prevented the supply of methadone to the adult or altered their doctor’s prescribing conditions. The coroner found that the mutual sharing of information between police and the PSB presented opportunities to more effectively prevent harms in the community related to the misuse of drugs.

Coronial recommendations

The coroner made the following recommendations related to this case:

• I recommend that Tasmania Police and the Pharmaceutical Services Branch, together, develop systems, procedures and/or understandings for the effective sharing of information or reports regarding persons misusing prescription medication.

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Coronial recommendations: Fatal facts

<table>
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<tr>
<th>Case number</th>
<th>TAS.2017.223</th>
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</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Child and infant death</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>59 – cases closed between October and December 2018</td>
</tr>
</tbody>
</table>

Case summary
A male infant died due to complications of unsafe sleeping.

The infant was sleeping in a bed with their parent on the night of the incident. The other parent awoke the next morning, entered the room and found the infant unresponsive. Resuscitation was attempted and ambulance paramedics were called to the scene. The infant was unable to be revived.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the infant likely died due to suffocation caused by overlaying while sleeping alongside their parent. The coroner found that the dangers of co-sleeping and warnings against the practice continued to be disregarded, leading to the deaths of infants across the state and nationally.

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

- That persons responsible for the care of infants under the age of 12 months ensure that such infants do not sleep in the same bed as any other person.

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Coronial recommendations: Fatal facts

Case number | TAS.2017.23
--- | ---
Primary category | Adverse medical effects
Additional categories | Physical health
Fatal facts edition | 59 – cases closed between October and December 2018

Case summary

A middle aged male died due to probable infection in the setting of multiple health conditions.

The adult had previously undergone a kidney transplant due to polycystic kidney disease, for which they took immunosuppressant drugs to prevent transplant rejection. The adult’s health had been deteriorating over several months, and they had undergone various tests and procedures to determine the cause.

A family member attempted to contact the adult over a number of days but received no response. When they attended the adult’s home, they found them deceased.

Coronial findings

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

The coroner found that there were multiple failings in the adult’s medical care and expressed concern that the adult’s blood test results, which the pathologist considered critical, were not sighted by a treating doctor in a timely manner, which may have enabled earlier intervention.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That [medical centre] and other general practices in the State carry out a review of their practices and procedures around the sighting of pathology results with a view to ensuring that those results which require an urgent response do not ‘fall through the cracks’ and are seen and responded to at the earliest opportunity.

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Coronial recommendations: Fatal facts

<table>
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<tr>
<th>Case number</th>
<th>TAS.2018.167</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Aged care</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Falls, Older persons</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>59 – cases closed between October and December 2018</td>
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</table>

Case summary

An older male died due to heart failure aggravated by a fall.

The adult resided in a nursing home and had become increasingly debilitated and immobile over time. They were unable to stand or walk unaided. They used a ‘princess chair’ designed to provide pressure relief.

The adult fell from their chair while in a communal section of the nursing home. An ambulance was called, and they were conveyed to hospital, where they were found to have sustained serious injuries. The adult was returned to the nursing home for palliative care and later passed away.

Coronial findings

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

The coroner found that the chair had multiple faults, was not fit for use and should have been removed from service prior to the incident.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the [nursing home], as a matter of urgency undertake a review of its protocols surrounding the regular inspection, maintenance and repair of its equipment, coupled with its fault reporting procedures in the hope that it leads to the implementation of new and more effective processes which prevent a repeat of an event similar to that which befell [the deceased].
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.2014.197</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Child and infant death</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Drugs and alcohol</td>
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<tr>
<td>Fatal facts edition</td>
<td>59 – cases closed between October and December 2018</td>
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Case summary

A female infant died shortly after birth due to complications of maternal substance abuse.

During the pregnancy, the infant’s mother failed to attend several maternal health appointments and reported drug use throughout the pregnancy. The mother declined a referral to the maternal services program at the hospital.

The infant was born spontaneously but soon began to deteriorate. Resuscitation efforts were made for several hours but the infant was unable to be stabilised. They were palliated and died the following day.

Coronial findings

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

The coroner found that the mother was known to child protection due to their drug use. The coroner found that despite the mother’s reluctance to engage in antenatal care, there were missed opportunities for prevention.

Coronial recommendations

The coroner made the following recommendations related to this case:

To Safer Care Victoria

- That Safer Care Victoria Maternity and Newborn Clinical network replicate the ‘Substance Use during Pregnancy’ information currently located in the electronic neonatal handbook within the electronic Maternity handbook. The ‘Substance Use during Pregnancy’ information highlights the necessity of assertive follow up by primary care providers, which includes checking on referrals made on behalf of pregnant women using substances to establish the woman attended the maternity service for pregnancy care. The ‘Substance Use during Pregnancy’ information includes what to do when a woman has not attended their appointments or pregnancy care.
To the Victorian Department of Health and Human Services

- That the Victorian Department of Health and Human Services articulates referral pathways to suitable home visitor services or outreach workers to follow up with the pregnant woman at home or wherever she might be found when she fails to attend pregnancy care. The ‘Substance Use during Pregnancy’ information includes direction on how and when to share information about high risk individuals to relevant agencies or organisations. This includes an explanation to the woman when a consultation with a specialist service or other support worker is required.

- That the Victorian Department of Health and Human Services undertake research to establish the current rate and timing of risk screening for substance use by pregnant women.

- That the Victorian Department of Health and Human Services support maternity services in educating staff on how to frame the risk enquiry questions for substance use and the appropriate response upon disclosure.

- That the Victorian Department of Health and Human Services undertake a review to identify opportunities in program delivery to improve early intervention by outreach services for women who are pregnant and use substances. This focus on early intervention will help to improve pregnancy outcomes and prevent the severity of parenting difficulties.

To the Royal Australian College of General Practitioners (RACGP)

- That the Royal Australian College of General Practitioners develop a RACGP website link to the ‘Substance Use during Pregnancy’ information.

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Coronial recommendations: Fatal facts

Case number | VIC.2014.4586
Primary category | Child and infant death
Additional categories | Drugs and alcohol
Fatal facts edition | 59 – cases closed between October and December 2018

Case summary
A male infant died due to complications of birth.

The infant’s mother’s antenatal care during pregnancy was limited, and they were using illicit substances during the pregnancy. The infant was born prematurely in a breech position in an ambulance. They suffered severe injury to several organs due to oxygen deprivation and were palliated as a result. The infant died shortly afterwards.

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

The coroner found that child protection was involved with the family but was not aware that the mother was pregnant with the infant until after delivery.

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

To Safer Care Victoria
- That Safer Care Victoria Maternity and Newborn Clinical network replicate the ‘Substance Use during Pregnancy’ information currently located in the electronic neonatal handbook within the electronic Maternity handbook. The ‘Substance Use during Pregnancy’ information highlights the necessity of assertive follow up by primary care providers, which includes checking on referrals made on behalf of pregnant women using substances to establish the woman attended the maternity service for pregnancy care. The ‘Substance Use during Pregnancy’ information includes what to do when a woman has not attended their appointments or pregnancy care.

To the Victorian Department of Health and Human Services
- That the Victorian Department of Health and Human Services articulates referral pathways to suitable home visitor services or outreach workers to follow up with the pregnant woman at home or wherever she might be found when a she fails to attend pregnancy care. The ‘Substance Use during Pregnancy’ information includes direction on how and
when to share information about high risk individuals to relevant agencies or organisations. This includes an explanation to the woman when a consultation with a specialist service or other support worker is required.

- That the Victorian Department of Health and Human Services undertake research to establish the current rate and timing of risk screening for substance use by pregnant women.
- That the Victorian Department of Health and Human Services support maternity services in educating staff on how to frame the risk enquiry questions for substance use and the appropriate response upon disclosure.
- That the Victorian Department of Health and Human Services undertake a review to identify opportunities in program delivery to improve early intervention by outreach services for women who are pregnant and use substances. This focus on early intervention will help to improve pregnancy outcomes and prevent the severity of parenting difficulties.

To the Royal Australian College of General Practitioners (RACGP)

- That the Royal Australian College of General Practitioners develop a RACGP website link to the 'Substance Use during Pregnancy' information.
Coronial recommendations: Fatal facts

Case number | VIC.2014.4256
Primary category | Adverse medical effects
Fatal facts edition | 59 – cases closed between October and December 2018

Case summary
An adult female died due to a stroke following an elective surgery to repair a fracture.

The adult fractured their limb while on an overseas holiday. They returned to Australia and met with an orthopaedic surgeon for an examination and to discuss surgery. The adult agreed to proceed with a surgery, which was scheduled for several days after the fracture occurred.

In the days preceding the surgery, the adult experienced shortness of breath and palpitations while mobilising. This was reported to the anaesthetist prior to surgery. The adult’s condition deteriorated post-operatively and they passed away.

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

The adult had known risk factors for the development of deep vein thrombosis (DVT), including a long-haul flight, the location of the fracture and the subsequent immobility. The coroner found that there was insufficient consideration given to these risk factors.

The coroner found that the initial examination of the adult’s leg by the orthopaedic surgeon was not consistent with good medical practice. If the signs and symptoms of DVT were present at the time, a full examination would have identified this and altered the course of the adult’s medical management. The coroner was unable to determine if the signs and symptoms of DVT were present at the time of the examination. The orthopaedic surgeon was unaware the adult had experienced palpitations as this had not been appropriately relayed to them prior to surgery.

The coroner found that had the adult chosen conservative management of the fracture, it is likely they would have died of complications of a pulmonary embolism. The coroner was unable to find that the death was preventable.

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

- With the aim of promoting public health and safety and preventing like deaths through the early detection of Venous Thromboembolism, I recommend that the Royal Australasian
College of Surgeons use the circumstances of [the deceased's] death to create a learning tool for orthopaedic surgeons on how to conduct fulsome and rigorous physical examination of a fractured limb.
Coronial recommendations: Fatal facts

Case number | VIC.2015.4551
Primary category | Adverse medical effects
Fatal facts edition | 59 – cases closed between October and December 2018

Case summary
An older male died due to complications of surgery.

The adult was diagnosed with an abdominal aortic aneurysm and underwent surgery for repair. The surgery was complex and lengthy. They remained in hospital for several days with multiple complications. They were discovered unresponsive in their room and were unable to be revived.

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

The coroner found that there was insufficient ongoing examination of the adult in regards to the complications they experienced while in hospital.

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

- I recommend that Executive Director of Medical Services and Clinical Governance at [hospital] confer with interested parties and provide further direction to nursing staff concerning when and in what circumstances a patient whose presentation following vascular surgery of the kind undertaken by [the deceased], should be made the subject of a discretionary MET [medical emergency team] call by a member of nursing staff.

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Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
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</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Transport and traffic related</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Law enforcement</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>59 – cases closed between October and December 2018</td>
</tr>
</tbody>
</table>

Case summary

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

The adult was struck by an electric bicycle that was being driven on the footpath. They sustained life-threatening injuries and were transported to hospital, where they passed away several days later.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the rider of the electric bicycle was unlicensed, and the bicycle was not registered. The power output of the motor on the bicycle was such that it should have been registered as a motorcycle.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Vehicle Safety Standards Bureau, Victoria Police, Bicycle Industries Australia and VicRoads collaboratively consider the circumstances in which [the deceased’s] death occurred and attempt to identify any new countermeasures that could be implemented to improve compliance with laws regarding the operation of electric bicycles, including but not limited to establishing how best to detect and prevent people operating high-powered electric bicycles without licence or registration as if they were power-assisted pedal cycles.

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Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
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<tbody>
<tr>
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<td>Transport and traffic related</td>
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<tr>
<td>Additional categories</td>
<td>Physical health</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>59 – cases closed between October and December 2018</td>
</tr>
</tbody>
</table>

Case summary
A middle aged male died as a result of injuries sustained in a vehicle incident in which they were a driver.

The adult had been driving their car along a road when they collided with the rear of a parked vehicle and died prior to emergency services arriving. The adult had a history of epilepsy and had previously had their licence suspended several times for medical reasons.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that evidence of erratic driving prior to the collision and the adult’s history of epilepsy indicated they were experiencing a seizure, which caused the collision. The coroner also found that VicRoads had not been informed of all seizure episodes the adult had experienced.

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

- That consideration be given by the Secretary of the Department of Economic Development, Jobs, Transport and Resources and VicRoads to adopting a framework requiring mandatory reporting to VicRoads when a medical practitioner forms an opinion that a person’s current medical condition renders them unfit to drive, whether for a particular period of time, or for the foreseeable future.
- That VicRoads considers amending the VicRoads medical details form to require examining doctors to report, not just the most recent seizure as it does currently, but all known seizures which have occurred within the preceding 12 months.

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Coronal recommendations: Fatal facts

**Case number**  
VIC.2017.900

**Primary category**  
Transport and traffic related

**Fatal facts edition**  
59 – cases closed between October and December 2018

**Case summary**

A middle aged female died as a result of a vehicle incident in which they were a driver.

The adult was driving when their vehicle travelled onto a gravel verge. They oversteered and the vehicle left the road, colliding with a tree. They passed away at the scene.

**Coronal findings**

The coroner found that the death was unintentional.

The coroner found that the road was not wide enough for two vehicles to safely pass each other and had crests that limited driver visibility. The coroner found that the local council had installed several advisory and warning signs along the road since the incident.

**Coronal recommendations**

The coroner made the following recommendations related to this case:

- VicRoads post speed limit signs on each side of the crest on [road] immediately in the vicinity of [the deceased’s] accident scene (near [road]) reducing the approach speed to less than 100 km/h pursuant to section 8 of the *Road Safety (Traffic Management) Regulations 2009* (Vic).
- VicRoads consider implementing the strategy referred to in [above recommendation] in relation to the other crest on [road] (and its continuation as [road]) between [road] and [road].
- The Council, with the support of VicRoads, widen approaches to and the road on the crest in [road] in the vicinity of [the deceased’s] accident scene near [road] be widened as soon as possible.
- The Council, within three months of receiving this Finding post ‘crest’ warning signs and speed advisory signs as referred to [in this Finding] on the crest on [road] (and its continuation as [road]) between [road] and [road].

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Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2015.5077</th>
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</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Transport and traffic related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>59 – cases closed between October and December 2018</td>
</tr>
</tbody>
</table>

Case summary

A young female died as a result of injuries sustained in a motor vehicle incident in which they were a passenger.

The young person was travelling in a car while sitting on the knee of another passenger and was not wearing a seatbelt. The driver had been drinking prior to the incident and was driving at excessive speed around a curve. The car impacted an oncoming vehicle in the other lane before leaving the road and colliding with a power pole. The young person died at the scene from their injuries.

Coronial findings

The coroner found that the death was unintentional.

The coroner found there had been frequent community concerns about unsafe driving on the road where the incident occurred. A number of other collisions had occurred on the road in the years prior.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That VicRoads conduct a Road Safety Audit of [road] to establish whether it is eligible for nomination as a Black Spot.
Coronial recommendations: Fatal facts

Case number
The coroner held a joint investigation into the following deaths which resulted from the same incident: VIC.2016.1166, VIC.2016.1167

Primary category
Transport and traffic related

Additional categories
Work related

Fatal facts edition
59 – cases closed between October and December 2018

Case summary
A middle aged male and an adult male died when the light aircraft they were flying in crashed.

The middle aged person was a hobby pilot who was involved in an informal arrangement with a television program to take passengers on a microlight aircraft flight. The adult was part of the film crew.

On the aircraft’s descent, it crashed into the ground. The two persons died on impact.

Coronial findings
The coroner found that the deaths were unintentional.

The coroner found that the middle aged person was a qualified pilot who had obtained certification to fly solo and carry passengers. No technical fault in the aircraft was found.

The coroner found that there was no formal arrangement between the pilot and the television program, but noted that it was not apparent whether a commercial arrangement would have led to more formal and structured event management.

The coroner found that pilot error was most likely the cause of the incident.

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

- That the Australian Transport Safety Bureau undertake an investigation to determine the proportion of weight shift microlight trikes involved in accidents and incidents compared to other recreational aircraft; and
- That the Australian Transport Safety Bureau provide the results of their investigation to the Civil Aviation Safety Authority so that they may consider the viability of stronger recency requirements for pilots operating weight shift microlight trikes.
- That the Secretary of the Department of Infrastructure, Regional Development and Cities consider implementing measures to ensure increased available resources for organisations

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National Coronial Information System

delegated the Australian Transport Safety Bureau's legislative responsibility to investigate civil aviation incidents.

- That the Secretary of the Department of Infrastructure, Regional Development and Cities consider implementing measures to ensure the Australian Transport Safety Bureau directly investigates all civil aviation incidents resulting in fatality.
Coronal recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2016.3731</th>
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</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Falls</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Aged care, Older persons</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>59 – cases closed between October and December 2018</td>
</tr>
</tbody>
</table>

Case summary

An older female died following a fall.

The adult lived in residential aged care and required assistance for mobility. Two care staff were using a sling attached to a ceiling track and a ceiling hoist to move the adult into a chair. The hoist separated from the ceiling track, causing the adult to fall to the ground. The adult was taken to hospital where their condition deteriorated, and they passed away.

Coronial findings

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

A WorkSafe investigation found that the latch disconnected from the strap on the equipment but there was no obvious failure of the hoist components. The coroner found there was no evidence to establish a cause of the incident, but noted that the aged care provider had since made changes to their ceiling hoists to increase safety.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that Leading Age Services Australia, the national peak body representing and supporting providers of age services across residential care, home care and retirement living, alert their members regarding this finding and encourage members to review their use of ceiling hoists in accordance with manufacturer’s instructions and their compliance with the WorkSafe Safety Alert on patient handling and portable ceiling hoists dated August 2013.

- I recommend that Aged & Community Services Australia, the leading peak body supporting church, charitable and community-based not-for-profit organisations that provide accommodation and care services to older Australians, alert their members regarding this finding and encourage members to review their use of ceiling hoists in accordance with manufacturer’s instructions and their compliance with the WorkSafe Safety Alert on patient handling and portable ceiling hoists dated August 2013.
I recommend that WorkSafe Victoria, the Victorian health and safety regulator consider once again publishing a Safety Alert regarding the use of ceiling hoists by aged care facilities and consider amending guidance notes and publications on transferring people using hoists to highlight the need to comply with manufacturer’s instructions and implementing a system of cross checking connections prior to use.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2016.5143</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Falls</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Domestic incident</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>59 – cases closed between October and December 2018</td>
</tr>
</tbody>
</table>

Case summary

A middle aged male died following a fall from a height.

The adult was cleaning guttering on their property. They used a ladder to climb to the top of the garage and proceeded to walk across the adjacent carport. The adult fell through the plastic section of the carport roofing and fell to the concrete below. The adult was taken to hospital where they were treated for several days but later passed away.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that while there had been safety awareness campaigns for ladder falls in the work context these did not address people working on ladders for ‘do-it-yourself’ (DIY) tasks at home.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Victorian Department of Health and Human Services consider extending the national ‘Ladder Safety Matters’ public education initiative to include falls from heights, including roofs, in the DIY context.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2017.406</th>
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</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Drugs and alcohol</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Law enforcement</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>59 – cases closed between October and December 2018</td>
</tr>
</tbody>
</table>

Case summary

An adult male died from mixed drug toxicity while on parole.

The adult was living with one of their parents, who had gone on holiday for a short period. The adult obtained heroin several days later and a friend noted they could not contact the adult. When the adult’s parent returned home, the adult was found deceased.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that while the adult had attended a pathology centre to be tested for illicit substances on several occasions, there were other occasions where there were no results to confirm their attendance. The coroner also found that there was a shortfall in the implementation of random drug testing as the adult was generally tested on the same day or following their supervision appointments.

The coroner noted a recommendation previously made by the State Coroner that:

- Corrections give consideration to the best manner of integrating random drug testing into the supervision and reporting regime for any parolee subject to a drug and alcohol testing condition as part of their parole order.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I endorse [State Coroner’s] recommendation noting that in September 2017, the State Coroner was advised that work had already commenced on exploring the best way for Corrections Victoria to implement a random drug testing arrangement for both prisoners on parole and offenders on other court-imposed orders. Corrections Victoria is considering the use of alternatives to urine analysis, such as mouth swabs given the logistical difficulties in random testing when a urine sample is relied upon. Such an approach would allow parolees to be tested on the spot at any location and remove the potential for parolees to attempt to provide false, diluted, or doctored samples thus enabling a more complete
picture than a reliance on observations by Community Correctional Services and parolees 'self-reporting'.

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Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
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<tr>
<td>Primary category</td>
<td>Natural cause death</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>59 – cases closed between October and December 2018</td>
</tr>
</tbody>
</table>

Case summary

A middle aged female died of natural causes.

The adult went to hospital after a collapse and was assessed by emergency department staff. Following blood tests and consideration that they were suffering from musculoskeletal pain, the adult was discharged. Several days after their hospital attendance the adult was located deceased in their home.

Coronial findings

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

The coroner found that the correct diagnosis for the adult's condition was missed due to a combination of a lack of medical knowledge by the treating doctor, and inadequate supervision.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That [the adult's] case be discussed at the [hospital's emergency department] 'morbidity and mortality meeting' highlighting the clinical red flags of aortic dissection, the cognitive biases and system issues involved in the case, as well as the strategies to combat these.
- That the [hospital] utilise a structured cognitive de-biasing strategy such as the NSW Clinical Excellence Commission's 'Take 2, think do' for all discussions between junior staff and senior staff and for transitions in care in the department such as handovers and transfers to the Short Stay Unit.
- That [health service] management ensure adequate senior staffing to allow adequate supervision of junior staff is possible. Staffing levels - both number and seniority - should reflect workload.

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Coronial recommendations: Fatal facts

<table>
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<td>Natural cause death</td>
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<tr>
<td>Fatal facts edition</td>
<td>59 – cases closed between October and December 2018</td>
</tr>
</tbody>
</table>

Case summary

A middle aged male died due to complications of a brain injury.

The adult resided in a disability group home funded by the Department of Health and Human Services. The adult had a severe acquired brain injury and suffered multiple intellectual and physical health conditions. The adult’s health had been deteriorating over a long period. They were admitted to hospital for end-of-life care and later passed away.

Coronial findings

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

The investigating coroner was concerned that neither the department, the group home, nor staff at the palliative care unit recognised their duty to report the death to the Coroners Court of Victoria.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Department of Health and Human Services implement training to educate the staff of their residential units on their specific and general obligation to report “in care” deaths to the Coroners Court of Victoria.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
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<td>Work related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>59 – cases closed between October and December 2018</td>
</tr>
</tbody>
</table>

Case summary

A middle aged male died as a result of undertaking domestic vehicle maintenance.

The adult was working on their vehicle at their home. The vehicle had two wheels positioned on ramps and was placed in park with the handbrake engaged. While the adult was working underneath the vehicle, it rolled down the ramps and came to rest on the adult’s torso. They were discovered by neighbours; the vehicle was removed and the adult was transported to hospital. They did not recover and died several days later.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that there were no wheel chocks in place behind the vehicle wheels on the ground, thus there were no contingencies in place to support the weight of the vehicle when it failed to remain on the ramps.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Australian Competition and Consumer Commission (ACCC) consider renewing its national DIY [do it yourself] vehicle safety campaign and once again including DIY motor vehicle repairs in their next ‘Safe Summer’ campaign.
- That WorkSafe Victoria consider once again working with the ACCC to promote safety of DIY motor vehicle repairs.

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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: VIC.2017.2994, VIC.2017.3000</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Drugs and alcohol</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Geographic</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>59 – cases closed between October and December 2018</td>
</tr>
</tbody>
</table>

Case summary

An adult male died as a result of a heroin overdose.

The adult had a history of heroin abuse and had been in a residential rehabilitation program prior to their death. They left the facility due to issues with other patients and were noted to be using heroin again. The adult travelled to a different suburb to purchase and use heroin on the day of the incident. They were discovered unresponsive and were transported to hospital. They were unable to be revived and died later that day.

Case summary

An adult male died as a result of a heroin overdose.

The adult travelled to a suburb to purchase and use heroin with a friend. The friend left the adult for a short time and on returning noted that the adult was unresponsive. The friend contacted emergency services and the adult was declared deceased on arrival of the paramedics.

Coronial findings

The coroner found that the deaths were unintentional.

The coroner found that the council area visited by the adults was one of the most frequent locations for sourcing heroin and for heroin-involved overdose deaths over several years.

Coronial recommendations

The coroner made the following recommendations related to these cases:

- That the Secretary of the Department of Health and Human Services note that two deaths, [the two deceased], occurred within a day of each other in [suburb]. [Suburb] is within the [council] and has a higher concentration of heroin-related deaths than the [council] as a whole, which itself was, in 2017, the LGA [local government area] with the highest number of heroin-related deaths in Victoria.
• That the Secretary of the Department of Health and Human Services consider applying a place-based approach to drug overdose prevention along the lines of their place-based approach to suicide prevention, setting a similarly ambitious target for overdose death reduction.
Coronial recommendations: Fatal facts

<table>
<thead>
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<th>Case number</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Intentional self-harm</td>
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<td>Additional categories</td>
<td>Law enforcement</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>59 – cases closed between October and December 2018</td>
</tr>
</tbody>
</table>

Case summary

A middle aged male took their own life by hanging.

The adult was approached by police in relation to alleged child sex offences the week prior to their death. Police scheduled an interview for the following week to discuss the allegations. The adult was discovered hanging in their home on the day of the interview and was transported to hospital. They suffered a severe brain injury and died a few days later.

Coronial findings

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

The coroner found that there was a heightened risk of self-harm and suicide amongst persons who become aware of allegations of sexual offences against them. The coroner found that at the time, police practice was to provide the Information Support and Referral Brochure [ISR] after a suspect had been interviewed, and not at the point of first contact.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Victoria Police consider updating the Code of Practice for the Investigation of Sexual Crime and relevant policies procedures and protocols, to explicate the increased risk of suspects engaging in self harm, between notification that allegations have been made against them and the intended interview date and to emphasise the significance of suspect welfare management at the first point of Victoria Police contact.
- That the Victoria Police consider updating the Code of Practice for the Investigation of Sexual Crime and relevant policies, to require that investigating police provide the ISR Brochure to suspects at the first point of contact.

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### 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>
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</tr>
<tr>
<td>Location</td>
<td>Cases where the location type of either the incident or the discovery of the body is of significance. Does not refer to geographic location.</td>
</tr>
<tr>
<td>Mental illness and health</td>
<td>Incidents where the existence of mental illness issues were involved in the circumstance on death, both diagnosed and anecdotal. Note: mental illness is included as a contributing factor to death at the discretion of the coroner.</td>
</tr>
<tr>
<td>Misadventure</td>
<td>Risk taking behaviour such as train-surfing.</td>
</tr>
<tr>
<td>Natural cause death</td>
<td>Cases where the death is due to natural causes.</td>
</tr>
<tr>
<td>Older persons</td>
<td>Cases where the agedness of a person was a factor in the death.</td>
</tr>
<tr>
<td>Physical health</td>
<td>Cases where the existing physical health of the person contributed but was not necessarily the cause of death.</td>
</tr>
<tr>
<td>Sports related</td>
<td>Cases where a sporting incident contributed to death.</td>
</tr>
<tr>
<td>Transport and traffic related</td>
<td>Cases involving road, water and air vehicle incidents, motorised or naturally powered. Also includes cases where pedestrians are impacted by transport vehicles.</td>
</tr>
<tr>
<td>Water related</td>
<td>Includes swimming, scuba, snorkelling, boating, fishing and all water-related activities in either a recreational or commercial context.</td>
</tr>
<tr>
<td>Weather related</td>
<td>Cases where the environmental conditions such as heatwave or storm conditions contributed to death.</td>
</tr>
<tr>
<td>Work related</td>
<td>Includes cases where work is related to the death.</td>
</tr>
<tr>
<td>Weapon</td>
<td>Cases where the involvement of a weapon is significant.</td>
</tr>
<tr>
<td>Youth</td>
<td>Cases where the youth of a person was a factor in the death.</td>
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</table>