Coronial recommendations: Fatal facts

A summary of cases and recommendations made between April and June 2017

Edition 53
## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coroners’ Recommendations</td>
<td>4</td>
</tr>
<tr>
<td>New South Wales</td>
<td>5</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>18</td>
</tr>
<tr>
<td>Queensland</td>
<td>26</td>
</tr>
<tr>
<td>Tasmania</td>
<td>35</td>
</tr>
<tr>
<td>Victoria</td>
<td>47</td>
</tr>
<tr>
<td>Western Australia</td>
<td>74</td>
</tr>
<tr>
<td>Appendix A: Fatal Facts Web Tool Category Tags</td>
<td>79</td>
</tr>
</tbody>
</table>
CORONERS’ RECOMMENDATIONS

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

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

Coronial recommendations: Fatal facts includes case summaries and recommendations for cases closed between April and June 2017.

Previous summaries and recommendations are available at:
NEW SOUTH WALES

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>NSW.2011.5543</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Homicide and assault</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Law enforcement</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>53 – cases closed between April and June 2017</td>
</tr>
</tbody>
</table>

Case summary
A middle aged female died in hospital due to a head injury.

The adult’s partner called emergency services and reported that the adult was in bed unconscious and suffering a seizure. The adult was taken to hospital where a computed topography (CT) scan suggested they had suffered a significant blunt force trauma to the head.

The adult’s prognosis was poor and they were extubated. They regained consciousness for several days and gave conflicting accounts of how the injuries occurred, including that their partner had hit them. The adult’s condition deteriorated once more and they later passed away.

Coronial findings
The coroner was unable to determine the cause of the deceased’s fatal injuries.

The coroner found that the police investigation was incomplete following a report of potential domestic violence. This was as a result of staffing arrangements and poor handover in a busy office. The coroner found that the inadequacies were due to human error and no systemic issues were identified. The coroner found that the Local Area Command had since made changes to avoid these issues in the future.

The coroner found that at the time of the adult’s death, electronic hospital records were in their infancy and domestic violence screening tools were not communicated across different hospital departments. The coroner noted that at the time of inquest, a trial for domestic violence screening in emergency departments was in place in the local health district in question.

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

The Director of the [health district]:

ncis@ncis.org.au | +61 3 9684 4442 | ncis.org.au
• That the electronic/training booklet (e-booklet) presently provided by the [health district] to doctors at the commencement of their employment in Emergency Departments with the [health district] (including [hospital]) be modified to include a requirement mandating notification to police of reasonably suspected incidents of domestic violence in accordance with NSW Health Policy and Procedures for identifying and responding to domestic violence.

• That the [health district] follow up the results of the trial of the emergency department domestic violence screening tool being carried out by the [another health district] at [hospital] with a view to assessing its potential usefulness in the [health district].

The Minister for Health:

• That NSW Health give consideration to further exploring the viability and appropriateness of providing a means by which a patient’s domestic and family violence history is the subject of an alert recorded on the patient’s electronic medical record where that patient is at risk of serious threat resulting from domestic or family violence. Consideration of this proposition will understandably include examining the significant privacy concerns involved.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>NSW.2014.4717</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Sports related</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Water related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>53 – cases closed between April and June 2017</td>
</tr>
</tbody>
</table>

Case summary

A middle aged male died when they were thrown from a boat during a high speed water ski race.

The adult was a member of an experienced water ski race team. On the day of the incident they were competing with a driver with whom they had extensive competition experience. The team performed standard pre-race inspections and preparations of the boat and were satisfied it was in perfect racing condition.

While travelling around a corner at high speed during the race, control of the boat was lost and the adult and driver were thrown overboard. The adult was found face down in the river, and resuscitation attempts were made. They were declared deceased on arrival of paramedics.

Coronial findings

The coroner found that the death was unintentional.

The coroner was unable to determine the cause of the boat's loss of control and subsequent crash.

The coroner found that speed contributed to the death. The coroner noted that a number of witnesses at inquest who were involved in the sport supported speed restrictions being introduced.

Coronial recommendations

The coroner made the following recommendations related to this case:

Recommendations in relation to Ski Racing Australia:

- That Ski Racing Australia give consideration to introducing speed restrictions in the unlimited and super class categories.
- That Ski Racing Australia give consideration to introducing a requirement that all vessels competing in a Ski Racing Australia sanctioned event carry spinal boards, neck braces.
and defibrillators and that the driver, observer and skier/s are adequately trained and/or certified in the use of spinal boards, neck braces and defibrillators.

- That Ski Racing Australia give consideration to using a device, such as a net of an appropriate depth, cage or some other suitable device, when sweeping aquatic courses for Ski Racing Australia sanctioned events, to collect debris that may be submerged or partly submerged beneath the water surface.

- The Ski Racing Australia, through its affiliate NSW Water Ski Federation, give consideration to having additional paramedics stationed on water at appropriate intervals during the [event].

Recommendations in relation to the Roads and Maritime Service (RMS):

- That the RMS give consideration to ensuring that licensees of RMS issued aquatic licences for any [event] comply with the conditions of the aquatic licence including by undertaking adequate checks to confirm that the licensee is satisfying the aquatic licence conditions.

- That the RMS consult with Ski Racing Australia and other relevant stakeholders to determine whether it is desirable or necessary for a speed restriction to be a condition of an aquatic licence for any [event].
Case number: NSW.2015.1060
Primary category: Intentional self-harm
Additional categories: Mental illness and health
Fatal facts edition: 53 – cases closed between April and June 2017

Case summary

A young female died due to self-inflicted hanging while a patient in an intensive care mental health facility.

The young person had a recent history of depression, anxiety and suicidal thoughts. In the months prior to their death, they had several admissions to mental health services following suicide threats and deterioration in their mental state.

The young person had been a patient in an intermediate stay mental health unit for several months prior to their death and was internally transferred a couple of times to acute care based on their psychiatric needs. They attempted self-harm a few times while in the unit. The day prior to their death, the young person was transferred to a different ward within the same facility to match their residential address. This negatively affected the young person as they felt comfortable at the first unit. The treating team were not made aware of the transfer or consulted prior to it occurring.

Soon after the transfer the young person was assessed by a psychiatrist who determined they were at high risk of self-harm and there was an immediate need to transfer them to a psychiatric intensive care unit. The young person was classified as medium risk on their admission to the unit and placed on 15 minute observations. They were discovered hanging in their room shortly after the nursing shift handover the following morning. They were unable to be revived.

Coronial findings

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

The coroner found that the transfer between units due to residential address was unnecessary, as it was for administrative purposes only. The coroner found that administrative details should not take precedence over patient wellbeing.

The nursing staff at the psychiatric intensive care unit were not made aware of all the young person’s incidents of self-harm at the prior unit. The coroner found that complete
information relevant to the young person’s care was not communicated during each handover in the lead-up to the incident.

The coroner found that the downgrading of the young person’s risk level on admission to the psychiatric intensive care unit was inappropriate.

The coroner found that given how busy the psychiatric intensive care unit was on the night of the young person’s admission, it was unlikely that they were effectively observed during their admission. The coroner found that it was likely the young person had fatally self-harmed prior to handover, and a minimum of two observations should have occurred between then and the final discovery. Observations only required the patient to be sighted, and did not necessarily stipulate staff ensuring the patient was safe.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the Chief Executive, [health district]:

- I recommend that the [health district] amend any procedures and policies regarding the transfer of patients between mental health services and units to include a mandatory requirement that patients are not to be transferred without agreement from a patient’s consulting psychiatrist or a member of a patient’s medical treating team.

- I recommend that the [health district] provide specific targeted training to all mental health clinical staff in relation to any changes in patient care policies introduced since March 2015.

- I recommend that the [health district] provide ongoing periodic training to all mental health clinical staff in relation to the need for a holistic consideration of the needs of a patient in determining the level of observation that is to be afforded to a patient.

- I recommend that the [health district] provide increased and regular education and training to nursing staff within mental health units regarding completion of patient observation charts to ensure that observations are accurately recorded at the times that they are performed, and to avoid the practice of “block recording” where observations are recorded collectively and subsequent to the time of the actual observations.

- I recommend that the [health district] amend the Mental Health: Levels of Observation Psychiatric Intensive Care Unit policy issued on 31 July 2015 to ensure that clear instructions are given to nursing staff regarding the performing of observations day and night, and how observations should be performed in order to ensure the safety of patients.

- I recommend that the [health district] develop policies and procedures to clearly identify the roles and duties of incoming and outgoing nursing staff within mental health units during handover times. In particular, I recommend that any such policies and procedures clearly identify the nurse responsible for performing observations of patients that occur during handover times.
In the event that the application by the Black Dog Institute for an innovation grant to trial back-to-base pulse oximetry units across a number of Local Health Districts is unsuccessful, I recommend that the [health district] give consideration to independently conducting its own trial to access the acceptability and feasibility of using pulse oximetry units to continuously monitor inpatients in mental health intensive care units within the district.

To the NSW Minster for Health:

- I recommend that a copy of these findings be forwarded to the Minister for Health for consideration in conjunction with the application by the Black Dog Institute for an innovation grant to trial back-to-base pulse oximetry units across a number of Local Health Districts.
- I recommend that the NSW Minister for Health give consideration to increasing nurse-to-patient ratios within the Psychiatric Intensive Care Unit of the [mental health centre], [location] to ensure that patient safety is not compromised.
Coronial recommendations: Fatal facts

**Case number**  
NSW.2015.4068

**Primary category**  
Sports related

**Additional categories**  
Work related

**Fatal facts edition**  
53 – cases closed between April and June 2017

**Case summary**

An adult male died due to an injury sustained during a professional boxing contest.

The adult suffered a number of blows during earlier rounds of the match but was not examined by the ringside doctor. A timing error in a latter round resulted in the adult suffering further blows after the round should have ended. The adult appeared concussed before the final round but was not assessed by the doctor and the fight continued. Concussion greatly impaired the adult’s ability to defend themselves, and a blow in the final round knocked them unconscious.

Ambulance officers attended following difficulties identifying the location of the event. The adult was transported to hospital where they were diagnosed with a severe brain injury. Life support was withdrawn, and they died some days later.

**Coronial findings**

The coroner found that the death was unintentional.

The coroner found that the referee failed to recognise the adult was suffering from a concussion at the beginning of the final round. The coroner noted that the referee’s failure to recognise the seriousness of the adult’s condition emphasised the need for an examination by a ringside doctor trained to detect concussion, to properly assess a fighter’s fitness to continue.

The coroner found that the ringside doctor understood their role to be a limited one. The doctor’s only training for the ringside role was through experience. The coroner found that the criticism of the doctor for failing to assess the adult during the fight was justified, and noted that the doctor had no specific training in ringside resuscitation.

The coroner found that there were no pre-existing evacuation or emergency plans, nor any rehearsal of emergency procedures prior to the event. As a result, the emergency response was delayed.
Coronial recommendations

The coroner made the following recommendations related to this case:

To the Minister for Sport, Office of Sport and Combat Sports Authority:

• I recommend that consideration is given to the following changes, relevant to the sport of boxing in NSW, after appropriate consultation with relevant sporting bodies and interest groups.

To the Minister for Sport:

• A transcript of this inquest be provided to the next review of the Combat Sports legislative scheme and consideration be given in that review to:
  o Whether the legislative scheme should be amended to provide a comprehensive set of rules to govern the conduct of all boxing contests in NSW;
  o whether the obligations on an attending medical practitioner to stop a combat sports contest currently expressed in s. 63 of the *Combat Sports Act 2013* should be amended to better protect the health and safety of combat sport participants, in particular in circumstances where:
    – in the opinion of the medical practitioner there is a serious impairment of the combatant/boxer’s ability to defend him or herself; or
    – there is a likelihood of serious injury to the combatant/boxer’s health if the contest were to continue; or
    – it is desirable to do so in the interests of the safety or welfare of the combatant.

To the Office of Sport:

  o To continue to develop training for registered industry participants, attending medical practitioners and promoters, on the following topics:
    – the rules applicable to combat sports contests in New South Wales;
    – the roles of industry participants, attending medical practitioners and promoters in boxing contests;
    – when a contestant should be medically examined during a contest and when a contest should be stopped on account of the condition of the combatant.
    – the identification, significance and risks associated with serious head injuries including concussion; and
    – when a contestant should be medically examined during a contest and when a contest should be stopped on account of the condition of the combatant.
  o investigate and implement mechanisms, including an accreditation process, which will best ensure that every relevant industry participant and attending medical practitioner complete training on those topics at least annually.

• Amend the Combat Sports Rules to provide that:
  o there be a clear pre-determined means, whether by bell, hammer, prescribed hand signal or another method, by which the attending medical practitioner can indicate
the need for or desirability of a medical examination of a combatant during the contest;

- at the commencement of a combat sport contest the referee and the attending medical practitioner must confer to agree on a means by which the referee can indicate the need for or desirability of a medical examination of a combatant during the contest;

- the attending medical practitioner must examine a combatant during a combat sport contest on the occurrence of prescribed “trigger” events, which should include:
  - knockdown caused by a blow to the head;
  - suspicion of concussion; or
  - a direction to that effect by the Combat Sports Inspector or referee.

- an examination must include a medical assessment to ascertain whether or not the combatant is suffering from a concussion having regard to the “pocket concussion guide” or another applicable guidance document;

- the attending medical practitioner may examine the combatant at any other stage during a combat sport contest, including during a round and during the break between rounds including to carry out medical assessment to ascertain whether or not the combatant is suffering from a concussion having regard to the “pocket concussion guide” or another applicable concussion tool;

- the round must be stopped to enable an examination [...] to take place during a round, and if necessary the time between rounds must be extended to enable such examination to take place;

- the referee must confer with the attending medical practitioner about the need for a medical examination following any round in which a combatant receives a significant number of heavy blows to the head or appears to be suffering from signs and symptoms consistent with a concussion;

- there be a clear definition of a knockdown; and
  - the attending medical practitioners must position themselves to allow effective communication with referees and to ensure as far as reasonably practicable that they have an unobstructed view of the combatants.

- Ensure that the following medical equipment must be present ringside during a boxing contest:
  - airway support;
  - an oxy-viva mask; and
  - oxygen.

- Introduce a requirement that:
  - the promoter must submit to the Combat Sports Authority an Evacuation Plan for the venue prior to holding a boxing contest. Such a plan must include:
    - the street address of the venue and the route by which paramedics can access the ring from the street with a stretcher and medical equipment and evacuate a patient safely;
- the identity of the person who will call emergency services in the event of an injury;
- the information about the patient which must be conveyed, including the state of consciousness, bleeding, breathing, and any apparent head injury;
- confirmation that the plan has been discussed with the attending medical practitioner prior to the contest; and
- the location of the nearest hospital with neurosurgical facilities.

- The attending medical practitioner, the promoter, and all industry participants present at the contest must inspect the route for the execution of the evacuation plan at the venue before the commencement of a boxing contest.

- Investigate whether a paramedic should also be required to attend a combat sports contest in addition to the attending medical practitioner.
- Introduce automatic timing systems for all boxing contests.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>NSW.2016.2205</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Water related</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Leisure activity</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>53 – cases closed between April and June 2017</td>
</tr>
</tbody>
</table>

Case summary

A young male disappeared while snorkelling with friends.

A thorough search was conducted of the area but they were not recovered. A swim fin belonging to the young person was recovered nearby.

Coronial findings

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

Coronial recommendations

The coroner made the following recommendations related to this case:

- To the [location] Board and Marine Parks Authority for the erection of Warning Signs at the access points to [location] with the Minimum Warnings of:
  - No lifesaving service
  - Strong and variable currents
  - Submerged objects

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

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

Case number: NT.2014.115
Primary category: Adverse medical effects
Additional categories: Child and infant death
Fatal facts edition: 53 – cases closed between April and June 2017

Case summary

A female child died of sepsis as a result of a twisted ankle.

The child presented at a health clinic twice for a twisted ankle. No fracture was observable via x-ray, and they were sent home. When their pain worsened, they presented to the hospital emergency department. Nurses suspected an infection, but the on-call doctor did not attend to examine the child.

The following day the child’s condition deteriorated and arrangements were made for an emergency airlift to a major hospital. Their condition declined significantly before arrival of the airlift and at no stage was the child stable enough to transfer to the major hospital. They passed away despite extensive resuscitation efforts.

Coronial findings

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

The on-call doctor stated at inquest that based on the child’s reported heart and respiratory rate, they should have attended the hospital to examine them.

The coroner found that there was no policy or procedure at the time that required the doctor to see patients presenting at the emergency department while they were on call. The coroner found that the hospital was not staffed with doctors after a certain time in the afternoon, and that patients presenting after those hours would be treated much the same as if they presented to a health clinic.

The coroner found that a case of undiagnosed sepsis causing death had occurred within the same hospital some years prior. Training was given in relation to recognition of sepsis as a result. The coroner found that the child’s sepsis should have been recognised in the wake of the prior case. The coroner was critical of the inadequate systems in place at the time that resulted in the child not being seen by a doctor and allowing their condition to deteriorate until it was too late to save their life.
Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the Top End Health Service Board give consideration to implementing the Emergency Medicine Stream for all hospitals.
- I recommend the System Manager (as defined by the Health Services Act 2014) give consideration to a sustainable model for the emergency medicine stream.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>NT.2015.149</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Drugs and alcohol</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Adverse medical effects</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>53 – cases closed between April and June 2017</td>
</tr>
</tbody>
</table>

Case summary

An adult female died due to prescription medication overdose.

The adult was in a car incident some decades prior, had multiple operations as a result and suffered from pain. They were prescribed significant levels of opioids for the pain and became addicted.

A reduction of the adult’s opioid prescription levels was attempted over the years but was unsuccessful. The adult maintained the dosage due to several factors including receiving prescriptions from multiple doctors at the same time.

The adult underwent surgery to relieve pain issues and was prescribed more opioids in the months prior to their death. Their general practitioner sought clarification from the specialist about reducing the opioids prescribed but no reduction was made. The adult died of an unintentional overdose several months later.

Coronial findings

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

The coroner found that the adult’s receipt of prescriptions from multiple doctors was undetected by the doctors and the Drug Management System overseen by the Department of Health. The coroner noted that this system was not ‘real-time’ and that it took several days for information from pharmacies to be entered into the system.

The coroner found that there was no meaningful coordination or collaboration between the specialists and general practitioners treating the adult in the last years of their life. The coroner found that attempts should have been made to taper the adult’s opioid prescriptions earlier.

Coronial recommendations

The coroner made the following recommendations related to this case:
• I recommend that the Northern Territory Government implement real time monitoring of Schedule 8 drugs as soon as possible.
• I recommend that the Northern Territory Government give consideration to maximum prescribing levels for opioids.
• I recommend that the Department of Health and the Health Service Boards consider implementing restrictions on the provision of unnecessary opioids to patients being discharged from hospital.
• I recommend that the Health Service Boards do all such things as are reasonable to ensure collaboration between the Pain Specialists and Addiction Medicine Specialists with the view to ensuring safe use of addictive medications used for the control of pain.

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

Case number
NT.2015.190

Primary category
Transport and traffic related

Additional categories
Law enforcement

Fatal facts edition
53 – cases closed between April and June 2017

Case summary
A young male died due to a vehicle incident in which they were a passenger. The incident occurred in the course of a police operation.

The young person frequently stole vehicles for ‘joy riding’ with friends. On the day of the incident, the young person and their friends carjacked a vehicle and proceeded to commit a series of offences. Police twice engaged in pursuits of the vehicle, but due to the group’s unsafe driving the pursuits were terminated. Police were of the view that the group were attempting to bait police into a pursuit, and a decision was made not to engage in further pursuits.

The group was soon reported to engage in threatening behaviour with a firearm, and the police Tactical Response Group (TRG) was called on duty. Police and the TRG attempted to intercept the vehicle for some hours without success. While evading police, the vehicle entered an intersection against a red traffic signal at speed and collided with another vehicle.

The young person was taken to hospital with severe injuries and passed away shortly afterwards.

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

The coroner found that at the time of the collision, the driver believed they were being pursued by police. The young person was not wearing a seatbelt at the time of the collision.

The coroner found that the group posed a significant risk to the public and themselves, and it was desirable they be apprehended as soon as possible. The coroner noted that apprehension was not possible until after a collision that caused the death of the young person. The coroner found that the incident highlighted the limited options available to police when attempting apprehension of a joyriding vehicle.

The coroner found that the police had an existing system, the Northern Territory Incident Control System – An Incident Management Framework for any Emergency or
Operation (NTICS), that could be used to coordinate a police response to an incident. The coroner found that the NTICS was not utilised by police at any time during the incident, and as such there were missed opportunities for the identification of the group members and the location of the vehicle. The coroner found that some confusion remained among police about when to utilise the NTCIS as definitions of critical incidents were not yet finalised.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that Police finalise the draft Joint Emergency Services Communications Centre Procedure as soon as possible.
- I recommend that Police fit Automated Vehicle Locators to their vehicles as soon as possible.
- I recommend that Police implement a system for review of all critical incidents with the intent to ensure continuous learning and improvement.
Coronial recommendations: Fatal facts

Case number: NT.2015.216

Primary category: Misadventure

Fatal facts edition: 53 – cases closed between April and June 2017

Case summary

A young male died as a result of long-term petrol sniffing.

More than a dozen Applications for Assessment had been made under the *Volatile Substance Abuse Prevention Act* by medical professionals who believed the young person to be at risk of severe harm. Nearly half of these applications were made in the final weeks of their life.

Coronial findings

The coroner found that the death was unintentional. The coroner found that the young person was at risk of severe harm as defined by the *Volatile Substance Abuse Prevention Act*, but that the powers provided under the Act were never used to make treatment orders for the young person. Many individuals and groups, including the young person’s family, local health clinics and police, requested court ordered treatment be instituted, however this was not done.

The health service did not undertake a review of the care and treatment provided to the young person. The coroner noted that at the time of inquest, the health service and the Department of Health provided draft terms of reference for undertaking a comprehensive review of the Volatile Substances Abuse processes, procedures, Guideline and Act.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the Top End Health Service and the Department of Health conduct as soon as possible the review proposed in the Chief Executive Memorandum provided to my Office.
- I recommend the Top End Health Service provide such training and supervision as may be necessary to ensure their processes and procedures are in accordance with substance and intent of the *Volatile Substance Abuse Prevention Act*.

This Fatal facts summary has been produced by the National Coronial Information System and is released with the approval of the relevant State or Chief Coroner.
QUEENSLAND
The following cases summaries and recommendations relate to deaths reported to a coroner in Queensland.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>QLD.2011.3188</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Natural cause death</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Mental illness and health</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>53 – cases closed between April and June 2017</td>
</tr>
</tbody>
</table>

Case summary

An adult male died in a mental health ward at hospital while in seclusion under an involuntary treatment order.

The adult had several mental illnesses and had spent significant time in involuntary mental health care. On the day of the incident, the adult was brought to hospital by police under an emergency examination order. They were in a psychotic state and were placed under an involuntary treatment order and admitted to the hospital’s short stay unit to address their physical and mental ailments, including a serious respiratory illness.

Due to an administrative misunderstanding, the adult was transferred to a mental health ward. The adult exhibited aggressive behaviour on the ward and was placed in seclusion. Shortly after, the adult was noted to be unresponsive. Immediate resuscitation attempts were made but they were unable to be revived.

Coronial findings

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

The coroner found that the decision to take the adult to hospital was appropriate, and in the original triage process an adequate assessment was made of the adult’s mental and physical state.

The coroner found that the decision to transfer the adult to the mental health ward was premature and exposed the adult to grave risk in the context of their respiratory illness. The coroner found that the decision to place the adult in seclusion, while not strictly in accordance with the requirements of the statute, was appropriate in the circumstances.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the CIMHA [Consumer Integrated Mental Health Application] system should be reviewed and optimized in order to provide information summarizing the mental health
history of any patient who has been subject to an Involuntary Treatment Order, in order to assist a practitioner making a subsequent Emergency Examination Order under the Mental Health Act and that the CIMHA system should be available to (at least some) police on a read-only basis.

- I note the review undertaken by Queensland Health and the recommendations arising out of that review and I endorse those recommendations. I also note the changes to seclusion orders in the _Mental Health Act 2016_.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>QLD.2013.745</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Adverse medical effects</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Aged care, Older persons</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>53 – cases closed between April and June 2017</td>
</tr>
</tbody>
</table>

Case summary

An older adult male died suddenly and unexpectedly at their low level nursing care residential facility.

The adult lived independently within the residential facility. They had notified nursing staff that they were feeling unwell and were reviewed by a registered nurse. The nurse recorded the adult’s symptoms, including an umbilical hernia, vomiting and pain, and requested the adult’s general practitioner (GP) attend for a review.

The GP attended and examined the adult. The GP reduced the hernia and instructed nursing staff to monitor the adult’s condition. The adult deteriorated and died a few days later.

Coronial findings

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

The coroner found that the adult’s general practitioner did not read the nursing home progress notes, nor seek information from the nursing staff who requested the medical review for the adult. The coroner found that the history taken by the GP was inadequate, as were their instructions to the nurses responsible for the adult’s care following the review.

The coroner found that the nurses responsible for the adult’s care following the review were unfamiliar with the adult and their habits, and therefore did not recognise the symptoms of deterioration.

Coronial recommendations

The coroner made the following recommendations related to this case:

- It is recommended [care facility group] introduce a requirement for personal carers and assistants in nursing to enter any variation in a resident’s condition in the progress notes. The note should document to whom it was escalated and the enrolled nurse or registered nurse record in the progress notes the assessment and response.
• [Care facility group] encourage visiting medical officers to document the diagnosis and management plan, including any planned review and indications for earlier escalation. Such a policy might introduce procedure and training for registered nurses, enrolled nurses and endorsed enrolled nurses to assist them in requesting visiting medical officers to state and preferably record their diagnosis and treatment plan. It is not intended in this recommendation that the primary responsibility for communication and documentation would transfer from the doctor. However, the interests of the resident/patient should be the primary focus in ensuring that there is a written record of a doctor’s instructions to nursing staff following an attendance at a nursing home facility. The record must be sufficient to inform nursing staff from one shift to another what action the doctor requires and in what circumstances the doctor or emergency services should be contacted.

• [Care facility group] consider further training of personal carers and assistants in nursing authorising them to make entries in the medical records where appropriate. This recommendation recognises it is people in these roles who often have greatest continuity of contact with the resident and therefore the greatest appreciation of any change in the wellbeing of a resident in a nursing care facility.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>QLD.2014.1978</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Adverse medical effects</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Child and infant death</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>53 – cases closed between April and June 2017</td>
</tr>
</tbody>
</table>

Case summary

A male infant died following complications that occurred during their birth.

The infant was to be born via caesarean section. There were difficulties during the procedure, following which the infant was delivered.

The infant suffered significant head injuries and despite resuscitation efforts, they passed away a short time after delivery.

Coronial findings

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

The coroner found that the head injuries most likely occurred when the midwife used their hands in a certain manner to push the infant’s head upwards during delivery. An obstetrics and gynaecology specialist at inquest expressed the opinion that this was not done from any careless or negligent attitude and was an appropriate response in an emergency situation.

Coronial recommendations

The coroner made the following recommendations related to this case:

- The [hospital] Root Cause Analysis (RCA) review made a recommendation that any changes to the patients’ plan of care or issues identified must be documented by medical staff in the Medical and Obstetric Issues Management Plan in the Pregnancy Health Record and the charts were to be randomly audited to measure compliance. The family has concerns regarding whether the decisions recorded in the Medical and Obstetric Issues Management Plan are considered as there was some evidence it is not always looked at. I note this evidence and comment that the recommendation made in the RCA does need to be reinforced with staff and audits should continue.

- I recommend that Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) reconsider the policy statement C-Obs 37 Delivery of Fetus at Caesarean Section as to whether C-Obs 37 should include more information about the
Techniques to be adopted in the event of a presentation of a deeply impacted fetal head, consistent with the evidence of [inquest experts].

- In conjunction with the above recommendation, and consistent with the evidence of the experts that this is an area where not enough is taught or practised, it is incumbent on those involved in national training programs of obstetricians and midwives, as well as within teaching hospitals such as [hospital], to ensure there is ongoing training in simulated emergencies such as this event. I note staff spoke about receiving increased mandatory training in such topics as identifying obstructed labour, the use of Fetal Pillows, simulated emergencies, cardiotocography (CTG) interpretation and RANZCOG workshops, and this training needs to continue. I accept there may be some resistance to mandating that midwives receive such training but ultimately this would be limited to midwives who are likely to be involved in emergency situations in theatre, rather than midwives generally.
Coronial recommendations: Fatal facts

**Case number**
QLD.2015.3185

**Primary category**
Intentional self-harm

**Additional categories**
Law enforcement

**Fatal facts edition**
53 – cases closed between April and June 2017

**Case summary**
A young male died due to self-inflicted hanging.

The young person had threatened suicide earlier that day. Their partner contacted police when the young person locked themselves in the bathroom with a ligature. The young person communicated that they were attempting suicide.

Police arrived at the scene minutes later and spoke to occupants of the address before attempting to enter the bathroom. By the time police forced entry, the young person was unresponsive. They were transported to hospital but were unable to recover and died several days later.

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

The coroner found that the responding police did not hear specific information regarding the attempted suicide or the possession of the ligature in the bathroom over the police radio. The coroner found that the incident address was well known to police for domestic violence-related disturbances, and responding police believed they were responding to a similar incident.

The coroner found that the level of risk posed to responding police at the address was unknown, and they appropriately took the time to assess the situation to ensure the safety of the occupants. The coroner was unable to conclude if the earlier arrival of police at the address or in the bathroom would have altered the outcome.

The coroner found that information relating to jobs needs to be provided to first response officers in a way that is more reliable than a police radio. The coroner was satisfied that QLite devices provide police with effective access to significant real-time information about a job.

**Coronial recommendations**
The coroner made the following recommendations related to this case:
I recommend that the QPS [Queensland Police Service] continues to prioritise the distribution of QLite devices to front line officers, and that the Queensland Government provides the QPS with the necessary resources to enable the rollout of these devices.
TASMANIA

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>TAS.2014.72</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Misadventure</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Sports related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>53 – cases closed between April and June 2017</td>
</tr>
</tbody>
</table>

Case summary

A young male died due to environmental exposure while undertaking a notoriously difficult hiking trail.

The young person, an international student, undertook a physically challenging multi-day hike with fellow international students. Weather conditions were very poor on their day of departure, and staff at the visitor centre were unconvinced the group were adequately prepared for the hike.

Weather conditions were extreme by the time the group started walking, and the young person soon began to experience hypothermia. A group member ran ahead to seek help from other walkers, who returned to find them unresponsive. Resuscitation attempts were made and due to extreme weather a rescue party did not arrive until some hours later. The young person was declared deceased on their arrival.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the group’s clothing and food supplies were inadequate for the hike.

The coroner found that the Parks and Wildlife Service had no effective power to stop people from walking the track, but that the visitor centre staff try to provide guidance when they identify an individual who is ill-prepared to safely complete the hike. The coroner found that the staff in this case used their best efforts to communicate with the group but were hindered by language barriers. The coroner found that the group were largely inexperienced walkers, they considered they were sufficiently prepared and did not appreciate the weather conditions they were likely to encounter. No further discussion or advice from staff would have caused them to increase their preparation or understanding of the danger posed by the weather conditions.
The coroner found that a Walker Safety Checklist was available but optional at the time of the incident. The coroner noted that this checklist had since become a requirement for walkers to complete prior to departure.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that Parks and Wildlife Service (PWS) give consideration to the availability and use of legislative powers, and consequent development of procedures, to prevent persons embarking on the [hiking trail] walk when they are observed to be inadequately prepared for the conditions such as to place the safety of themselves and others at risk.
- I recommend that PWS introduces language buttons on the [hiking trail] web page that enable translation of the information, including the Walker Safety Checklist, into the main languages used by those undertaking the walk.
- I recommend that PWS introduces clear signage in the Visitors Centre in the main languages used by walkers, alerting them to the potentially difficult and changeable conditions that they may encounter and the need for thorough preparation for the walk.
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: TAS.2015.250, TAS.2015.258, TAS.2015.324</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Law enforcement</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Intentional self-harm, Natural cause death</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>53 – cases closed between April and June 2017</td>
</tr>
</tbody>
</table>

Case summary - TAS.2015.250

An adult male died due to self-inflicted hanging. They were being transported in a prison van at the time of the incident.

The adult was arrested the previous day and taken to a police watch house. While in the watch house, the adult noted that they suffered from anxiety, were feeling suicidal and expressed concern about being in a confined space. They requested a doctor a short time later, but the request was not actioned by police. The adult was behaving erratically while in their cell and threatened self-harm.

The adult was transported to a remand centre, where their behavioural and mental health concerns were relayed verbally to centre staff by police. There was no written record of this handover. Due to staff shortages at the remand centre, the adult did not undergo a Suicide and Self-Harm (SASH) risk assessment, and at no time was identified as ‘at-risk’, despite their reporting of suicidal thoughts.

The adult was then transported to a prison for psychological assessment via a prison escort van. The transporting officers were not made aware of the reason for the adult’s psychological assessment, nor of their recent threats of self-harm. During the journey, the adult fatally self-harmed. They were not discovered until the van reached its destination some time later.

Coronial findings

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

The coroner found that the care, supervision and treatment of the adult while in police custody and at the remand centre was not of an acceptable standard. The coroner found that the lack of risk assessment undertaken was unacceptable, as was the failure to identify the adult as being at risk of self-harm at any time while in custody. No steps were taken to ensure the adult’s safety during transfer.
The coroner found that the adult was clearly visible on the closed-circuit television (CCTV) footage in the van. The coroner found that the transporting officers did not view CCTV footage of the prisoners in the van as often as they were required to do so.

Case summary - TAS.2015.258
A middle aged male died due to self-inflicted hanging. They were a prisoner at the time of the incident.

The adult had been imprisoned a few months prior and was having difficulty adjusting to prison life. They had attempted suicide prior to being arrested and imprisoned. They were reviewed by a prison doctor who rated them as at potential high risk of self-harm if their case did not go well. A fellow inmate reported concerns that the adult may self-harm, and a partial risk assessment was undertaken as a result.

The adult was discovered hanging in their cell.

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

The coroner found that the adult’s physical and mental health was as well catered for as the circumstances of their incarceration allowed. The coroner found that their mental health and wellbeing was monitored, and concerns relayed by a fellow inmate were appropriately addressed.

The coroner found that the adult was a suicide risk and was accurately assessed as such by the prison doctor. The adult kept the warning signs hidden from those with the responsibility of caring for and close to them. The coroner found that there was little that could have been done to prevent the death.

Case summary - TAS.2015.324
A young male died due to natural causes while serving a prison sentence.

Upon their entry into the prison system, the young person was assessed as low risk, and there was no indication of physical or mental health concerns. They had a history of methamphetamine use.

The young person was discovered collapsed in their cell. Correctional officers, medical personnel and ambulance officers attended, but they were unable to be revived.

Coronial findings
The coroner found that the death was due to natural causes.
The coroner found that the care, supervision and treatment of the young person while in custody were of an acceptable standard. The coroner found that the young person was appropriately treated and cared for by all parties who responded to their fatal collapse.

Coronial recommendations

The coroner made the following recommendations related to these cases:

- I recommend that all police officers who are responsible for the custody of detainees and those responsible for cell watch duties be clearly reminded of their duties under section 7.2 of the Tasmania Police Manual and particularly order 7.2.10.
- I recommend that at least fully up-to-date prisoner admission and assessment forms be provided by Tasmania Police to the Tasmania Prison Service at the moment custody of a detainee passes from Tasmania Police to the Tasmania Prison Service.
- I recommend that all Tasmania Prison Service officers processing inmates undergo further training as to the proper method of processing including the need to check the inmates’ records relating to previous periods of custody.
- I recommend that adequate staff be rostered on at all times at the [prison] so as to enable correctional Tier 1 assessments to be completed as mandated by Director’s Standing Order 2.06.
- I recommend that all Correctional Primary Health Service nursing staff receive further training in relation to the completion of nursing (or health) Tier 1 forms and nursing staff at the [prison] be provided with, trained in the use of, and required to use, a computer upon which to complete such assessments.
- I recommend that the Tasmania Prison Service ensure that the appropriate staff mix is available at the [prison] to enable Risk Intervention Teams to operate at that facility in accordance with Order 14.1 of Director’s Standing Order 2.01.
- I recommend that the Tasmania Prison Service [location to location] escort seating plan form be amended so that it accords with the categories contained in Director’s Standing Order 1.20 – External Escorts.
- I recommend that the Tasmanian Prison Service review Emergency Operating Procedure 03 ‘Code Blue’ regarding the continuation of CPR [cardiopulmonary resuscitation].
- I recommend that the carrying of cut down knives by first and second response teams continue and that cut down knives continue to be located in each accommodation area and carried in escort vehicles.
- I recommend that slip on footwear replace all footwear with laces for all prisoners and detainees in the Tasmania Prison Service.
- I recommend the establishment of a specialist Tasmania Prison Service escort unit.
- I recommend an appropriate vehicle be purchased to enable special escorts to be safely carried out.
- I recommend all prisoner escort vans in Tasmania be fitted with a seatbelt of the type designed by [company] for Corrections Victoria.
• I recommend that the Tasmania Prison Service engage a medical practitioner to enable face-to-face consultations occur as and when needed at the [location] Prison.

• I recommend that a sufficient number of suitably trained medical practitioners are always rostered on by Correctional Primary Health Service.

• I recommend that a proper evaluation of the Prison Health Pro System be carried out in it and if as a result of that evaluation it is identified that improvements can be made to the system then those improvements be implemented.

• I recommend that formal training be provided to all new nursing staff in the proper use of Prison Health Pros System and that refresher training be provided to all nursing staff at least once per year.

• I recommend that the external medical records of any inmate going into custody are to be made available within 48 hours of any request being made by Correctional Primary Health Service.
Coronial recommendations: Fatal facts

Case number | TAS.2015.267
Primary category | Drugs and alcohol
Fatal facts edition | 53 – cases closed between April and June 2017

Case summary
An adult female died as a result of a cardiac arrest of unknown cause.

The adult had a history of chronic pain, depression, alcohol abuse and illicit drug use. They suffered a cardiac arrest at home and were transported to hospital, where circulation was restored. Urine tests taken on the adult’s admission to hospital indicated the presence of alcohol and amphetamines. They did not recover and died some weeks later.

Coronial findings
The coroner was unable to determine the circumstances of the death.

The coroner found that the cardiac arrest was due to hypokalaemia, which in turn was likely attributable to poor diet, alcohol abuse and amphetamine use.

The coroner found that although blood samples were taken at the time of the adult’s admission to hospital, they were discarded without any toxicological testing. The coroner found that without knowing the levels of alcohol or amphetamines in the adult’s blood at the time of the cardiac arrest, there was no information to verify a link between the hypokalaemia and the arrest.

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

- This situation leads me to recommend that the Tasmanian Health Service, in liaison with its Forensic Medical Services, put in place a procedure to ensure that samples of blood taken from patients whose hospital admission is suspected to be associated with abuse of alcohol and/or illicit substances are retained so that they are available for toxicological testing in the event of death. Obviously, the samples would not need to be retained in those cases where the patient recovers and is discharged.

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

Case number: TAS.2015.298
Primary category: Adverse medical effects
Additional categories: Falls
Fatal facts edition: 53 – cases closed between April and June 2017

Case summary
A middle aged female died due to an undiagnosed head injury.

The adult suffered a fall at a building site and presented to their general practitioner for treatment. The adult suffered from headaches following the fall and was conveyed to hospital a few days later. The hospital had no beds available and the adult was sent home in the care of their partner. They were found deceased at home the following day.

The adult was taking blood thinning medication at the time of their fall.

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

The coroner found that the general practitioner did not order a computed tomography (CT) scan until several days after the adult first presented for treatment, as they determined at that time that the adult had not suffered any major head trauma.

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

- That they inform their members of the contents of the several guidelines as they relate to the prompt scanning of anti-coagulated patients with a head injury.
Coronial recommendations: Fatal facts

Case number  | TAS.2015.526
-------------|-------------------
Primary category  | Adverse medical effects
Fatal facts edition  | 53 – cases closed between April and June 2017

Case summary
A middle aged female died from complications caused by a dislodged percutaneous endoscopic gastrostomy (PEG) tube.

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

The coroner found that results from the x-ray taken to determine if the adult’s PEG tube had been dislodged were incorrectly interpreted and an erroneous report was produced. As a result, the PEG tube displacement was not identified and the adult developed peritonitis, which rapidly proved fatal.

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

- That more care must be taken in interpreting and reporting upon the results of radiological examination in circumstances where PEG tubes are suspected of being dislodged or wrongly positioned.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>TAS.2015.546</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Adverse medical effects</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Falls</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>53 – cases closed between April and June 2017</td>
</tr>
</tbody>
</table>

Case summary

An older adult female died due to complications resulting from a fall.

The adult resided in a nursing home. Staff were mobilising the adult using a stand-up lifter when a strap on the lifter detached, causing the adult to fall to the floor.

Coronial findings

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

The coroner found that prior to the incident, the adult had undergone a mobility assessment. The assessment report stipulated that the adult required full hoist transfers as they were unable to weight bear safely enough to use the stand-up lifter. A notice had been affixed to the adult’s room reminding staff of the transfer requirements.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That [nursing home] carry out a comprehensive review of its practices with a view to reducing the risk of its staff members failing to comply with patient care plans. [The deceased’s] unfortunate death illustrates the urgent need for this to be done and for any recommended system changes to be implemented.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>TAS.2016.393</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Adverse medical effects</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>53 – cases closed between April and June 2017</td>
</tr>
</tbody>
</table>

Case summary

A middle aged female died due to complications following gastric sleeve surgery.

The adult suffered from obesity, type 2 diabetes and hypertension. They had been on a waiting list for medical intervention to aid in weight loss.

The adult suffered a series of difficulties in the post-operative recovery period, and they spent time in and out of hospital. They were scheduled for an additional surgery but became short of breath while in hospital. Resuscitation was commenced by the adult was unable to be revived.

Coronial findings

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

The coroner found that the adult’s care management in the months following their procedure was ad hoc, unstructured, unmonitored and without direct supervision.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the [hospital] conduct a review of its practices surrounding the post-operative care of weight reduction patients with a view to having in place a structured and closely monitored plan designed to maximise the prospects of patient recovery particularly in those instances where post-surgical complications arise.
VICTORIA

The following cases 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.2011.4801</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Natural cause death</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Child and infant death</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>53 – cases closed between April and June 2017</td>
</tr>
</tbody>
</table>

Case summary
A female child died due to natural causes.

From birth up until their death, the child experienced significant difficulty in toileting, resulting in visits to a medical practitioner. The child continued to complain of stomach pains over a few years, but their parent did not seek further medical treatment for them.

On the day of the incident, the child became severely ill while staying with relatives. Their condition deteriorated and emergency services were contacted. They were conveyed to hospital where they later passed away.

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

The coroner found that the death would not have been unexpected had the child received the appropriate and necessary medical treatment for encopresis prior to their presentation at hospital on the day of their death.

The coroner found that there was a lack of understanding of how to manage children suffering from encopresis among persons responsible for the child’s care outside their family.

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

- That [education provider] and the Department of Education and Training each review its training policies and procedures for their respective staff, who have contact with children, to ensure that it is consistent with the Royal Children’s Hospital document titled ‘Recommended Management for Constipation Associated with Faecal Incontinence in Children’.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2012.745</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Water related</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Transport and traffic related, Leisure activity</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>53 – cases closed between April and June 2017</td>
</tr>
</tbody>
</table>

Case summary

A middle aged male died due to a head injury sustained during a watercraft incident.

The adult was swimming at a beach when they were struck by a jet ski. The adult was towed to shore for medical attention. They were conveyed to hospital where they were found to have suffered a severe brain injury. The adult passed away a few days later.

The adult was a frequent swimmer in the area and always swam within the ‘swimming only’ zone. The jet ski user had recently obtained a recreational boat licence and had been driving the jet ski in a water vessel exclusion area at high speed.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the effectiveness of the Victorian marine licencing regime and the safety of the public could be enhanced by the introduction of a practical element to licencing assessments.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Minister for Roads and Road Safety take the necessary steps to introduce a relevant practical component as part of the assessment process for general and restricted marine licences and for personal watercraft endorsements.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2012.3325</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Homicide and assault</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Mental illness and health</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>53 – cases closed between April and June 2017</td>
</tr>
</tbody>
</table>

Case summary

A young female died due to an assault inflicted by their former partner.

The partner struggled to deal with the recent ending of the couple's relationship; they began drinking excessively, taking illicit drugs and attempted to take their own life. The partner was taken to hospital and referred to a youth mental health organisation for treatment. The partner later came to possess a weapon which they stated they would use to kill the young person.

On the night of the incident, the young person was attending a party. The partner drove to the party, collected the young person in their car under the pretence of wishing to speak to them, and drove to a park where they inflicted the fatal assault.

Coronial findings

The coroner found that the death was due to assault.

The coroner found that there was room for improvement in public policy regarding the mental health care and practitioner reports of persons demonstrating threats and acts of violence.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the State of Victoria through the Department of Health and Human Services gives consideration to the removal of the requirement that a "serious risk of harm" be also one which is "imminent", this by amendment to the Health Records Act 2001, (Vic), HPP [Health Privacy Principle] 2.2 (h).
- That the existing Australian Psychological Society Code of Ethics and relevant Guidelines, together with the current training protocols provided to psychologists in this State, be reviewed by the Psychology Board of Australia in collaboration with the Australian Psychological Society with a view to providing greater clarity as to:
the need to enter into clearly understood arrangements with patients, which 
arrangements define the importance of patient confidentiality while setting out 
the circumstances in which confidentiality may be breached under HPP 2.2(h);

when it should be reasonably concluded that the psychologist's obligation to 
disclose confidential Health record information under HPP 2.2(h) arises;

whom notification under [the point] above should be made and with what if any 
recommendation offered, this with a view to best manage the threatened 
behaviour under consideration;

the need or other for a psychologist to seek to obtain collateral or third party 
information concerning the progress being made by a patient suffering from 
mental illness, when undertaking a risk analysis in respect of that patient.

That the Australian Psychological Society develop a separate online e-Learning course 
specific to risk of harm to include assessment and management similar to the existing 
suicide prevention professional development training but focussed on prevention of harm to others.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2013.1786</th>
</tr>
</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>53 – cases closed between April and June 2017</td>
</tr>
</tbody>
</table>

Case summary

An older adult female died due to complications from a fall.

The adult was a resident at an aged care residential facility and required a high level of nursing care. The adult was being transferred from their bed to a chair by two staff members using a hoist machine. As the hoist was being operated, it began to lower unexpectedly. A staff member grabbed the adult to avoid them being struck by the hoist and the adult fell to the ground. The adult was conveyed to hospital where their condition deteriorated, and they later passed away.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that there was no evidence available to firmly establish the cause of the incident. The hoist machine and sling were found to be in safe working order at the time of the incident.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I make a recommendation to [hoist distributor], the Victorian supplier and distributor of the [hoist model], to notify the manufacturer in relation to a possible design review of existing safety features within their ceiling hoist product range in light of the circumstances of [the deceased's] death.

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

Case number  
VIC.2013.2821

Primary category  
Homicide and assault

Additional categories  
Law enforcement, Drugs and alcohol

Fatal facts edition  
53 – cases closed between April and June 2017

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

The adult ran a retail business. An armed assailant entered the premises of the business, inflicting fatal injuries upon the adult. Despite the efforts of bystanders, the adult was unable to be resuscitated and passed away at the scene.

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

The coroner found that the assailant had an extensive history of criminal activity and drug use. The coroner found that improvements could be made to practices of Corrections Victoria and the Adult Parole Board with regard to parolees.

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

- I recommend that the Minister for Corrections explore whether Corrections Victoria and the Adult Parole Board should be granted coercive powers to obtain the health and medical records of offenders, in order that they are accurately informed of all relevant matters when conducting risk assessments for parole applications.
- I recommend 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.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2013.4432</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Work related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>53 – cases closed between April and June 2017</td>
</tr>
</tbody>
</table>

**Case summary**

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

The adult worked as a truck driver. On the day of the incident, the adult delivered a load of livestock to an abattoir. The adult reversed their truck to an unloading ramp. While standing on the ramp, a component of the hoist mainframe above the ramp broke, causing the hoist to fall and strike the adult. They were conveyed to hospital where they later passed away.

**Coronial findings**

The coroner found that the death was unintentional.

The coroner found that the adult had previously attended the abattoir but had not received any formal training or induction by the abattoir operator. The coroner found that the abattoir operator breached its obligations to ensure, as far as reasonably practicable, that persons other than its employees were not exposed to safety risks with respect to the design, maintenance and instructions for use of the ramp.

**Coronial recommendations**

The coroner made the following recommendations related to this case:

- That Standards Australia consult with relevant stakeholders as to the feasibility and desirability of developing a single Australian Standard applicable to the construction, inspection and maintenance of livestock ramps and the induction to premises containing such ramps.

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

Case number | VIC.2014.2440
Primary category | Drugs and alcohol
Additional categories | Law enforcement
Fatal facts edition | 53 – cases closed between April and June 2017

Case summary
A middle aged male died due to drug toxicity.
The adult had been remanded in custody at a police station and was found unconscious in their cell. Emergency services were contacted and resuscitation was attempted. 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 response of a Custodial Health Advice Line nurse consulted regarding the adult’s welfare was neither reasonable nor appropriate. As a result, the adult was denied the opportunity of receiving immediate hospital transfer and straightforward medical intervention.
The coroner found that the nurse’s training for the role did not reflect best practice.

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

- That Victoria Police introduce training for Custody Sergeants and Custody Staff regarding identifying and communicating signs and symptoms of life-threatening conditions. Such training ought to include the practicalities of understanding aspects of the medical checklist and ought to train on using the ISBAR [identify, situation, background, assessment, recommendation] philosophy to communicate concerns.
- That Victoria Police review the medical checklist to incorporate difficulty of rousability into the checklist. Exactly how this is done is a matter for further medical opinion and advice, although it is submitted that as a starting point, if a person is not orientated to time and space (i.e. is on the scale anything lower than a 5) and is difficult to rouse then this should arguably lead to the need for an ambulance to be called.
• That Victoria Police consider the viability of introducing web camera or similar device into the CHAL [Custodial Health Advice Line] system (one roving camera per police gazetted cell block facility) to be live-streamed to the CHAL nurses.
• That Victoria Police develop a formal training module for CHAL nurses along the lines proposed by [nursing expert] and ensure that they undergo training and appropriate support/review of their work prior to undertaking the role of providing telephone advice regarding the health of detainees in police custody.
• That CHAL protocols be amended as suggested by [nursing expert] to include a basic primary survey structure and appropriate physiological descriptors.
• That Victoria Police redevelop a training package which highlights the mandatory requirement that medical checklists are always referred to when concerns for prisoner welfare are held. In addition, whether there is a more appropriate tool to assess the need for urgent medical treatment.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2014.4138</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Natural cause death</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Mental illness and health</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>53 – cases closed between April and June 2017</td>
</tr>
</tbody>
</table>

Case summary

An adult male died due to natural causes.

The adult suffered from schizophrenia. They were admitted as a voluntary patient to a rehabilitation facility to assist with decreasing alcohol use and improving their medication management.

On the day of the incident, the adult was feeling tired and unwell. They were later found unresponsive by nursing staff. The adult was conveyed to hospital where they later passed away.

Coronial findings

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

The coroner noted that sudden deaths due to unknown causes were more common among persons with schizophrenia than the general population.

Coronial recommendations

The coroner made the following recommendations related to this case:

- The Victorian Government Department of Health and Human Services promote research into the underlying reasons for and the prevention of sudden death in people with schizophrenia through means such as the multidisciplinary and cross-sectional Mental Illness Research Fund.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2014.4712</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Adverse medical effects</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Child and infant death</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>53 – cases closed between April and June 2017</td>
</tr>
</tbody>
</table>

Case summary

A male infant died due to an infection and renal failure.

The infant was assessed by multiple general practitioners in the days leading up to their death with a variety of symptoms. When their symptoms worsened, emergency services were contacted and they were conveyed to hospital for further assessment. They were later discharged from hospital.

The infant was again seen by a general practitioner for continued symptoms the next day. Before being taken to hospital, the infant suffered a seizure and emergency services were called. Despite attempts to resuscitate the infant, they 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 the initial assessment and treatment provided to the infant in hospital was inappropriate and inadequate. The coroner found that the infant’s discharge from hospital was inappropriate and that guidelines for their re-presentation were not provided to the infant’s caregivers. The opportunity to recognise and treat the infant’s critical condition was missed, resulting in their death.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Department of Health and Human Services require that Emergency Departments in hospitals be mandated to provide a legible discharge summary if it is reasonably foreseeable and that upon discharge from the treating department, follow-up of a patient is required by another health service or health professional.
- That the [hospital] Emergency Department uses [the deceased’s] specific case example in staff education to highlight:
  - The Royal Children’s Hospital Clinical Practice Guidelines for assessment and treatment of a febrile child;
The importance of evaluating hydration status and taking a blood pressure in paediatric patients;

The importance of considering differential diagnoses;

The importance of formal follow up arrangements and provision of discharge information to families; and

The consideration of consultation with specialist paediatric services in certain situations, such as, when there have been multiple presentations to medical services for the same issue.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2014.6491</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Transport and traffic related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>53 – cases closed between April and June 2017</td>
</tr>
</tbody>
</table>

Case summary

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

The adult was riding a motorcycle when they were involved with a heavy vehicle performing an illegal U-turn. The adult suffered significant injuries and passed away at the scene.

The adult was riding the motorcycle at excess speed at the time of the collision.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that a combination of factors contributed to the collision, but that the ease and frequency with which heavy vehicles performed illegal U-turns at the location was unsatisfactory and unsafe.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the [ports corporation] and VicRoads review the area and consider remediation of the road layout at the [dock and road] intersection, [suburb], either by construction of a physical barrier to prevent illegal U-turns at the collision site, a viable roundabout or U-turn facility further down [road] or otherwise.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2015.831</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Child and infant death</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Location, Transport and traffic related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>53 – cases closed between April and June 2017</td>
</tr>
</tbody>
</table>

Case summary

A male child died due to heatstroke.

The child had been inadvertently left in a motor vehicle by their parent, who had experienced significant illness and sleep deprivation in the period leading up to the incident.

When discovered, attempts were made to resuscitate the child and emergency services were contacted. The child was unable to be revived.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the parent’s short-term memory was compromised, leading them to accidentally leave the child in the vehicle.

The coroner found that a multi-level response was required to avoid such deaths occurring, and that modifications to vehicle safety features could be made to prevent children from being inadvertently left in vehicles.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That Standards Australia a review Australian and New Zealand Standard AZ/NZS 1754 ‘Child restraint systems for use in motor vehicles’ and any other relevant standard within its portfolio for the purpose of determining whether the introduction of hard-wired safety features in a child restraint will deliver an overall benefit to the Australian community (the review).
- If it is concluded that the review would deliver an overall benefit to the Australian community, that Standards Australia take such steps as are necessary to modify AS/NZS 1754 ‘Child restraint systems for use in motor vehicles’ and any other relevant Standard to ensure that hard-wired safety features are introduced where appropriate.
• That the Department of Education and Training expand its current public facing awareness campaign related to children being left in motor vehicles to include circumstances that involve a child being inadvertently left in a motor vehicle.
• That the Department of Education and Training develop a fact sheet and/or risk assessment tool for relevant professionals that addresses the physiology and cognitive neuroscience of the human memory specific to the circumstances similar to those involved in [the deceased’s] death.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2015.3497</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Intentional self-harm</td>
<td></td>
</tr>
<tr>
<td>Additional categories</td>
<td>Mental illness and health</td>
<td></td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>53 – cases closed between April and June 2017</td>
<td></td>
</tr>
</tbody>
</table>

Case summary

An adult male took their own life by hanging.

The adult had a history of psychological illness and drug use. They had been admitted to hospital on multiple occasions for mental health treatment and absconded from hospital numerous times.

Upon their final admission to hospital, the adult remained in the emergency department as there were no psychiatric inpatient beds available. They absconded again and were later found deceased in a park.

Coronial findings

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

The coroner found that security provisions at the hospital were suboptimal and that the assessment area for mental health patients within the emergency department was lacking.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That [public health service] implement a Behavioural Assessment Room at [hospital] and, if appropriate, across the network of [public health service] hospitals.
- That [public health service], in conjunction with Better Care Victoria, implement a Behavioural Health Precinct at [hospital] and, if appropriate, across the network of [public health service] hospitals.
- That [public health service], in conjunction with Better Care Victoria, increase the acute mental health inpatient bed capacity at [hospital] and, if appropriate, across the network of [public health service] hospitals.
- That [public health service] review the manner in which clinical histories are obtained by staff when performing mental health assessments for patients presenting at the emergency department.
That [public health service] review its policies or procedures (if any), for incorporating information received from third parties about patients who present to the emergency department, particularly with psychiatric conditions.
Coronial recommendations: Fatal facts

Case number: VIC.2015.4328
Primary category: Drugs and alcohol
Additional categories: Mental illness and health
Fatal facts edition: 53 – cases closed between April and June 2017

Case summary
An adult female died due to combined drug toxicity.

The adult was an involuntary patient at a hospital psychiatric unit. The adult was visited in hospital by their spouse, who supplied them with heroin. The adult was later found unresponsive by nursing staff and was unable to be revived.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the spouse had not been searched upon their entry to the unit, allowing them to conceal the heroin. The coroner concluded that existing search procedures could be enhanced and that more could be done to educate hospital patients and visitors about the risks posed by patients’ use of illicit drugs.

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

- [Health service’s] Searching of a Consumer and their Property/Belongings procedure be amended [...] so that it contains the words: ‘Staff should not touch the contents but the visitor should be requested to remove the contents of their bags and their pockets for inspection’.
- The [psychiatric unit] Visitor Information Sheets be amended [...] so that it contains the warning: ‘HOSPITAL PATIENTS HAVE AN INCREASED RISK OF OVERDOSE FROM ILLICIT SUBSTANCES’.
- [Health service] take steps to ensure that the [psychiatric unit] Visitor Information Sheets and warning signs are available in other languages or otherwise capable of being understood by persons with non-English speaking backgrounds or poor English literacy.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2015.4603</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Natural cause death</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>53 – cases closed between April and June 2017</td>
</tr>
</tbody>
</table>

Case summary

An older adult female died due to complications of a brain tumour.

Several years prior to their death, the adult was found to have a brain tumour. At the time, it was described as small and incidental, and no recommendation was made for follow-up in the report on its identification.

The adult presented to hospital with a recent history of unsteadiness, falls and headache. The tumour was identified, management options were discussed, and the adult was scheduled for surgery. A few days prior to the surgery, the adult was found unresponsive by nursing staff and was unable to be resuscitated.

Coronial findings

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

The coroner found that the opportunity for surveillance of the tumour’s growth was lost due to the lack of follow up and monitoring in the years prior to the adult’s death.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the Royal Australian and New Zealand College of Radiologists develop guidelines with regard to the reporting of incidental meningiomas, so that the reporting radiologist is required to make specific recommendations to the referring doctor regarding appropriate follow up, such as surveillance imaging or neurosurgical review.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2015.4687</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Water related</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Child and infant death, Domestic incident</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>53 – cases closed between April and June 2017</td>
</tr>
</tbody>
</table>

Case summary

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

The child had gone to sleep alongside their parent. When the parent woke, the child was missing. The child was found in the backyard swimming pool a short time later.

Emergency services were contacted, and resuscitation attempts were made. The child was unable to be revived.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the pool’s safety barriers were badly damaged and faulty.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That during the review of the Building Regulations 2006, the Minister for Planning consider adopting elements of the framework enacted in Queensland, including but not limited to, requiring that a pool safety certificate be obtained prior to a property with a pool being sold or leased.
- That, as anticipated in the recommendation made by Deputy State Coroner [name] in [similar case], the Minister for Planning consider the creation of a statewide pool register.
- That the Minister for Consumer Affairs, Gaming and Liquor consider that Consumer Affairs Victoria also produce a pro forma Routine Inspection Report document, which incorporates reference to 'pool fence and gate' and 'spa fence and gate', as in its condition report.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>The coroner held a joint investigation into the following deaths which resulted from the same incident: VIC.2015.5120, VIC.2015.5122</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Water related</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Transport and traffic related, Leisure activity</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>53 – cases closed between April and June 2017</td>
</tr>
</tbody>
</table>

Case summary

Two older adult males drowned when their recreational fishing vessel capsized near a reef. Neither was wearing a personal flotation device (PFD), although they were both poor swimmers.

The adults had checked the weather forecast before launching the boat and motoring to a nearby channel on a reef to commence drift fishing. While weather conditions on the day were not objectively poor, the conditions in the area they chose were known locally to be dangerous.

The adults were experienced in fishing. One of the adults often fished near the reef where the fatal incident occurred.

Coronial findings

The coroner found that the deaths were unintentional.

The coroner found that the older persons were not required to wear PFDs under the Marine Safety Regulations 2012 due to the size of the vessel and the fact they were not boating at a time of ‘heightened risk’. The coroner found that the chances of survival would have been enhanced by the wearing of PFDs.

The coroner found that the definition of ‘heightened risk’ as noted in the Marine Safety Regulations 2012 was not well understood by boaters and found that boaters were not equipped to conduct adequate risk assessments.

Coronial recommendations

The coroner made the following recommendations related to these cases:

- If it has not already done so, Maritime Safety Victoria should conduct a systematic review of existing safety markings of Victorian coastal reefs to assess their adequacy and where necessary to provide additional signage and cardinal markers.
• The legislation regulating the use of PFDs should be reviewed, in particular as to the adequacy of the definition of 'heightened risk' and whether it should include boating in coastal reef areas and adverse weather or water conditions other than the ones currently specified.
• Maritime Safety Victoria produce and disseminate educational information about the dangers of coastal reefs and the advisability of wearing PFDs at all times, particularly given the unpredictability of weather and water conditions.
Coronial recommendations: Fatal facts

Case number | VIC.2015.5622
Primary category | Electrocution
Additional categories | Work related
Fatal facts edition | 53 – cases closed between April and June 2017

Case summary
An older adult male died due to a workplace incident.

The adult was retired but performed odd jobs and gardening at a farm. On the day of the incident, the adult was found slumped over a fence at the farm. They were unresponsive.

Emergency services were contacted, and resuscitation was attempted. The adult was unable to be revived.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the adult died as a result of electrocution when they made contact with a live star picket and a metal fence.

The coroner found that there were multiple factors that contributed to the incident, including the failure of an interconnector plug and a broken earth cable.

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

- That Energy Safe Victoria issue a Safety Alert to registered electrical contractors in regional Victoria notifying them of the circumstances of this death and the importance of installing a residual current device protected power point or utilising a portable residual current device on a power point when installing or performing maintenance work on an external water pump.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2015.5676</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Natural cause death</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>53 – cases closed between April and June 2017</td>
</tr>
</tbody>
</table>

Case summary

A middle aged male died due to natural causes.

The adult resided with their sibling, who received disability services from the local council. The adult was believed to suffer from a mild intellectual disability but did not receive disability services. On the day of the incident, the sibling was unable to rouse the adult. When a care worker visited the premises later that day, they found the adult deceased.

Coronial findings

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

The coroner found that significant opportunities to provide specialised individual care to the adult had been lost due to the lack of a clear avenue for care workers to escalate concerns at the local council.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the [local council] develop and implement appropriate policies and procedures within the context of an overarching home care policy, for home care staff to support the escalation of health and welfare concerns about a client and/or household member.
- That the [local council] review its training for staff around their policies and procedures in general, but more specifically around the implementation of the new policies and procedures related to the home care policy as identified in [the first recommendation].
- That the Department of Health and Human Services, if it has not already done so, review its processes for maintaining a knowledge base about the needs of people requiring such services.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2016.1113</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Transport and traffic related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>53 – cases closed between April and June 2017</td>
</tr>
</tbody>
</table>

Case summary

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

The adult was crossing a road between stationary traffic when they lost their balance, falling into the path of a heavy vehicle as it accelerated.

Bystanders alerted the vehicle’s driver and emergency services were contacted. The adult was confirmed to have passed away at the scene.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the area was not a designated pedestrian crossing and the driver was unable to see the adult from their vehicle.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Victorian Transport Association Inc. and the Transport Industry Safety Group continue to investigate previously identified concerns about the lack of forward visibility in trucks and heavy vehicles, and what can be done to improve pedestrian safety.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2016.4027</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Intentional self-harm</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>53 – cases closed between April and June 2017</td>
</tr>
</tbody>
</table>

Case summary
A young female took their own life by asphyxiation.
The young person had a history of depression, anxiety and self-harm.

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

The coroner found that the investigation into the death of the young person did not identify where the helium gas was purchased from. The coroner noted that helium gas bottles were often sold direct from retail stores and photographic identification was not required for purchase.

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

- That the Australian Competition and Consumer Commission consider working to restrict the ease of access to helium gas by members of the Australian public.

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

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>WA.2011.774</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Water related</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Work related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>53 – cases closed between April and June 2017</td>
</tr>
</tbody>
</table>

Case summary
An adult male died due to drowning in a workplace incident.

The adult was working on scaffolding situated directly over water. The scaffolding collapsed, causing the adult to fall into the water. They did not resurface.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the adult was not wearing a personal floatation device (PFD) at the time of the incident. It was not industry practice for workers who were working over areas of water or liquid to wear a PFD.

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

- That the committees responsible for the relevant Australian Standards consider amendments to ensure that people working over or adjacent to water or liquid who may be at risk of falling into the water and drowning wear an approved personal floatation device (PFD) – including AS/NZS 1891.4:2009 (committee SF-015 and AS/NZS 4576:1995 (committee BD-36).
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>WA.2011.967</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Work related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>53 – cases closed between April and June 2017</td>
</tr>
</tbody>
</table>

Case summary

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

The adult was an experienced and qualified rigger. They were working on a construction site when a soakwell lid being moved by a crane fell on them, causing fatal injuries.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the equipment used to attach the soakwell lid to the crane cable was inappropriate and did not comply with the National Code of Practice for Precast, Tilt-up and Concrete Elements in Building Constructions (the code). However, it was not required to comply because the code did not apply to civil construction works.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Western Australian Commission for Occupational Safety and Health and the Minister of Commerce consider and, if appropriate, implement as soon as possible amendments to the *Occupational Safety and Health Regulations 1984* to apply the requirements of AS 3850:2015 to civil construction works.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>WA.2012.1277</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Child and infant death</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>53 – cases closed between April and June 2017</td>
</tr>
</tbody>
</table>

Case summary

A female child died due to unexplained cardiac arrest.

The child was in the care of a foster family and under the management of the Department for Child Protection and Family Support (DCP). The child had recently relocated and been placed with another foster family in a different location.

Coronial findings

The coroner was unable to determine the circumstances of the death.

The coroner found that the care for the child provided by the foster family became suboptimal. The child suffered bouts of injury, regression in progress and demeanour which were either unnoticed or not acted upon due to the circumstances that surrounded the child’s care and monitoring.

The coroner found that when the child was relocated to another foster family, the DCP office in charge of the child’s case management placed them on a monitored list which removed the need for a permanent case manager.

The coroner found that concerns for the child and their demeanour were reported to each case support officer at each supervised visit by the child’s biological parents. However, as the child was no longer in the care of a case manager, reports from each supervised visit were not read.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That on the transfer of children in care from one location and set of carers to another, there be appropriate assessment by consultant paediatricians in the new location to record a child’s welfare and progress. This is on top of and in addition to their annual assessments.
• All children transferred from one location to another have a case worker. Only successful long-term foster placements should be placed on a monitored list, after a suitable period of reasonable review.

• All contact of Department for Child Protection and Family Support (DPC) workers with children in care be recorded and appropriately assessed in a group meeting to ensure there is adequate supervision of the care and treatment provided to children in departmental care.

• Resourcing for the State Mortuary to be provided with a Computed Tomography (CT) scanner. It would assist the forensic pathologists to have appropriate technology for their investigations and enable more compatibility of language between pathologists and clinicians. In evidence [doctor] indicated the [hospital] CT scanner was state of the art and would be available on opening of the new children hospital, which hoped to have raised funds by then for new improved technology in the form of optical coherence tomography to assist [hospital] clinicians with imaging.
## APPENDIX A: FATAL FACTS WEB TOOL CATEGORY TAGS

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adverse medical effects</td>
<td>Adverse after effects from a recent medical or surgical treatment, failure to comply with medical advice.</td>
</tr>
<tr>
<td>Aged care</td>
<td>Incidents that occurred in an aged care or assisted living facility or residence including a retirement village.</td>
</tr>
<tr>
<td>Animal</td>
<td>Incidents where an animal was involved in the cause of death.</td>
</tr>
<tr>
<td>Child and infant death</td>
<td>Any case involving a child or infant.</td>
</tr>
<tr>
<td>Domestic</td>
<td>Fatal incident that occurred as a result of domestic injury or event.</td>
</tr>
<tr>
<td>Drugs and alcohol</td>
<td>Death where drugs or alcohol or both were a primary or secondary cause of death.</td>
</tr>
<tr>
<td>Electrocution</td>
<td>Cases where electrocution contributed to death.</td>
</tr>
<tr>
<td>Falls</td>
<td>Incidents where a fall was involved in the circumstances or cause of death.</td>
</tr>
<tr>
<td>Fire related</td>
<td>Incidents where a fire was involved in the circumstances or cause of death.</td>
</tr>
<tr>
<td>Geographic</td>
<td>Cases where the geographic region is significant to the cause of death, for example remote location.</td>
</tr>
<tr>
<td>Homicide and assault</td>
<td>Includes interpersonal violence and family domestic violence.</td>
</tr>
<tr>
<td>Indigenous</td>
<td>Cases related to a specific demographic group.</td>
</tr>
<tr>
<td>Intentional self-harm</td>
<td>Cases determined intentional self-harm (ISH) by coronial investigation</td>
</tr>
<tr>
<td>Law enforcement</td>
<td>Includes police pursuit, death in custody, parole issues, pending or previous court cases including family court, restraining order and coronial investigation procedures.</td>
</tr>
<tr>
<td>Leisure activity</td>
<td>Any leisure activity that directly influenced the circumstances of death.</td>
</tr>
<tr>
<td>Category</td>
<td>Description</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Location</td>
<td>Cases where the location type of either the incident or the discovery of the body is of significance. Does not refer to geographic location.</td>
</tr>
<tr>
<td>Mental illness and health</td>
<td>Incidents where the existence of mental illness issues were involved in the circumstance on death, both diagnosed and anecdotal. Note: mental illness is included as a contributing factor to death at the discretion of the coroner.</td>
</tr>
<tr>
<td>Misadventure</td>
<td>Risk taking behaviour such as train-surfing.</td>
</tr>
<tr>
<td>Natural cause death</td>
<td>Cases where the death is due to natural causes.</td>
</tr>
<tr>
<td>Older persons</td>
<td>Cases where the agedness of a person was a factor in the death.</td>
</tr>
<tr>
<td>Physical health</td>
<td>Cases where the existing physical health of the person contributed but was not necessarily the cause of death.</td>
</tr>
<tr>
<td>Sports related</td>
<td>Cases where a sporting incident contributed to death.</td>
</tr>
<tr>
<td>Transport and traffic related</td>
<td>Cases involving road, water and air vehicle incidents, motorised or naturally powered. Also includes cases where pedestrians are impacted by transport vehicles.</td>
</tr>
<tr>
<td>Water related</td>
<td>Includes swimming, scuba, snorkelling, boating, fishing and all water-related activities in either a recreational or commercial context.</td>
</tr>
<tr>
<td>Weather related</td>
<td>Cases where the environmental conditions such as heatwave or storm conditions contributed to death.</td>
</tr>
<tr>
<td>Work related</td>
<td>Includes cases where work is related to the death.</td>
</tr>
<tr>
<td>Weapon</td>
<td>Cases where the involvement of a weapon is significant.</td>
</tr>
<tr>
<td>Youth</td>
<td>Cases where the youth of a person was a factor in the death.</td>
</tr>
</tbody>
</table>