Coronial recommendations: Fatal facts

A summary of cases and recommendations made between July and September 2017

Edition 54
NATIONAL CORONIAL INFORMATION SYSTEM
65 Kavanagh Street, Southbank VIC 3006
+61 3 9684 4442
ncis@ncis.org.au
ncis.org.au

© National Coronial Information System. Reproduction requires written permission from the NCIS.

DISCLAIMER
Released 2020. While every effort is made to ensure information is accurate, the NCIS does not provide any warranty regarding the accuracy, currency and completeness of the information in this publication. The NCIS and the Victorian Department of Justice and Community Safety accept no responsibility for any loss or damage that may arise from any use of or reliance on the data in this report.

ACKNOWLEDGMENTS
The NCIS is funded by all State/Territory Justice Departments, New Zealand Ministry of Health, Commonwealth Department of Health, Commonwealth Department of Infrastructure, Regional Development and Cities, Australian Competition and Consumer Commission, the Australian Institute of Criminology and Safe Work Australia. Coronial data has been provided by each State and Territory Coroner’s Office in Australia and New Zealand. Additional codes are provided by the Australian Bureau of Statistics (ABS) and Safe Work Australia. We gratefully acknowledge their support.
CONTENTS

CORONERS’ RECOMMENDATIONS 4
AUSTRALIAN CAPITAL TERRITORY 5
NEW SOUTH WALES 9
NORTHERN TERRITORY 21
QUEENSLAND 23
TASMANIA 28
VICTORIA 43
WESTERN AUSTRALIA 63
APPENDIX A: FATAL FACTS WEB TOOL CATEGORY TAGS 68
CORONERS’ RECOMMENDATIONS

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

The National 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 July and September 2017.

Previous summaries and recommendations are available at:
AUSTRALIAN CAPITAL TERRITORY CASES

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>ACT.2013.100</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Natural cause death</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Drugs and alcohol</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>54 – cases closed between July and September 2017</td>
</tr>
</tbody>
</table>

Case summary
An adult female died from Sudden Unexpected Death in Alcohol Misuse.
The adult had a history of chronic alcohol misuse. They were found deceased in their home and could not be revived by attending ambulance officers.

Coronial findings
The coroner found that the death was due to natural causes.
The coroner found that the adult had a history of depression and alcoholism, and had been prescribed antidepressants by their general practitioner. Following investigations the coroner found that while there was concern over the general practitioner’s practices, the combination of sedative medications and alcohol use did not contribute to the adult’s death.

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

- The Royal Australian College of General Practitioners may wish to consider reviewing the guidance material and education it provides to its members in relation to the treatment of drug and alcohol addicted patients in the community, and specifically in relation to:
  - current practices and guidelines for treating; and
  - baseline blood testing for patients who are about to commence treatment for drug and alcohol misuse.

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>ACT.2015.68</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Adverse medical effects</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Physical health</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>54 – cases closed between July and September 2017</td>
</tr>
</tbody>
</table>

Case summary
An adult female died of unascertained causes several days after giving birth.
The adult suffered bleeding during and after the delivery of their infant. The adult collapsed in the bathroom of their hospital room and was found hours later. They could not be revived.

Coronial findings
The coroner found that the death was due to complications of medical or surgical care.
The coroner was unable to determine the specific cause of death following post-mortem investigations. The coroner found that a nurse had checked the adult’s room after their collapse and did not locate them, with another check not occurring until several hours later. The coroner made no findings as to whether the adult’s treatment contributed to their death.

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

- The [hospital]’s maternity service should have a system for hourly rounds and wellbeing checks of postnatal patients. This could be achieved through the Maternity Care and Accountability Plan, which is presently under trial.
- The [hospital]’s policy in relation to handling death scenes for deaths reportable to the Coroner be revised to indicate that deceased persons and death scenes should not be cleaned or altered in any way until after police or the Coroner have been contacted for advice and where appropriate permission.
- [Doctor] recommended that the Therapeutic Goods Administration be advised of [the adult]’s death and the administration of thrombolysis agents during her attempted resuscitation. If the [hospital] has not already made this report, I recommend that this be done.

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>ACT.2017.47</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Transport and traffic related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>54 – cases closed between July and September 2017</td>
</tr>
</tbody>
</table>

Case summary
A young male died from injuries sustained in a motor vehicle incident in which they were a motorcyclist.

The young person was riding a motorcycle and attempted to overtake a car in front of them that had indicated it was making a turn. The motorcycle struck the side of the car and the young person was thrown from the vehicle.

Coronial findings
The coroner found that the death was unintentional.

The coroner found the young person was attempting to overtake on the left side of the car in front which was also turning left, which was the direct cause of the collision. The coroner found that the young person had a provisional motorcycle licence and was riding a loan vehicle at the time of the incident while their own vehicle was being repaired.

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

- The ACT Government should review its adoption of the national LAMS [Learner Approved Motorcycles] scheme and reconsider its lack of adoption of the engine capacity limit for such motorcycles which applies in every other Australian jurisdiction.
- Access Canberra (who I believe to be the responsible area within government) should review the 'List of approved motorcycles' it has promulgated to provide better guidance to learner and provisional riders of the status of the law in this area, and if it cares to, provide suggestions as to the appropriate type or classification of motorcycles it recommends for inexperienced riders.

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

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>NSW.2012.2381</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Drugs and alcohol</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Law enforcement</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>54 – cases closed between July and September 2017</td>
</tr>
</tbody>
</table>

Case summary

A young female died due to mixed drug toxicity. The young person was a prisoner at the time of the incident. They were found unresponsive by staff on a mattress in their shared house with other inmates after having received a quantity of drugs the previous evening.

Coronial findings

The coroner found that the death was unintentional. The coroner found that the young person consumed drugs illegally delivered to them in the correctional centre. Inmates did not use the alarm system to notify staff of the young person's condition.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the Commissioner of Corrective Services:

- That the induction process for any new inmate to the correctional centre and any information provided (in writing and orally) during that process should specifically note:
  - The presence of the duress alarm within each house.
  - If the alarm is pressed it will sound in the Administration Centre to alert Corrective Services staff who will attend the house.
  - Pressing the alarm will not cause an alarm to sound nor a light to flash within or around the house.
- That the Commissioner of Corrective Services give consideration to approaching the Commissioner of the New South Wales Police Force to request update briefings on current concealment methods and packaging for heroin, so as to assist in detecting contraband within New South Wales Correctional facilities and training Corrective Services staff.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>NSW.2013.1191</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Intentional self-harm</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Drugs and alcohol</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>54 – cases closed between July and September 2017</td>
</tr>
</tbody>
</table>

Case summary

A young male took their own life by hanging.

The young person had a history of drug use and had been admitted to hospital several times in the weeks before their death following a number of suicide attempts using drugs. After being discharged, medication was returned to the young person which had been removed upon admission. They were found unresponsive in their home and later died in hospital.

Coronial findings

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

The coroner found that the young person had been assessed by multiple medical personnel who had appropriately decided not to detain them as an involuntary patient, and that guidelines and policy for suicide risk assessments had since been changed. The coroner found that medication removed from the young person at the time of admission was inappropriately returned to them upon discharge due to incorrect labelling.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the Chief Executive Officer, [Local Health District]:

- To amend the policy “Accountable Drugs – Handling and Recording [...]” as follows:
  - to include at clause 13, “patients own accountable drugs” (and consequentially at clause 5) the following requirement; “where a patient is admitted with deliberate self-poisoning, the discharging medical practitioner, should be consulted before the patient’s own accountable drugs that were brought into the hospital are returned to the patient from ward storage”.
  - to include at the appropriate place a reminder that a patient’s identifiable sticker/label should not be applied to the patient’s own accountable drugs brought into the hospital.
• That the proposed recommendation be brought to the attention of all staff at the relevant emergency departments involved in patient admission in the [Local Health District].

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 findings

The coroner found that the death was unintentional.

The coroner found that the young person had been using amphetamines which had likely caused a drug-induced psychosis. The coroner found that facilities and procedures at the hospital that were used to hold the young person, including a secure room, could be improved, and that changes had already been made following the incident.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the Minister for Health:

- That the Minister [for Health] give consideration to having [their] Department convene a state wide forum to discuss best practice management procedures for patients with acute behavioural disturbances presenting to NSW Emergency Departments.

To the [local health district]:

- That the [Local Health District] give effect to the requirements of the existing leave policy by developing a written document to be provided to patients exercising gate leave and any family or carers who may be responsible for the patient while they are on such leave. The document should set out information concerning leave, including the purpose of leave, the time at which the leave commences and when the patient is due back and any
particular requirements or restrictions such as ensuring the patient remains in the carer’s company at all times or does not attend certain locations etc.

- That, pending the redevelopment of the Emergency Department at [hospital], the [Local Health District] develop and implement a site-specific policy relating to the use of the [secure room] to give effect to the intent and aims of the existing NSW Health Policy concerning aggression, seclusion and restraint in mental health facilities in NSW.
Coronial recommendations: Fatal facts

Case number
NSW.2015.811

Primary category
Intentional self-harm

Additional categories
Law enforcement

Fatal facts edition
54 – cases closed between July and September 2017

Case summary
A middle aged male died of a gunshot injury.

The adult had experienced several personal difficulties in life and suffered from mental health problems. Police attended the adult’s residence on the day of the incident due to a report of domestic violence. The adult was shot by a police officer as they ran towards the officer holding knives with the intent of ending their own life.

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

The coroner found that the adult had a history of aggressive encounters with police and was noted to be potentially violent in police records. The coroner found that the adult’s mental health deteriorated in the weeks before their death and they had made threats and plans of getting the police to shoot them, including immediately before the incident. The coroner found that there were some gaps in information sharing and planning by officers on the scene.

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

To the NSW Commissioner of Police:

- That the NSW Police Force consider using the circumstances of the death of [the adult] as a guide for future training to highlight the risks arising from a person who intends to use police to commit self-harm.

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

**Case number**

The coroner held a joint investigation into the following deaths which resulted from the same incident: NSW.2015.1546, NSW.2015.1547, NSW.2015.1548

**Primary category**

Weather related

**Additional categories**

Water related

**Fatal facts edition**

54 – cases closed between July and September 2017

**Case summary**

Two older males and one older female died during a flood.

Flooding trapped the three adults inside their individual homes. Due to the rapid and rising waters of the floods, the adults were unable to escape and they each drowned.

**Coronial findings**

The coroner found that the deaths were unintentional.

The coroner found that the area had been hit with extremely high winds and heavy rain which had caused flooding.

**Coronial recommendations**

The coroner made the following recommendations related to these cases:

To the Minister for Emergency Services NSW, Minister for Environment and Energy (Cth), and the General Manager of the (Local) Council:

- That the NSW State Emergency Service, the Bureau of Meteorology and the [council] work together to convene a technical advisory group involving representatives from each organisation, and liaise with any officer of the Office of Environment and Heritage, and any consulting engineer(s) and local flood expert(s) engaged from time to time, to look at solutions for warning and responding to flood and flash flood events in [area] (including the [creek] catchment):
  - On an interim basis while an automated flood warning system is developed; and
  - On a long term basis, to consider developing an automated flood warning system designed to use a combination of rainfall and riverine water levels relevant to flood in the [creek] and its tributaries.
To the Minister for Emergency Services NSW:

- That further consideration be given to providing the NSW State Emergency Service with access to an out-posted meteorologist from the Bureau of Meteorology for ongoing planning and consultation, on a part-time basis, as well as assistance during weather events.

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

**Case number**  
NSW.2015.2183

**Primary category**  
Intentional self-harm

**Additional categories**  
Mental illness and health

**Fatal facts edition**  
54 – cases closed between July and September 2017

**Case summary**

An adult female took their own life by hanging. The adult had borderline personality disorder and died within hours of being discharged from a hospital. The adult had been assessed under the *Mental Health Act* at the hospital and it was determined they were not to be detained. The adult was found deceased in their home.

**Coronial findings**

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

The coroner found that medical practitioners who initially scheduled the adult to be taken to hospital due to suicide risk to had acted appropriately. However, the practitioner who assessed their release was not appropriately qualified to do so and that the adult should have been referred to a specialist mental health service as per policy. The coroner also found that proper discharge procedures were not followed by the hospital.

**Coronial recommendations**

The coroner made the following recommendations related to this case:

To the Chief Executive Officer, [local health district]:

- The policies and procedures relating to persons presenting at the Emergency Department with a risk of suicide be reviewed, in particular to provide for the following:
  - Any persons presenting to the Emergency Department with any risk of suicide, or under the auspices of the *Mental Health Act*, must be referred to [specialist mental health service] for comprehensive mental health assessment.
  - Discharge management plans must be formulated and documented prior to discharge.
  - Discharge management plans for future care must be formulated in writing and provided to the patient at the time of discharge [...], regardless of whether or not they are assessed by [specialist mental health service].
• Procedures should be put in place to ensure that appointments required by discharge management plans are made for the patient, and that appropriate follow up occurs.
• Any patient who is being discharged (or not admitted) must be asked whether a support person can be contacted on their behalf.
• Simple and clear direction be included outlining the steps required to be followed in [the points] above, including who is responsible for undertaking those steps and who is responsible for ensuring that all required steps have been followed prior to the patient’s discharge.

• All emergency staff be given training and support to understand the applicable polices, and steps taken to ensure that they are being implemented.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>NSW.2015.5339</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Natural cause death</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>54 – cases closed between July and September 2017</td>
</tr>
</tbody>
</table>

Case summary

An adult male died of a heart condition.

The adult had collapsed a number of times in the weeks prior to death and visited a medical practitioner the day before the incident. The medical practitioner diagnosed them with a viral illness and sent them home. The following day the adult’s condition deteriorated and despite efforts from paramedics they could not be revived.

Coronial findings

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

The coroner found that the medical practitioner treating the adult the previous day failed to detect their heart condition, and that it was likely they would have survived had further investigations been undertaken at the time of the consultation.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that a transcript of these proceedings and a copy of these findings be forwarded to the Health Care Complaints Commission (HCCC) so that consideration may be given to this matter being investigated.

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.
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.2015.248
Primary category | Intentional self-harm
Additional categories | Law enforcement
Fatal facts edition | 54 – cases closed between July and September 2017

Case summary

An older male took their own life by hanging.

The adult was a prisoner at the time of the incident and had recently been approved for parole. The adult cancelled their own parole due to their concerns over parole requirements and being a burden on their family. The adult was found deceased in their room by correctional staff several weeks later.

Coronial findings

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

The coroner found that the fans installed in the correctional centre did not have mechanisms to ensure they could not be used as hanging points.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend the Commissioner of the Northern Territory Correctional Services ensure that the risk posed by the fans in the [correctional centre] being used as hanging points are mitigated by the fitting a load sensing mechanism or other similar device.

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.
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.2014.161</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Drugs and alcohol</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>54 – cases closed between July and September 2017</td>
</tr>
</tbody>
</table>

Case summary
An adult female died from mixed drug and alcohol toxicity.

The adult’s partner called paramedics when they found the adult was not breathing in bed. They could not be revived. Investigations revealed that the adult had been abusing prescription medications and illicit substances for some time, and that the adult’s partner had likely supplied them with some of the substances.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the adult had been visiting various doctors to obtain prescription medications for their mental health issues. The coroner found that the adult’s partner had a history of drug dealing, was evasive about multiple aspects of the incident, and had waited to phone paramedics about the adult’s condition until the adult was likely already deceased.

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

- I recommend that the Queensland government adopt a similar provision to s. 155 of the Criminal Code Act (NT) in the Criminal Code Act 1999 (Qld). This may provide more incentive to people not to simply stand by when someone is dying, especially drug users in the context of drug overdoses.

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.2014.1963</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Transport and traffic related</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Drugs and alcohol, Law enforcement</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>54 – cases closed between July and September 2017</td>
</tr>
</tbody>
</table>

Case summary

A male child died due to a motor vehicle incident in which they were a pedestrian.

The child was walking or skateboarding along a road when they were struck by a vehicle and died at the scene from their injuries. The driver was travelling in excess of the speed limit while intoxicated.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the driver’s intoxication and defects in their vehicle likely contributed to the incident. The coroner reviewed a number of submissions about road infrastructure at the location of the incident and found that since investigations began, a footpath had been constructed along the road where the incident occurred.

The coroner found that police procedures relating to drug and alcohol testing after the incident and actions taken by the city council to improve pedestrian safety were adequate but identified several areas where improvements could be made.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the [city council]:
  - Request the [city] Speed Management Committee to conduct a speed review of all roads on [location]. Consideration should be given to reducing the speed limit to 50km/h (with the exception of the ferry terminal area which should be 40km/h due to pedestrian activity, the school zone, which should remain at 40km/h during school hours and dirt roads, which should be 40km/h due to dust suppression and visibility issues); and
  - Continue to consult with [location] residents to determine whether priority should be given to increased street lighting on the Island and extending the shared pathway system to [beach], and if so, the way in which these projects should be funded.
I recommend that the Queensland Police Service:
  o Increase permanent police numbers on [location] to keep up with demand. (The former OIC [officer in charge] of the [location] Police Station's suggestion of one Sergeant and three Constables is recommended);
  o Increase speed enforcement activities generally on [location] to support any reduction in speed limits on the Island implemented by the [city] Speed Management Committee;
  o Allocate a vehicle mounted radar to the [location] Police station, and training, to facilitate more effective speed enforcement on the Island;
  o Amend the Queensland Police Service Traffic Manual to include a time limit for a second alcohol breath test;
  o Allocate a saliva drug swab testing device to the [location] Police station, and training, to enable police officers the ability to conduct initial drug tests on drivers, to determine whether it is necessary to escort drivers to the mainland for a blood test;
  o Implement a policy that all drivers on [location] involved in a serious motor vehicle accident be subjected to an initial road side breath test and saliva drug test; and
  o Nominate a Police Liaison Officer to attend each [city] Transport Advisory Group meeting and to liaise with the [location] police regarding traffic safety matters.

I recommend that the Department of Transport and Main Roads:
  o Introduce a public bus service on [location], utilising the [transport smartcard ticketing] system; and
  o Take the lead in a safety campaign on [location] (in" consultation with the [city council] and the [location] Primary School) to promote safe road usage by children (including the importance of using footpaths, not riding skateboards and other wheeled devices on the roads, and wearing helmets).

I recommend that the Queensland government:
  o Amend regulation 240 of the Transport Operations (Road Use Management - Road Rules) Regulations 2009 (Qld) (TORUM Road Rules) to prohibit skateboards, scooters, and similar wheeled recreational devices from all public roads; or
    - At the very least, amend regulation 256 of the TORUM Road Rules to mandate helmets, and the use of reflective clothing / illumination devices at night time, for all riders of skateboards, scooters, and similar wheeled recreational devices on roads;
  o Amend section 80 of the Transport Operations (Road Use Management) Act 1995 (Old) (TORA) to mandate an initial drug saliva swab test or blood test on all drivers involved in motor vehicle accidents that have resulted, or are likely to result in a fatality;
  o Amend section 80 of the TORA, to only require police officers to take one saliva swab for initial drug testing (rather than two). (As was done previously to comparable provisions in relation to alcohol breath testing); and
Review whether it is feasible to amend section 80 of the TORA, so that Queensland Ambulance officers can be authorised to take blood tests from drivers involved in serious motor vehicle accidents for drugs. This provision could be limited to remote communities, such as [location], where there are no after hours doctors, nurses or qualified assistants to take blood tests.
TASMANIA

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>The coroner held a joint investigation into the following deaths which resulted from similar incidents: TAS.2013.303, TAS.2013.308, TAS.2014.327, TAS.2014.517, TAS.2015.492, TAS.2016.91</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Work related</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Youth</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>54 – cases closed between July and September 2017</td>
</tr>
</tbody>
</table>

Case summary – TAS.2013.303

A middle aged male died in a tree felling incident.

Whilst the adult was cutting the tree, it fell onto them and caused fatal injuries.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult made several crucial and ultimately fatal errors which directly led to their death. The adult failed to ensure there was a cleared work area around the base of the tree before they began cutting. The tree had already been noted as hazardous.

Case summary – TAS.2013.308

A middle aged male died in a tree felling incident.

The adult attempted to fall a hazardous tree on their own.

The adult was found some time after the incident. Emergency services were called and declared the adult deceased at the scene.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that there was no evidence to suggest the adult had undergone any formal training in relation to safe tree felling techniques.

Case summary – TAS.2014.327

An older adult male died in a tree felling incident.
The adult was alone on their property felling trees with a chainsaw at the time of their death. A tree fell on top of the adult, trapping them. The adult maintained consciousness and called emergency services. However, shortly after the arrival of emergency services, the adult lost consciousness and was unable to be resuscitated.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the adult’s death was a result of poor tree felling technique.

Case summary – TAS.2014.517
An older adult male died in a tree felling incident.

The adult was cutting rounds off a log. The log rolled free of the wedges holding it and struck the adult, causing fatal injuries.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the cause of the incident was unsafe chainsaw handling technique.

Case summary – TAS.2015.492
A young male died in a tree felling incident.

The young person was cutting and splitting wood from a fallen tree with their parent. The young person waited for five minutes after felling the tree to see if any limbs were going to fall off surrounding trees. Once satisfied it was safe, the young person began cutting the fallen tree. A short time later, their parent heard a loud crack. A limb fell from a nearby tree, striking the young person. They suffered fatal injuries as a result.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the young person was not wearing any personal protective equipment.

Case summary – TAS.2016.91
A young male died in a tree felling incident.

The young person was cutting wood with a friend. They were standing directly in the path of a falling tree which struck them and caused fatal injuries.
Coronial findings

The coroner found that the death was unintentional.

The coroner found that the young person had been deemed not competent to fall trees by a teacher at a tree felling course.

The coroner found that the location in which the young person had been felling trees was an extremely hazardous area with several dangerous trees nearby.

Coronial recommendations

The coroner made the following recommendations related to these cases:

- I recommend that all chainsaw operators must undertake approved chainsaw training prior to purchasing or using a chainsaw.
- I recommend that all persons selling chainsaws must be accredited chainsaw operators.
- I recommend that all chainsaw operators must undergo regular practical reassessment.
- I recommend that all landowners be required to ensure that people permitted to use chainsaws on their land be appropriately qualified.
- I recommend that no person under the age of 16 years be permitted to own or use a chainsaw in any circumstances.
Coronial recommendations: Fatal facts

**Case number**  
TAS.2013.308

**Primary category**  
Work related

**Fatal facts edition**  
54 – cases closed between July and September 2017

**Case summary**

A middle aged male died due to a tree felling incident.

The incident occurred when the adult attempted to fall a tree on their own. The tree was very hazardous in that it was burnt and was double-headed, situated on sloping ground. The adult was found some time after the incident. Emergency services were called and declared the adult deceased at the scene.

**Coronial findings**

The coroner found that the death was unintentional.

The coroner found that there was no evidence to suggest the adult had undergone any formal training in relation to safe tree felling techniques.

**Coronial recommendations**

The coroner made the following recommendations related to this case:

- I recommend that all chainsaw operators must undertake approved chainsaw training prior to purchasing or using a chainsaw.
- I recommend that all persons selling chainsaws must be accredited chainsaw operators.
- I recommend that all chainsaw operators must undergo regular practical reassessment.
- I recommend that all land owners be required to ensure that people permitted to use chainsaws on their land be appropriately qualified.
- I recommend that no person under the age of 16 years be permitted to own or use a chainsaw in any circumstances.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>TAS.2013.345</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Adverse medical effects</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Drugs and alcohol</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>54 – cases closed between July and September 2017</td>
</tr>
</tbody>
</table>

Case summary

A middle aged female died unexpectedly from a heart condition contributed to by their medication.

The adult suffered from mental illness and had been commenced on antipsychotic medication for treatment several months before their death. The adult was found deceased in their home a day after their last observed dose of medication.

Coronial findings

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

The coroner found that there was no opportunity for the adult to have overdosed on their medications. The coroner found that the highly elevated blood levels for the antipsychotic medication detected after their death were a result of post mortem redistribution.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I formally recommend that upon the death of a person who is administered clozapine, a blood sample be taken immediately upon the admission of the body of that person to the [hospital] and at multiple stages within a 48 to 72 hour period of time.
Coronial recommendations: Fatal facts

### Case number
TAS.2013.530

### Primary category
Intentional self-harm

### Additional categories
Mental illness and health

### Fatal facts edition
54 – cases closed between July and September 2017

#### Case summary
An adult female took their own life by hanging.

The adult suffered from Crohn’s disease and had undergone several surgeries to treat the condition. The adult was taken to hospital a few days prior to their death following instances of attempted self-harm, where they were assessed as suffering depression. The adult’s spouse found them deceased in their home.

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

The coroner found that the hospital’s decision to discharge the adult was too hasty and should have been better informed by the adult’s recent mental health history. The coroner found that the failure of the hospital to notify the Crisis Assessment and Treatment Team [CAT team] of transfer of the adult’s care to them in a timely manner meant that the CAT team was unable to offer support to the adult prior to their death.

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

- [...] I recommend that the [hospital department], as a matter of urgency, undertake a review of its processes with the aim of implementing a new process which guarantees the timely delivery of transfer of care documentation to the CAT team and its receipt.
- I have noted earlier that the [hospital department] now has in place a practice whereby it requires its discharge notification form to be emailed to the patient’s general practitioner within seven days of discharge. It is my further recommendation that the rules around this practice be re-assessed with a view to them being modified to ensure that the general practitioner has had delivered to him/her a copy of the discharge notification, either prior to their next consultation with the patient or within seven days of discharge, whichever is the earlier. In [the adult’s] case such a requirement would have ensured that...
[doctor] had access to [their] discharge notification form on the day following [their] hospital discharge when it would have been of maximal benefit to [the doctor].
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>TAS.2014.468</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Adverse medical effects</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Physical health</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>54 – cases closed between July and September 2017</td>
</tr>
</tbody>
</table>

Case summary
An adult male died from a bacterial infection.

The adult had been taken to hospital with a diagnosis of gastroenteritis several days before their death and was discharged when their condition appeared to have improved. Test results the following day found that the adult had a bacterial infection and they were contacted by the hospital, but they died at home before appropriate treatment could commence.

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

The coroner found that there were failures in the decision to discharge the adult and in hospital’s response to act on and communicate the test results for the bacterial infection once they were known.

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

- I recommend that the [hospital] and the [hospital] laboratory ensure that written protocols are in place for the immediate communication of positive Staphylococcus Aureus urine culture results once known from the laboratory to the treating physician at the [hospital] and, in the event that the patient has been discharged, to the patient’s general practitioner.
- I recommend that the [hospital] ensures that it has a system in place whereby discharge summaries are forwarded immediately to the patient’s general practitioner. In the event this is not available, then the patient should be provided with a hard copy upon discharge.
- I recommend that consideration be given to increasing staffing levels in the [hospital] ED [emergency department] and EMU [emergency management unit], so that an additional
experienced physician is available to undertake a largely supervisory role for both units and to review and approve each discharge.

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: TAS.2015.60, TAS.2015.61</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Transport and traffic related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>54 – cases closed between July and September 2017</td>
</tr>
</tbody>
</table>

Case summary

A middle aged female and male died due to a motor vehicle incident.

The two adults were travelling home on a motorcycle. A truck that passed them on their journey was towing a trailer. The truck and trailer were both fully loaded with round bales of silage. Two bales fell from the trailer into the immediate path of the motorcycle. Both adults on the motorcycle suffered fatal injuries as a result.

Coronial findings

The coroner found that the deaths were unintentional.

The coroner found that the stacking of the bales on both the truck and trailer did not comply with the Heavy Vehicle National Law.

The coroner found that drivers of heavy vehicles did not receive any formal training or instruction on load restraint in Tasmania.

Coronial recommendations

The coroner made the following recommendations related to these cases:

- That Transport Tasmania give consideration to incorporating in its licencing test for drivers of heavy vehicles suitable questions relating to the Load Restraint Guide and appropriate loading methods.
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.2012.450, TAS.2012.505, TAS.2013.79, TAS.2014.331, TAS.2015.2, TAS.2015.207, TAS.2015.535</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Transport and traffic related</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Work related, Leisure activity</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>54 – cases closed between July and September 2017</td>
</tr>
</tbody>
</table>

Case summary – TAS.2012.450

A middle aged female died in a quad bike incident.

The adult was travelling along an unsealed track that was in reasonable condition. On one corner of the track, a steep incline led into a sweeping left hand bend. Subsequent investigation suggested that when the adult entered the corner, they lost control of the quad and ran off track. The adult was found deceased near their quad bike in a paddock.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult was a careful and cautious rider but had no formal training in quad bike riding.

Case summary – TAS.2012.505

A middle aged male died in a quad bike incident.

The adult was travelling home with their spouse and friends after a social outing. The group were travelling on quad bikes. The adult’s quad bike flipped and landed on top of them while they were attempting to climb a hill with their spouse as a pillion passenger. Various members of the group carried out cardiopulmonary resuscitation (CPR) until ambulance personnel arrived. Despite attempts to resuscitate the adult, they were unable to be revived.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the incident was caused by the adult carrying a pillion passenger on a quad bike not designed for that purpose.
The coroner found no evidence that the adult had ever undertook any formal quad bike training.

**Case summary – TAS.2013.79**

A young male died in a quad bike incident.

A young male was riding a quad bike along an isolated beach with a friend. Whilst travelling along the beach, the quad bike became stuck from flooded water. The young person and their friend were both thrown over the front of the quad bike. The friend found the young person lying unconscious in the sand. Emergency personnel attended the scene and the young person was transported to hospital. They passed away a few days later due to a traumatic brain injury.

**Coronial findings**

The coroner found that the death was unintentional.

The coroner found that the use of a helmet would have prevented the extent of head injuries suffered and that the young person would have likely survived the crash.

**Case summary – TAS.2014.331**

A middle aged female died in a quad bike incident.

The adult was travelling home when they collided with a passing motorcycle. The adult was thrown off their quad bike and their helmet came off during the crash. Emergency personnel were called and attempted to resuscitate the adult, but they passed away at the scene.

**Coronial findings**

The coroner found that the death was unintentional.

The coroner found that the adult’s helmet may not have been done up properly or at all, and that had they been wearing a properly fastened helmet at the time of the crash, they would likely not have suffered fatal head injuries.

**Case summary – TAS.2015.2**

An adult male died in a quad bike incident.

The adult was riding a quad bike while heavily intoxicated and not wearing a helmet. The adult was attempting to perform a trick on the quad bike in front of friends when they lost control, falling from the vehicle and landing heavily on the road surface. Emergency personnel arrived but were unable to resuscitate the adult. They died due to extensive head injuries.
Coronial findings
The coroner found that the death was unintentional.

The coroner found that the adult’s intoxication was an associated risk factor in the incident.

The coroner found that the adult would have survived had they been wearing a helmet at the time of the crash.

Case summary – TAS.2015.207
A young male died in a quad bike incident.

The adult was thrown from a quad bike as they attempted to turn into a street. The adult was intoxicated and speeding at the time and was not wearing a helmet. They suffered fatal head injuries as a result of the crash and died in an ambulance in transit to hospital.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the crash would not have occurred if the adult had not been intoxicated and speeding.

The coroner found that the adult likely would have survived had they been wearing a helmet.

Case summary – TAS.2015.535
An older male died in a quad bike incident.

The adult was travelling on a quad bike on their property. The adult applied the brakes as the quad bike travelled downhill and approached a bend. However, the quad bike slid and rolled before coming to land on the adult. The adult died due to asphyxiation from the weight of the quad bike.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the adult was not wearing a helmet, but that the crash may still have proved fatal if they were.

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

- I recommend that consideration be given by the Tasmania Law Reform Institute and the Attorney-General to the introduction of legislation requiring mandatory training and licensing of all persons using quad bikes.
I recommend that urgent consideration be given, by the Tasmania Law Reform Institute and the Attorney-General, to the introduction of legislation requiring the use of a suitable approved helmet by all persons using quad bikes.

I recommend that consideration be given by the Tasmania Law Reform Institute and the Attorney-General to the introduction of legislation that:
- Prohibits children under the age of 16 from operating adult sized quad bikes;
- Prohibits children between the ages of 6 and 16 from operating “youth sized” quad bikes other than in accordance with what is specified by the manufacturers to be the appropriate minimum age for such vehicle; and
- Prohibits children under the age of 6 from ever operating any quad bike in any circumstances whatsoever.

I recommend that consideration be given, by the Tasmania Law Reform Institute and the Attorney-General, to the introduction of legislation prohibiting the carrying of passengers on Type I quad bikes and any more than one passenger on Type II quad bikes.

I recommend that interested parties, including the FCAI [Federal Chamber of Automotive Industries] and State and Commonwealth industrial safety authorities, work collaboratively with a view to initiating the process of implementing a safety and design standard for quad bikes that is in the terms of the relevant American National Standards Institute (ANSI) standard applying for the time being; and, pending implementation of any such standard by Standards Australia, any quad bikes imported into Australia should comply with the applicable ANSI standard.

I recommend that Commonwealth and State industrial safety authorities work collaboratively with other interested parties to develop a star rating system to assist in the reduction of serious injury and deaths to users of quad bikes.

I recommend that a taskforce be established across relevant state government agencies to consider and develop strategies to reduce fatalities and serious injuries arising from work and recreational use of quad bikes.

I recommend that Tasmania Police liaise with other state and territory police services to ensure that the approach to investigation of quad bike serious and fatal accidents is standardised and to ensure ongoing training and improvement in quad bike accident investigation.

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

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

Case number | VIC.2011.3936
---|---
Primary category | Homicide and assault
Additional categories | Law enforcement
Fatal facts edition | 54 – cases closed between July and September 2017

Case summary

A middle aged female died from assault.

The adult had previously been subjected to violence by their de facto partner and had taken out a family violence intervention order against them. The adult later died as a result of fatal injuries inflicted by their partner in breach of the intervention order. The partner was already facing criminal charges for their previous assault on the adult at the time of the incident.

Coronial findings

The coroner found that the death was due to assault.

The coroner found that while there were numerous shortcomings in the handling of the adult’s case by police at the time of the incident, there had been significant efforts made since that time to improve systems and responses relating to family violence.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that Victoria Police conduct systemic reviews of family violence-related deaths where there was a known history of family violence between the deceased person and the perpetrator of family violence.
- I recommend that the Victorian Government annually review the adequacy of resources and funding provided to family violence support services to ensure that the demand for services in Victoria is met.

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.2013.4027</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Drugs and alcohol</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Youth</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>54 – cases closed between July and September 2017</td>
</tr>
</tbody>
</table>

Case summary

A young female died from mixed drug toxicity.

The young person was in the care of the Department of Health and Human Services (DHHS) at the time of the incident and resided in a residential care unit. The young person had a history of absconding from care and substance abuse.

The young person was in a drug affected state when they left the unit contrary to the conditions of their custody order and was found deceased the next morning in a friend’s home.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that there were multiple shortcomings in the management of the young person’s care, particularly in the context of their complex history and needs. The coroner found that there was a failure by the DHHS to monitor the [care organisation’s] delivery of services to the young person, and that the care organisation failed to ensure proper training of staff and consultation of client documents. The coroner found that overall there was a loss of opportunity to intervene in the incident by obtaining police assistance through a warrant or request to attend the young person’s location.

Coronial recommendations

The coroner made the following recommendations related to this case:

- With the aim of preventing like circumstances where children/adolescents at high risk require urgent detection and apprehension, but the process for accessing the DHHS AfterHours Child Protection Emergency Service in fact impedes the contract care workers from seeking an urgent warrant, I recommend that this system be reviewed.
- With the aim of preventing like circumstances where children/adolescents at high risk require urgent detection and apprehension but the process for accessing the DHHS AfterHours Child Protection Emergency Service in fact impedes the contract care workers...
from seeking an urgent warrant, I recommend that contracted agencies such as [care organisation] be provided with a dedicated direct telephone line to access DHHS After Hours Child Protection.

- With the aim of preventing like circumstances where children/adolescents at high risk require urgent detection and apprehension, I recommend that the DHHS review the efficacy of the range of means of detection/apprehension tools that are available to Child Protection and its Agents such as but not necessarily limited to, the use of the Missing Persons reports to Victoria Police and the use of a "Red Flag" system on the Police LEAP [Law Enforcement Assistance Program] system as was the subject of a Recommendation made following an Inquest into the Death of [person].
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2014.3653</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Water related</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Physical health</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>54 – cases closed between July and September 2017</td>
</tr>
</tbody>
</table>

**Case summary**

A middle aged male died due to drowning. The adult had motor neurone disease and required supervision while swimming. The adult was located by lifeguards face-down in a pool at a leisure centre. Paramedics took the adult to hospital where they later passed away.

**Coronial findings**

The coroner found that the death was unintentional. The coroner found that the lifeguard supervising the pool at the time of the incident was distracted by an attempt to secure their lifesaving equipment. The coroner found that lifeguards at the leisure centre undertaking other tasks whilst also doing lifesaving surveillance was not consistent with their lifesaving duties.

**Coronial recommendations**

The coroner made the following recommendations related to this case:

- That, notwithstanding the evidence of [executive staff member], the [community organisation] review its training and procedures to ensure that the duties of life savers are clear when conducting supervisory and non-supervisory tasks.
- That the [community organisation] review it Pool Operations Manual (if that manual in some form is still being used) to clarify the role and duties of lifeguards.
- That the [community organisation] review its training and procedures and continue to engage with Life Saving Victoria current guidelines and recommendations to ensure both that staff are trained sufficiently in the need to identify and adequately supervise pool patrons in need of closer supervision, and that staff are in practice doing this.
- That the [community organisation] review its procedures to ensure that safety equipment for lifeguards, and in particular bum bags, is ready and available to life savers before a shift is commenced.

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.2014.4863</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Intentional self-harm</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Mental illness and health, Physical health, Youth</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>54 – cases closed between July and September 2017</td>
</tr>
</tbody>
</table>

Case summary

A young male died due to intentional drug overdose and asphyxia.

The young person was born with a number of heart conditions and had undergone Fontan surgery early in life, for which they required ongoing medication and medical reviews. The young person struggled with depression and had made several self-harm attempts with drugs. The young person was located deceased in their home after a period where they could not be contacted.

Coronial findings

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

The coroner found that the young person’s perception of their long-term prognosis was poor and that this was a significant stressor. The coroner investigated what transitional arrangements were in place for cardiac patients transitioning from paediatric care to adult care, noting that several changes had been made to these processes by the hospitals in the period since the incident.

The coroner found that research into Fontan surgery patients suggests a higher incidence of depression and anxiety disorders, and that clinicians should be alert for emotional difficulties and to treat both physical and psychosocial aspects of their health.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That, as part of the initial decision to transition a patient to [hospital A], clinicians at [hospital B] formally refer a child/young adult to a social worker who remains involved as a support throughout the transition period and until after the first appointment at the [hospital 1].
- That [hospital B] and [hospital A] introduce the routine, serial administration of an age-appropriate screening tool that measures a child/young adult’s capacity and resilience for
events such as the transition between health services and the possible future outcomes from Fontan surgery, such as [hospital A’s] Adolescent Resilience Questionnaire.

- That [hospital A] require the Congenital Liaison Nurses to complete mental health training to improve their capacity to identify and respond to their patients’ mental health issues, such as Mental Health First Aid training.
- That [hospital B] and [hospital A] review and, if necessary, change their care pathways and systems to ensure there is a focus of the emotional and psychological impacts of the Fontan surgery and its implications for patients’ quality of life.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2015.778</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Transport and traffic related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>54 – cases closed between July and September 2017</td>
</tr>
</tbody>
</table>

Case summary

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

The young person was wearing dark clothing and walking quickly. The young person approached a crossing when the pedestrian signal flashed red. They tripped and fell onto the ground whilst crossing, and a truck turning onto the street ran over them. Emergency services were called and pronounced them deceased at the scene.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the driver did not spot the young person prior to the collision due to the height and limited visibility awarded from the driver’s seat in the truck and due to the young person’s position on the ground.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That VicRoads convene a working group to examine technological solutions to improve pedestrian visibility to heavy vehicle operators.

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.
Case number: VIC.2015.2123
Primary category: Drugs and alcohol
Fatal facts edition: 54 – cases closed between July and September 2017

Case summary
An adult female died from combined drug toxicity.

The adult had a history of alcohol abuse and both illicit and prescription drug use. The adult was found deceased by a roommate after having returned from collecting a prescription the night before.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that various doctors had prescribed the adult with large quantities of pregabalin over numerous consultations as well as other drugs for the adult’s various conditions. The adult was noted to be a ‘doctor-shopper’ listed with the Prescription Shopping Information Service. The coroner found that the adult’s drug dependence was not formally diagnosed as the doctors were unaware of the medications being provided to them by other practitioners.

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

- I recommend that the Royal Australian College of General Practitioners provide education to its members as to the need for caution in prescribing pregabalin due to its risk of misuse and its potential for harm.

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.2015.2793</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Natural cause death</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>54 – cases closed between July and September 2017</td>
</tr>
</tbody>
</table>

Case summary

An adult female died in hospital due to natural causes.

The adult was admitted to hospital following an episode of apparent unconsciousness. A possible prescription medications overdose was suspected. No computed tomography (CT) scan was undertaken during admittance to determine the cause of the adult’s unconsciousness. The adult was found to have suffered a stroke and later passed away.

Coronial findings

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

The coroner found that investigations were not sufficiently thorough to confirm an overdose or to exclude the prospect of stroke or other alternate causes of the adult’s abnormal conscious state.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That in the event where an adequate collateral history cannot be obtained, and a clear cause for the altered conscious state cannot be determined, and stroke cannot be excluded, then consideration should be given for an urgent CT [computed tomography] scan to be conducted by [health service] medical clinicians.

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.2015.2986</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Adverse medical effects</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Physical health</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>54 – cases closed between July and September 2017</td>
</tr>
</tbody>
</table>

Case summary

An older adult male died in hospital due to complications following bowel surgery.

The adult had a history of bowel cancer, resulting in hospital admittance. The adult’s condition continued to deteriorate following surgery. They were extubated and later passed away.

Coronial findings

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

The coroner found that there was no documented process for withdrawal of futile care and that the case highlighted the importance of maintaining clear and concise contemporaneous medical notes.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That both committees, the Medical Staff Group and Critical Care committee give priority to documenting a process for withdrawal of futile care in accordance with the National Safety and Quality Healthcare Standards.
- That the hospital ensure through ongoing education and or procedures, that contemporaneous medical record documentation is maintained by staff.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2015.4706</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Natural cause death</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>54 – cases closed between July and September 2017</td>
</tr>
</tbody>
</table>

Case summary
An adult female died due to complications of pneumonia.

The adult had a history of difficult intubation and respiratory issues. The adult was admitted to hospital with shortness of breath and coughing. The adult’s condition was not fully appreciated upon admission. As a result, the adult to remained in the care of a rural hospital that did not have a high dependency or intensive care unit. The severity of the adult’s sepsis went undiagnosed, resulting in multiple organ failure, and the adult later passed away.

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

The coroner found that the hospital had improved a number of Organisational Responses, Clinical Education Activities and Clinical Practice Improvements by the time the coronial investigation concluded.

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

- That the Department of Health and Human Services and Safer Care Victoria be informed of the issues identified by a review of the circumstances of the adult’s death at [hospital] namely:
  - The severity and complexity of [the deceased’s] septic condition was not fully appreciated, which led to her remaining in the care of a rural hospital that was unsupported by a high dependency or intensive care unit.
  - The medical and nursing staff did not recognise, respond to [the deceased’s] deteriorating respiratory condition and escalate appropriately.
  - The possible contributing factors included an assumption that deranged liver function tests were alcohol related and a misinterpretation of respiratory related symptoms clouded by past familiarity with her anxiety symptoms when hospitalised.
  - Once [the deceased] collapsed, a MET [medical emergency team] code was called, rather than a Code Blue. There appeared to be no doctor present at the resuscitation possessing advanced airway skills, nor was one called.
That the Department of Health and Human Services and Safer Care Victoria, strengthen and support the [hospital] by providing the required resources and training to address these issues.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2015.5060</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Intentional self-harm</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Mental illness and health</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>54 – cases closed between July and September 2017</td>
</tr>
</tbody>
</table>

Case summary

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

The adult had a history of mental illness and was a recurring patient at a mental health facility.

Coronial findings

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

The coroner found that medical professionals involving in the adult’s care acted appropriately regarding the adult’s diagnosis and treatment and communicated effectively with all parties involved. The coroner found that concerns raised regarding health services’ reluctance to admit the adult and their recognition and response to the adult’s deterioration had been reviewed by the time the coronial investigation concluded.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Office of the Chief Psychiatrist and the Royal Australian and New Zealand College of Psychiatrists develop a shared protocol or guidelines to provide guidance for clinicians who share the responsibility for the care of patients across the public and private sectors. Matters that should be addressed include communication, transparency of arrangements with patients and carers, clinical responsibility in periods of crisis and negotiated care planning.

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.2015.5713</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Natural cause death</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Physical health</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>54 – cases closed between July and September 2017</td>
</tr>
</tbody>
</table>

Case summary

A young female died from a heart condition.

The young person had a short history of medical problems prior to their death. They became unresponsive in their sleep at home and passed away.

Coronial findings

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

The coroner found that the adult should have been referred to health services for investigation of their pre-existing abnormal medical conditions. The coroner also found that appropriate medical documentation and discharge information was not reported in a previous hospital visit.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the [hospital] improve its documentation follow up and discharge documentation.
- That the [hospital] clearly document non-obstetric medical issues on discharge documentation. Further, that non-obstetric medical issues have a clear follow up discharge plan.
- That the [hospital] develop and implement a hospital wide ECG [electrocardiogram] policy. This should include a specific section related to ECG review and reporting as well as the following:
  - All ECGs be reviewed and signed, including date and time of review by a medical officer.
  - In the [emergency centre], ECGs are the responsibility of the Doctor managing the patient at that time.
  - If a patient is admitted into the [hospital], the ECGs are the responsibility of the treating team.
  - All ECGs are to be formally reported by a cardiology registrar or above.
Review of the formal cardiology report is the responsibility of either the Doctor or the medical team.

Referral for further investigations for any detected ECG abnormalities.

That the [hospital] widely promote and distribute the ECG policy and change in practice to all staff members.
Coronial recommendations: Fatal facts

Case number | VIC.2016.984
Primary category | Falls
Additional categories | Work related, Physical health
Fatal facts edition | 54 – cases closed between July and September 2017

Case summary
A middle aged female died from the effects of injuries sustained in a fall.

The adult suffered a foot fracture when they tripped over whilst working. After the fall, the adult’s foot did not heal and caused multiple blood clots to develop. This prevented blood flow to the lungs. Medical treatment was unsuccessful, and the adult passed away in hospital.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the adult received reasonable and appropriate medical care.

No guidelines existed at the time of the adult’s death regarding venous thromboembolism (VTE) prophylaxis in the outpatient population. The National Health and Medical Research Guidelines (NHMRS) 2009 were out of date at the time of the adult’s death.

The coroner found no evidence to suggest the adult’s death could have been prevented.

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

- With a view to preventing like deaths and creating a consistent approach across medical specialities, I recommend that consideration be given by [...] the Victorian Minister for Health, to the need to encourage and support the development of new venous thromboembolism guidelines.
- With a view to preventing like deaths and creating a nationally consistent approach across medical specialities, I recommend that consideration be given by the Council of Presidents of Medical Colleges to encourage and support the development of new, national venous thromboembolism guidelines.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2016.3023</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Intentional self-harm</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Drugs and alcohol</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>54 – cases closed between July and September 2017</td>
</tr>
</tbody>
</table>

Case summary

An adult male died from a drug overdose.

The adult had a medical history of substance use disorder and panic disorder. The adult also had a history of self-harming. Prior to the adult’s death, they discussed suicide with their partner.

Coronial findings

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

The coroner found that the cause of death was mixed drug toxicity and that pharmaceutical drugs were involved in the adult’s fatal overdose.

Coronial recommendations

The coroner made the following recommendations related to this case:

- [The deceased’s] death reinforces the urgent, immediate need for a real-time prescription monitoring system. This system will help doctors make decisions in a clinical environment around drug prescribing. As such, I recommend that the Victorian Department of Health immediately take the necessary steps to implement a real-time prescription monitoring system in Victoria. This will help to tackle the increasing rates of fatal overdoses involving prescription medications and prevent such deaths into the future.

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.2016.3777</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Transport and traffic related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>54 – cases closed between July and September 2017</td>
</tr>
</tbody>
</table>

Case summary

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

The adult was using a pedestrian crossing whilst the green walk traffic control signal flashed. A vehicle collided with the adult before coming to a stop. The adult was stabilised by emergency services at the scene. The adult’s condition deteriorated in hospital where they passed away.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that there was no flashing ‘give way to pedestrians’ sign at the intersection.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend to VicRoads that they review signage at the intersection consider the installation of flashing ‘Give way to pedestrian’ signs.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>VIC.2016.5566</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Transport and traffic related</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Older persons</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>54 – cases closed between July and September 2017</td>
</tr>
</tbody>
</table>

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

The vehicle in which the adult was travelling failed to turn at an intersection and collided with a tree. The adult sustained multiple injuries during the crash and was taken to hospital. The adult’s condition continued to deteriorate, and they passed away in hospital.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the cognitive condition of the elderly driver could have been significantly impaired at the time of the collision.

The coroner also found that the driver was suffering from a very poor short-term memory and a decline in everyday activities. No action was taken by medical clinicians to notify VicRoads about the driver’s declining cognitive function prior to the incident.

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

- With a view to reducing harms to others and preventing like deaths, I repeat my recommendation that consideration be given by the Secretary of the Department of Economic Development, Jobs, Transport and Resources, and VicRoads, to adopting a framework requiring mandatory reporting to VicRoads when a medical practitioner forms an opinion that a person with a permanent or long-term injury or illness, is not or may not be medically fit to drive.

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.
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.2012.1510</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Natural cause death</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>54 – cases closed between July and September 2017</td>
</tr>
</tbody>
</table>

Case summary

A middle aged male died whilst working on board a ship.

The adult began feeling unwell and complained of severe back and stomach pains. They were assisted by other crew members and given medication. The adult’s condition continued to deteriorate rapidly within 24 hours of them becoming unwell. By the time medical personnel arrived, the adult was unable to be revived.

Coronial findings

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

The coroner found that the adult had developed a rapid onset infection in the days prior to their death and that the cause of death was bronchopneumonia. The coroner found that failure by the ship’s caption to alert medical services before conditions worsened prevented the adult from receiving appropriate medical treatment at an earlier stage.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend the Government of Western Australia initiate an independent strategic review of the aeromedical (rotary wing) retrieval services in Western Australia. The review should include consultation with AMSA [Australian Maritime Safety Authority], WA Health, St John Ambulance, the Royal Flying Doctor Service, WA Police, DFES [Department of Fire and Emergency Services] and the Harbour Masters of the various ports. A primary concern should be to ensure that there are appropriate assets that are stretcher capable, with properly trained medical staff, readily available. With that aim in mind, the review should consider whether it is practical to establish an emergency medical service involving rotary wing helicopters and staffed with trained medical personnel, in the State’s North West.

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

<table>
<thead>
<tr>
<th>Case number</th>
<th>WA.2013.1092</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Adverse medical effects</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Physical health</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>54 – cases closed between July and September 2017</td>
</tr>
</tbody>
</table>

Case summary

A middle aged female died from the effects of their prescribed medication.

The adult suffered from several health conditions as a result of their diabetes. The adult was admitted to hospital due to a recurrent infection. They were prescribed strong pain relief to manage the chronic pain caused by the infection. The adult developed breathing problems from the medications they were prescribed. They became unresponsive and passed away in hospital.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult’s death was a combination of the result of opioid drug exposure and their pre-existing health conditions.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the Department of Health amend the Department of Health Schedule 8 Medicines Prescribing Code to limit the authorisation to prescribe fentanyl transdermal patches to approved specialists for the treatment of pain, as set out in 2.5.8 of the current Schedule (2017). The current system in place for methadone, as set out in 2.5.3, might provide a helpful guide.

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>WA.2014.865</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Intentional self-harm</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Drugs and alcohol, Law enforcement</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>54 – cases closed between July and September 2017</td>
</tr>
</tbody>
</table>

Case summary

A middle aged male died from self-inflicted injuries.

The adult was a sentenced prisoner at the time of their death and had been placed on parole. The adult was found to have breached their parole conditions due to drug use, and a warrant was issued. When the adult became aware of the warrant, they self-harmed to avoid returning to prison. The adult died in hospital as a result of their injuries.

Coronial findings

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

The coroner found that there were failures by Adult Community Correction (ACC) officers to ensure the adult underwent frequent urinalysis and attended alcohol and drug intervention programs for long periods of time. These failures removed a regimen that could have assisted the adult to re-integrate into the community.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the Western Australian government review and, if appropriate, amend or repeal the requirement in s107B Sentencing Administration Act 2003 for the Prisoners Review Board to give a prisoner written notice of a decision to amend, suspend or cancel an early release order as soon as practicable after the decision is made.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>WA.2014.1757</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary category</td>
<td>Drugs and alcohol</td>
</tr>
<tr>
<td>Additional categories</td>
<td>Youth</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>54 – cases closed between July and September 2017</td>
</tr>
</tbody>
</table>

Case summary

A young female died from alcohol poisoning.

The young person was attending a party at their family home. The young person was inexperienced in drinking and had a low tolerance to alcohol. They drank a lethal amount of alcohol over the course of the party. They became incoherent at the end of the night and were put to bed. The young person stopped breathing in their sleep, and an ambulance was called. They passed away in hospital.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the young person died as a result of the toxic effects of alcohol, which impacted on their ability to breathe effectively. The coroner found that those who were helping the young person did not understand the seriousness of the young person’s condition and should have called an ambulance once the young person became uncoordinated.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend comprehensive education as to the effect of alcohol, specifically on developing brains and respiratory function, be provided to all students receiving secondary education whether they be involved in applied science courses or not. Such education to explain the need for hospitalisation for people unconscious due to the effects of intoxication and the need for CPR [cardiopulmonary resuscitation] to be commenced and continued until advised otherwise by attending paramedics if the intoxicated person ceases to breathe for themselves.

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.
## 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>