Coronial recommendations: Fatal facts

A summary of cases and recommendations made between January and March 2019

Edition 60
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CORONERS’ RECOMMENDATIONS

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

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

Coronial recommendations: Fatal facts includes case summaries and recommendations for cases closed between January and March 2019.

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

The following case summaries and recommendations relate to deaths reported to a coroner in the Australian Capital Territory.
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<table>
<thead>
<tr>
<th>Case number</th>
<th>ACT.2012.192</th>
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<tbody>
<tr>
<td>Primary category</td>
<td>Work related</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>60 – cases closed between January and March 2019</td>
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Case summary
A young male died due to injuries sustained in a workplace incident.

The young person was working at a construction site. They suffered fatal injuries when they were struck by a concrete pouring boom that collapsed due to a failure of its bolts.

Coronial findings
The coroner found that the death was unintentional.

The coroner was unable to determine the operative cause of the failure of the bolts that led to the boom’s collapse.

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

- Assuming that the failure may have been caused by the failure of the workmanship of employees or agents of [concrete pump manufacturer] (on its own or in association with other factors) it is recommended that the company undertake a review of the processes that apply to the installation of bolts in machinery of this type. In particular, a review should be conducted by that company of the methods employed to ensure individual bolts are uniformly tensioned and to ensure that load testing of booms is carried out after repairs of this type are undertaken. In this regard I note that Counsel for [manufacturer] advised that such reviews have already been undertaken.

- Assuming the failure of the bolts may have been caused by a failure of the bolt themselves (internal hydrogen embrittlement) or because of environmental hydrogen embrittlement (perhaps associated with the failure of the zinc coating), I recommend that the reports received in the coronial proceeding should be referred by WorkSafe ACT to the manufacturers and/or suppliers of the bolts for consideration as to whether bolts supplied and/or any zinc coating meet relevant industry standards both in Australia and in other countries.

- Assuming that the failure of the bolts occurred as a result of the combination of the matters set out above it is recommended that the reports received in these proceedings should be
referred by WorkSafe ACT to Safe Work Australia for consideration as to whether additional Australia wide standards should be put in place:

- to ensure bolts used in the context of securing booms are safe;
- to ensure replacement and repair processes of such bolts are appropriate;
- to ensure that the cycle of replacement of such bolts is appropriate; and

- to require those processes to be effectively audited to ensure individual bolts are uniformly tensioned and to ensure that load testing of booms is carried out after repairs of this type are undertaken.

- I also recommend that WorkSafe ACT consider whether at an ACT level there are appropriate safeguards in place to address the matters referred to [in the four points above].

- I further recommend that the ACT develop its own guidance for those in the construction industry undertaking concrete pours in the terms suggested by [engineering expert] in [their] report.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>ACT.2017.82</th>
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<tr>
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<td>Transport and traffic related</td>
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<tr>
<td>Fatal facts edition</td>
<td>60 – cases closed between January and March 2019</td>
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</tbody>
</table>

Case summary

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

The adult was participating in an unsupported cycle race at the time of the incident. They were riding on a highway at night when they were struck by a vehicle close to an intersection. They died at the scene.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the highway was single carriage and the adult had no choice but to ride in the main traffic lane. The coroner found that the area was not lit, and the adult's bicycle had a static rear reflector that could have been misinterpreted by drivers to be the static reflectors on the highway's guideposts.

Coronial recommendations

The coroner made the following recommendations related to this case:

- The ACT Government should conduct a review of the [intersection] to evaluate risk to road users, and a reassessment of funding priority in accordance with the review's findings.
- The ACT Government should define a clear outline of what constitutes a major intersection on the ACT portion of the [highway].
- The ACT Government should give consideration to the speed limits that should apply to major intersections along the [state] section of the [highway].
- Standards Australia should conduct a review of AS3562-1990 relating to bicycle lighting, and the Standard be either updated or replaced.
- The ACT Government should amend its relevant legislation to require a flashing rear light when riding a bicycle in low light conditions on rural roads. However, I also commend this recommendation to all Australian State and Territory Governments, for consideration of changes to the Australian Road Rules.
- The ACT Government should amend its relevant legislation to clarify whether bicycles require a wholly separate reflector to be on the back of the bicycle, or whether the reflector may be integrated into the rear light. However, I also commend this recommendation to
all Australian State and Territory Governments, for consideration of changes to the Australian Road Rules.
NEW SOUTH WALES

The following case summaries and recommendations relate to deaths reported to a coroner in New South Wales.
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<th>Case number</th>
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<td>Fatal facts edition</td>
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</table>

Case summary

An adult male disappeared in suspicious circumstances.

The adult was last known to have made a phone call to their spouse, after which they were not seen or heard from. They were known to be involved in the manufacturing of illicit drugs.

Coronial findings

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

The coroner found that the police investigation raised a strong suspicion that the adult’s death was due to homicide.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That the death of [the deceased] be referred to the Unsolved Homicide Unit of the NSW Police Homicide Squad for further investigation in accordance with the protocols and procedures of the Unit.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
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<td>Additional categories</td>
<td>Physical health</td>
</tr>
<tr>
<td>Fatal facts edition</td>
<td>60 – cases closed between January and March 2019</td>
</tr>
</tbody>
</table>

Case summary

A middle aged male died due to complications of a surgical procedure.

The adult had colon cancer, for which they underwent surgery at a private hospital. During the initial surgery, a vein was inadvertently resected, leading to serious complications.

Further surgery was undertaken at the hospital prior to the adult being transferred to another hospital, where additional surgeries were performed. The adult’s condition deteriorated, and they later passed away.

Coronial findings

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

The coroner found that there were no appropriate policies and review pathways in place to ensure that a full and open review of the incident was triggered and engaged in.

The coroner found that the death was not appropriately notified to a coroner in the first instance.

Coronial recommendations

The coroner made the following recommendations related to this case:

To Chief Executive – [Local Health District]:

• That where a patient transferred for care from a private health facility dies in [hospital], there be a written protocol which provides for:
  o the notification of the death to the Director of Clinical Services/General Manager of the private health facility from which the patient was transferred;
  o the Director of Clinical Services at [hospital] to notify the LHD [Local Health District] Director of Clinical Governance of any such deaths for consideration of what action is required to be taken under the NSW Health “Incident Management Policy”.

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To the Chief Executive Officer, [private hospital]:

- That where a patient transferred for care from a public health facility dies in the [private hospital], there be a written protocol which provides for:
  - the notification of the death to the General Manager/Chief Executive of the public health facility from which the patient was transferred;
  - communication between the Director of Clinical Services of [private hospital] and Director of Clinical Services of the public health facility as to whether follow up review is required, who is responsible and what resources should be shared.

- Where a transfer for escalated care follows surgery, the surgeon must complete and sign a transfer document, outlining the nature of the operation, the complication (if any) and reasons for transfer.

- That the Hospital implement training and education regarding the requirement of an RCA [root cause analysis] be conducted.

- That the Hospital implement training and education regarding the requirement to notify a Coroner of a death.

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Coronial recommendations: Fatal facts

Case number

The coroner held a joint investigation into the following deaths which resulted from the same incident: NSW.2014.352, NSW.2014.354

Primary category

Law enforcement

Additional categories

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

Fatal facts edition

60 – cases closed between January and March 2019

Case summary

An adult male and a female child died in a homicide-suicide incident perpetrated by the adult. The medical cause of their deaths was unknown.

The adult was the child’s parent and had separated from the other parent prior to the incident. The parents had a court ordered parenting plan in place determining the time allowances for each parent to spend with the child.

The child was in the care of the adult for a couple of weeks leading up to the incident. The other parent had virtual contact with the child during this time and a date was set for the child to return to the care of the other parent. The adult and the child did not attend the agreed pick up location and after failed attempts to contact them, the other parent reported the child missing to police.

The bodies of the adult and the child were discovered after a couple of weeks of searching.

Coronial findings

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

The coroner found that the adult had a history of mental ill health, including self-harm and anxiety focused on being permanently separated from the child. The coroner found that the adult had a number of suicide risks.

The coroner found that police initially treated the report as a custody dispute rather than a missing persons case. This resulted in the priority of the case being listed as much lower than had the child been considered a missing person. The coroner found that the usual checklist of questions and risk assessment for missing persons was not attempted in any coordinated or formal way once the adult and child were reported missing.

Coronial recommendations

The coroner made the following recommendations related to these cases:
• That the Missing Persons Standard Operating Procedure be amended to include advice that where a parent fails to return a child pursuant to a parenting plan or court order, and the child cannot be sighted by police, they are to be treated as a missing person.

• That the Chapter titled “Family Law” in the NSW Police Force Handbook, be amended to include advice that where a parent fails to return a child pursuant to a parenting plan or court order, and the child cannot be sighted by police, they are to be treated as a missing person.

• That a training package be developed to notify police of the changes to the Missing Persons Standard Operating Procedures and the NSW Police Force Handbook and the way in which it operates in practice.
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>The coroner held a joint investigation into the following deaths which resulted from similar incidents: NSW.2014.1370, NSW.2015.2598</th>
</tr>
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<tbody>
<tr>
<td>Primary category</td>
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<td>Additional categories</td>
<td>Domestic incident</td>
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<td>Fatal facts edition</td>
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</table>

A joint inquest was held into the following deaths as both children were born to the same mother.

Case summary – NSW.2014.1370
A female infant died due to Sudden Unexpected Death in Infancy (SUDI).

The child was found unresponsive in their home. There was a delay in calling emergency services. Attending paramedics found the infant to be deceased upon their arrival.

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

The coroner found that known risk factors for SUDI were identified at the scene. The infant’s parents were known to use illicit drugs and children in the home were subjected to neglect.

The coroner found that improvements could be made to Family and Community Services protocols in relation to at-risk children.

Case summary – NSW.2015.2598
A female infant died due to Sudden Unexpected Death in Infancy (SUDI).

The infant was born via caesarean section with antenatal abnormality. Maternal substance abuse and social issues were noted. The infant was released into the care of a foster carer, rather than their parent.

The infant was found unresponsive in their home. Despite the arrival of emergency services and attempts at resuscitation, the infant was unable to be revived.

Coronial findings
The coroner was unable to determine the circumstances of the death.
The coroner found that the infant was taken into care due to the risks of neglect, being drug affected and an unsafe environment following discharge from hospital.

The coroner found that the infant received appropriate care and attention from their foster carer during their short life.

The coroner found that improvements could be made to Family and Community Services protocols in relation to at-risk children.

Coronial recommendations

The coroner made the following recommendations related to these cases:

To the Minister for Family and Community Services and the Secretary of the Department of Family and Community Services ("FACS"):

- That FACS undertake a review of the types of risk of significant harm ("ROSH") reports currently being allocated, referred to services or "closed for competing priorities" at triage (including during weekly allocation meetings), so that the FACS Executive team (comprising of senior officers at monthly executive meetings in districts) can better monitor, consider and review resource allocation and address the need for any procedural changes.

- That FACS require all Managers Client Services to use the Resource Management Dashboard to monitor and report to the Director Community Services (using existing monthly executive meetings) on:
  - children reported at ROSH who have an open plan at a CSC [community services centre], with no triage activity and an allocation decision pending for over 28 days, and
  - children reported at ROSH where the report was closed after 28 days.

- That the FACS Quarterly Business Review between the Deputy Secretary Northern Cluster and Deputy Secretary Southern and Western Cluster, which examines the performance of each district and allows for discussion of any business risks, is to include:
  - monitoring of adherence to, and progress of, the Office of the Senior Practitioner’s serious case review and practice review recommendations,
  - monitoring of adherence to weekly group supervision requirements in line with the group supervision framework,
  - a measure capturing the volume and geographic data of reports reported at ROSH but then closed in each CSC to be implemented (both on a monthly and quarterly basis).

- That on every occasion that a FACS Serious Case Review Panel is convened for a child death review, it undertakes critical assessment of any applicable FACS policy and comments on any deficiencies in the drafting, implementation and compliance with such policy in the Serious Case Review Report prepared in relation to that death.

- That FACS consider urgently amending its current policies that deal with allocation of a ROSH report that has been assessed by a triager as requiring allocation to a caseworker (herein referred to as an "unallocated ROSH report") to provide as follows:
An unallocated ROSH report cannot be closed prior to assessment of that report at a WAM [weekly allocation meeting] or such other meeting at which the allocation of such reports at the CSC is considered (herein, collectively referred to as a “WAM”).

If an unallocated ROSH report cannot be allocated (and an increase in capacity is not expected by the next WAM), the CSC is to record this information in the Resource Management Dashboard and ensure that the Director Community Services is notified. The Director Community Services must then consider the lack of capacity at the CSC and decide whether to allocate additional resources to that CSC to enable the report to be responded to.

The closure of an unallocated ROSH report may only occur:
- after a triage assessment of the level of risk in the report;
- after consideration has been given to allocation at a WAM;
- after notification to the Director Community Services in accordance with [the above] has occurred;
- after consideration of an appropriate checklist of other options available (to ensure that a report is only closed as a last resort).

The closure of an unallocated ROSH report may not occur for “competing priorities” (or equivalent concept) prior to assessment of that report at a WAM.
Coronial recommendations: Fatal facts

Case number | NSW.2014.3768
Primary category | Intentional self-harm
Additional categories | Child and infant death
Fatal facts edition | 60 – cases closed between January and March 2019

Case summary
A female child took their own life by hanging.
The child resided with a foster family and experienced ongoing mental health issues in relation to their sense of belonging and adoption processes.
The child was found unresponsive on their property. Ambulance paramedics attended the scene and found that they had passed away.

Coronial findings
The coroner found that the death was due to intentional self-harm.
The coroner found that health professionals treating the child in the last few years of their life were not given the benefit of complete background histories or reports from previous treating practitioners. Similarly, the coroner found that when the child transferred schools, all information relevant to their ongoing welfare was not received by the new school.
The coroner found that a more coordinated and urgent response was required by the Department of Family and Community Services and the Out of Home Care non-government organisation responsible for the child’s foster placement, and that they failed to adequately recognise the series of serious cumulative risk factors the child presented with in the year leading up to their death.

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

To the Group Executive Manager, of the identified OOHC [Out of Home Care] NGO [non-government organisation] that consideration be given to:

Engagement of external clinicians
• Taking steps to reintroduce the use of a written form to be used when children in the care of the identified OOHC NGO foster carer are seen by an external clinician. Such a form could be revised [...], to include:
Details of the role of the identified OOHC NGO in relation to the child, including
authorising the provision of information by the clinician to the identified OOHC NGO.

Information regarding relevant past treatments and clinicians.

Provision for the external clinician to provide information regarding the clinician’s
diagnoses and recommendations.

• Reviewing relevant policies with a view to provision being made for:
  o Written reports to be obtained from external clinicians in relation to significant
    attendances relating to future management of foster children.
  o Proactive sharing of relevant previous reports of other clinicians with external clinicians.
  o External clinicians being invited to participate (either in person by or by way of written
    report) in multidisciplinary case conferences.

Communication with schools

• Reviewing relevant policies with a view to provision being made for:
  o A requirement that information be provided in writing to schools regarding significant
    past and emerging issues that affect the safety, welfare or well-being of a child in the
    care of the identified OOHC NGO foster carer (both at enrolment and on an ongoing
    basis). That information should include the name and contact details of mental health
    practitioners that have been engaged with the child where considered appropriate.
  o Where a child in the care of the identified OOHC NGO foster carer is to transfer schools,
    information in writing should be requested from the school from which the child is
    exiting as to any significant past and emerging issues that affect the safety, welfare or
    well-being of the child.
  o School representatives being invited to participate (either in person by or way of
    written report) in multidisciplinary case conferences.

Education of foster carers

• Taking steps to develop a training package for foster carers specific to the transition to
  adolescence.

• Developing and providing a training regime and schedule that prepares foster carers for
  various milestones in advance (such as commencement of school, transition to high school,
  adolescence, and leaving care), shortly before those milestones are reached. Communications of significant decisions to children in OOHC.

• Developing policies relating to significant decisions regarding a child in the care of the
  identified OOHC NGO foster carer (such as changes to case plan goal and decisions
  relating to respite care) with a view to:
  o Providing guidance on the steps to be taken to communicate significant decisions to
    the children.
  o Ensuring Case Managers are equipped to effectively explain such decisions.
  o Clinical support being available and considered in such cases.
Communication issues

- Updating the identified OOHC NGO’s “Parents information book” to include:
  - Guidance on appropriate communication to support the child’s sense of belonging.
  - Specific issues regarding communication via social media.
- Taking steps to develop social media fact sheets for foster parents and children in foster care.

To the Minister, Department of Family and Community Services [FACS]:

- Consideration be given to whether:
  - the currently available carer training used/recommended by FACS includes training directed at:
    - anticipating possible limit testing and oppositional behaviour in the adolescent child in Out of Home Care;
    - understanding why such behaviours may be exhibited (i.e. ‘acting out’ in response to underlying trauma and attachment issues);
    - providing strategies for responding to and dealing with such behaviours, including seeking clinical support; and
  - if the training in all or any of [the above three points] is not currently available, whether such training ought to be developed.
- That the above recommendations [...] directed to an identified OOHC NGO are circulated to all NGOs that provide OOHC in NSW, with a request that the NGOs review their policies and procedures to identify if there are any gaps which require remedying. (In making this recommendation, it is noted that this may complement a planned consultation by FACS with NGOs in 2019 to identify if there are any gaps in health and education pathways for children in OOHC).

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Coronial recommendations: Fatal facts

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<td>Fatal facts edition</td>
<td>60 – cases closed between January and March 2019</td>
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Case summary

A middle aged female died due to complications following a gastroscopy.

The adult attended hospital as an outpatient for an elective gastroscopy procedure. During the procedure, aspiration occurred which caused the adult to suffer a respiratory arrest. They were transferred to intensive care where they later passed away.

Coronial findings

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

The coroner found that the adult had brought documentation with them to the hospital which contained important information about their condition that should have resulted in the procedure being postponed. The coroner found that the gastroscopy should not have taken place, and that it commenced due to a failure to inform the surgeon about new information that was available.

Coronial recommendations

The coroner made the following recommendations related to this case:

To [area] Health District:
- That the policy now in place at [hospital] in its Clinical Handover from Day Surgery Nurse to Anaesthetic Nurse in [hospital] Perioperative Unit be accepted and incorporated to apply to all hospitals within the District and that consideration is given to ensure that the policy document identifies the particular staff member who will have responsibility for each assigned task.

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

A middle aged male died due to complications of deep vein thrombosis. The adult had been admitted to hospital following an altercation with police. They became distressed after meeting with a visitor and collapsed. Attempts to revive the adult were unsuccessful.

Coronial findings

The coroner found that the death was due to natural causes. The coroner found that the death occurred in the context of an extended period of hospitalisation.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the Chief Executive, [local health district]:

- I recommend that a copy of these findings be provided to the developer of the [electronic medication management] software system for consideration in relation to [the following recommendation].

- I recommend that, in consultation with the NSW Ministry of Health, consideration be given to requesting that the developer of the [electronic medication management] software system ensure that users of the system are readily able to distinguish between medication that is actively being administered to a patient and medication that has been cancelled, irrespective of the on-screen information chosen to be displayed by the user, and without detracting from the functionality and usability of the system.

- I recommend that consideration be given to the circumstances of [the deceased’s] death (with appropriate anonymization, and conditional upon consent being provided by [the deceased’s] family and following appropriate consultation with them) being used as a case study as part of education packages provided to clinical staff regarding venous thromboembolism risk assessment in the context of unexpected extension of a patient’s admission duration.

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

An adult male died during a police operation.

The adult had attempted to fatally harm their former partner on the day of their death and was the subject of a police pursuit. A stand-off ensued between the adult and police, during which the adult advanced on police while armed with a knife. The adult was fatally shot by police as a result.

Coronal findings

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

The coroner found that there was nothing further the attending police officers could have done to prevent the fatal outcome of the incident. However, the coroner considered that alternative tactical options could be explored and other measures implemented to avoid similar scenarios.

Coronal recommendations

The coroner made the following recommendations related to this case:

To the Commissioner of NSW Police Force:

- That the NSW Police Force continue to review other tactical options of a non-lethal nature for dealing with offenders armed with a knife, including the use of shields, in order to minimise the likelihood of serious harm in the event of a police response that requires an offender to be disarmed.
- That the NSW Police Force consider the implementation of an information sharing system to allow licensed weapons dealers to check if a person buying a knife has an outstanding apprehended violence order or apprehended domestic violence order.

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Coronal recommendations: Fatal facts

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<td>Transport and traffic related</td>
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<td>Fatal facts edition</td>
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Case summary

A young male died due to a vehicle incident in which they were a driver.

The young person’s vehicle was noted to be speeding by a passing police officer. The police officer commenced following the young person’s vehicle. The young person continued to drive at speed to evade police. They lost control of the vehicle, which collided with a tree. The young person passed away as a result of the collision.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the police vehicle was engaged in a pursuit of the young person’s vehicle at the time of the incident. The coroner found that improvements could be made to police policies to ensure clarity around the definition of a pursuit.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the Commissioner of Police, NSW Police Force:

That the Commissioner give consideration to the following:

- With respect to the Pursuit Guidelines in Part 7 of the Safe Driving Policy:
  - the first 2 paragraphs of 7-1 and 7-1-1 be combined, to avoid doubt as to what the definition of pursuit is;
  - a section is included to advise officers that if they are in doubt as to whether or not an offending vehicle has ignored a direction to stop, they should inform the DOI [Duty Operations Inspector], or the VKG [police radio operations centre] shift coordinator of their actions, and provide the information outlined in paragraph 7-5-1.

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ncis.org.au | ncis@ncis.org.au
Coronial recommendations: Fatal facts

<table>
<thead>
<tr>
<th>Case number</th>
<th>NSW.2018.2152</th>
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<tr>
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<td>Transport and traffic related</td>
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<tr>
<td>Fatal facts edition</td>
<td>60 – cases closed between January and March 2019</td>
</tr>
</tbody>
</table>

Case summary

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

The adult had a history of mental illness and alcoholism. They were seen walking alongside a road, and a short time later were believed to have laid down on the road. The adult was then struck by a vehicle and passed away as a result.

Coronial findings

The coroner found that the death was unintentional.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That an urgent assessment be conducted by the relevant authority/authorities of the efficiency of street lighting in [town] with a view to urgently replacing the existing lighting with lights which would cause greater illumination of both the footpath areas and the street areas so as to eliminate insofar as possible, dark spots so that public safety of the residents and visitors to [town] might be significantly enhanced.
Northern Territory

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

Case number | NT.2017.111
---|---
Primary category | Work related
Additional categories | Weapon
Fatal facts edition | 60 – cases closed between January and March 2019

Case summary

An adult male died due to injuries sustained in a live firing army training exercise. During the exercise the adult unknowingly situated themselves in a no-go area near a concealed target. They were shot by other personnel who were unaware of the adult's position.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult had not been trained on the range before and had not been given a walk-through or a blank fire rehearsal prior to the live firing exercise. The safety mitigation for such operations ('doctrine') required dry practices or blank firing prior to proceeding to live firing. The coroner found that the failure to follow doctrine exhibited a systemic failure in the armed forces.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that Army resolve the confusion as to the interpretation of Chapter 6 Annex J, LWP-G 7-3-1 (formally Chapter 15 Annex K LWP-G 7-3-1) by making it explicit what rehearsals are mandatorily required to be undertaken by participants on a range prior to it being used for a live fire exercise.
- I recommend that if Army determines that a rehearsal or rehearsals are required that the mandatory requirement of those be highlighted in the Annex as has now been done with the requirement for walk-throughs.
- I recommend that the ... Report recommendation, “that no-go areas behind concealed targets be marked on the outside of the walls containing such targets” be included in doctrine.

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TASMANIA

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

<table>
<thead>
<tr>
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<tr>
<td>Fatal facts edition</td>
<td>60 – cases closed between January and March 2019</td>
</tr>
</tbody>
</table>

Case summary
A middle aged male died due to a vehicle incident in which they were a pedestrian.

The adult was working as a traffic controller for roadworks, standing near the centre of road with a stop/slow sign to control flow of traffic. The adult was struck by a passing vehicle and passed away as a result.

Coronial findings
The coroner found that the death was unintentional.

The coroner stated that excessive speed and inattention by the driver were the principal reasons for the death.

The coroner determined that the absence of a barrier between the adult and the approaching vehicle was a significant factor and that had there been compliance with the applicable Australian standards related to roadworks, the death could have been avoided.

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

- All roadworks be carried out in a manner that complies as closely as practicable with the applicable Australian Standard.
- That under no circumstances should any road worker be positioned on the road without a physical barrier between her or him and the first approaching vehicle.

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Coronial recommendations: Fatal facts

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<tr>
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<td>Law enforcement</td>
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<tr>
<td>Fatal facts edition</td>
<td>60 – cases closed between January and March 2019</td>
</tr>
</tbody>
</table>

Case summary

An older female died due to complications of injuries sustained in a fall.

The adult was admitted to hospital subject to an order under the *Mental Health Act 2013*. Whilst in hospital the adult suffered an unwitnessed fall which resulted in a fracture. The fracture was treated surgically, however they later passed away.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that whilst the treatment of the adult was of an appropriate standard there was evidence in relation to lack of staff, poor staff-to-patient ratios, the distance of the adult’s room from the nurses’ station and the absence of motion sensors and a call button in the room.

The coroner determined that it was difficult to confirm if allegations made in relation to the death were the truth or otherwise as the original physical medical record had been destroyed.

Coronial recommendations

The coroner made the following recommendations related to this case:

- In every case where the death of a patient at the [hospital] is the subject of an investigation pursuant to the *Coroners Act 1995* all records be preserved and maintained until the conclusion of that investigation.

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Coronial recommendations: Fatal facts

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<tr>
<td>Additional categories</td>
<td>Mental illness and health, Drugs and alcohol</td>
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<tr>
<td>Fatal facts edition</td>
<td>60 – cases closed between January and March 2019</td>
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</table>

Case summary

A middle aged male died due to a cardiac arrest associated with prescribed medication.

The adult was subject to an order under the *Mental Health Act 2013*. They were admitted to hospital following inappropriate behaviour at a residential facility not suited for their care. During admission, medication in addition to their regular dosage was administered. This resulted in toxicity which fatally exacerbated the adult’s existing respiratory conditions.

Coronial findings

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

The coroner found that medical staff failed to take all possible steps to minimise the risk of complications arising from medication administration in the context of the adult’s respiratory conditions.

Coronial recommendations

The coroner made the following recommendations related to this case:

- Tasmanian Health Service, in concert with other relevant governmental authorities, co-ordinate a strategy to establish a suitable facility on the [coast] which can provide supported accommodation for persons suffering from mental illness and who are unable to care for themselves.
- Tasmanian Health Service continue and complete the implementation of all recommendations that arose from the clinical review and process review which arose from the death.

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Coronial recommendations: Fatal facts

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<td>Fatal facts edition</td>
<td>60 – cases closed between January and March 2019</td>
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Case summary
An older male died as a result of complications following surgery.

The adult underwent a hip replacement which was complicated by a fracture and excessive blood loss, requiring a transfusion.

The adult was discharged with anticoagulant medication. However, the adult suffered complications following discharged and passed away.

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

The coroner determined that although the adult had been discharged with anticoagulant medication to be taken for 28 days, they had ceased after six days. It was found that discharge notes advised the adult to take the medication for seven days.

The coroner found that the only explanation for this discrepancy was the adult acting on the nursing advice provided at discharge rather than the supplied medication.

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

- That the [hospital] review its discharge practices to ensure that there is a consistency between the medication prescribed for a patient and the advice provided to that patient upon that medication.
Coronial recommendations: Fatal facts

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<th>Case number</th>
<th>TAS.2017.47</th>
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<tr>
<td>Fatal facts edition</td>
<td>60 – cases closed between January and March 2019</td>
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Case summary

A young female died after accidentally falling from a cliff.

The young person attended a party with friends where they consumed alcohol. After the party, the young person and their friends attended a cliff near a beach. The young person was unfamiliar with the area, and the area was not lit. The group climbed over a fence on the cliff edge, and the young person landed awkwardly. Their momentum caused them to fall over the cliff and land on the rocks below. The friends attempted first aid and emergency services were contacted. The young person was pronounced deceased on arrival of paramedics.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that while appropriate warning signage at the cliff may not have deterred the young person and their friends, it could deter others from dangerous behaviour near the cliff face.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the [council] undertakes or initiates a comprehensive assessment of management and safety of the public area comprising the blowhole and the cliff face area from [location] beach to its end point on [road]; such assessment to include consideration of changes to the title of the land, and enhanced barriers, signage, lighting, seating and installation of CCTV [closed-circuit television] systems.
- I further recommend that the [council] gives consideration to recommendations from the assessment and, if it deems that action is required, devises a plan and schedule to undertake that action.

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Coronial recommendations: Fatal facts

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<td>Fatal facts edition</td>
<td>60 – cases closed between January and March 2019</td>
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Case summary

A middle aged male died due to complications of deep vein thrombosis.

The adult had been on holiday overseas. Whilst away, the adult was unwell and diagnosed with pneumonia and a chest infection. Upon their return home, the adult remained unwell and investigations were performed although nothing of concern was noted. The adult was found unresponsive in their home. Ambulance paramedics confirmed they had passed away.

Coronial findings

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

The coroner determined that although there were clues that the adult may have been suffering from a pulmonary embolism, the decision not to investigate was based on clinical assessment and the clinical absence of a deep vein thrombosis. However, use of the Pulmonary Embolism Rule Out Criteria (PERC) as set out by the Royal Australasian College of Physicians (RACP) would have resulted in further investigations being performed.

The coroner was unable to conclude the detection of the deep vein thrombosis would have prevented the death, though determined it would have given the best prospect of survival.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That medical practitioners, most particularly those in general practice, familiarise themselves with and apply the guide for the evaluation of suspected pulmonary embolism set out in the research paper published by the Royal Australasian College of Physicians (RACP) in the Internal Medicine Journal and entitled ‘Update on Diagnosis and Anticoagulant Therapy for Venous Thromboembolism.’

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Coronial recommendations: Fatal facts

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</tr>
<tr>
<td>Fatal facts edition</td>
<td>60 – cases closed between January and March 2019</td>
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</table>

Case summary

An adult female drowned after jumping from a bridge with the intention to end their life.

The adult had a history of mental and physical ill health. They left a suicide note stating they were unable to continue living with their physical pain.

Coronial findings

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

The coroner found that timely access to video footage on the bridge was vital in assisting police in locating and potentially saving persons who had been reported as present on the bridge in a state of crisis.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the establishment of transmission of live footage from the [bridge] cameras to the Police Radio Room be progressed with priority by the Cross Agency Working Group, Tasmania Police, and State Growth.
- I recommend that State Growth ensure that the cameras installed upon the [bridge] are subject to sufficient checks so as to ensure that they are operational and positioned to capture all pedestrian footways.
- I recommend that Tasmania Police continue to ensure that all investigating officers are aware of the existence of the high-quality, full-coverage camera footage and the means to view and obtain this footage from State Growth for use in relevant investigations.

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Coronial recommendations: Fatal facts

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<th>Case number</th>
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<tr>
<td>Fatal facts edition</td>
<td>60 – cases closed between January and March 2019</td>
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</table>

Case summary

A female child died following an ocean drowning incident.

The child attended a beach to swim with a friend. After some time swimming in the sheltered beach area, they moved to an unprotected rocky area and jumped into the ocean. The waves began increasing in size and frequency and the child began to struggle. They were unable to get out of the water and the friend attempted to assist. A large wave separated the child from their friend and the child was pulled under water. They emerged briefly and soon became unresponsive.

The friend contacted emergency services and the child was brought to shore where resuscitation attempts were made. They were transported to hospital but did not recover and passed away several days later.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the child and their friend would have passed at least one sign warning of the dangers of the rocky area. The coroner found that ongoing review of the safety plan for the area was critical in preventing further incidents of harm.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the [council] and Surf Life Saving Tasmania, together with other stakeholders, regularly review and update the Coastal Risk Assessment and Treatment Plan for the [location] with a view to determining, prioritising and implementing strategies to prevent injury and death in the area.

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Coronial recommendations: Fatal facts

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<th>Case number</th>
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<tr>
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<tr>
<td>Fatal facts edition</td>
<td>60 – cases closed between January and March 2019</td>
</tr>
</tbody>
</table>

Case summary

A young female died as a result septic shock due to meningococcal disease.

The young person was absent when meningococcal immunisations were administered and did not receive the vaccination prior to becoming unwell.

Coronial findings

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

The coroner noted that meningococcal disease was relatively uncommon in Tasmania, but that those who developed it could become extremely unwell and die in a very short period of time.

The coroner noted that the best protection against the disease was immunisation.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That pursuant to Section 28 of the Coroners Act 1995 that every eligible person avail themselves of the free immunisation service.
- That the current free immunisation programme be extended to include the meningococcal B vaccine.

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VICTORIA

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

Case summary

The adult male took their own life in a deliberate fall from a height.

The adult was an international student studying at university. The adult was believed to experience difficulties due to insomnia, change of environment, language barriers and relationship issues but did not seek medical assistance.

Bystanders stopped to render assistance and contacted emergency service following the incident. Attending paramedics confirmed the adult had passed away.

Coronial findings

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

The coroner stated that an international student struggling with English and studies was not a unique set of circumstances to the coronial jurisdiction, and that a lack of help-seeking for mental health issues was a recurring theme in suicide deaths of international students.

Coronial recommendations

The coroner made the following recommendations related to this case:

That the Australian Government Department of Education and Training:

- undertake consultation, in whatever form it believes most appropriate, with Victorian international student education providers as well as other organisations involved in international student education and support in Victoria, to identify strategies to engage vulnerable international students with mental health support;
- consider how critical incident reports maintained by education providers under Standard 6 of the National Code of Practice for Providers of Education and Training to Overseas Students, may be brought together to inform interventions to reduce suicide among international students studying in Victoria;
- amend Standard 6 of the National Code of Practice for Providers of Education and Training to Overseas Students to include a requirement that, when a death of an international student occurs, within four weeks the education provider forward a copy of the written
record of the critical incident and remedial action taken to the Coroner in the jurisdiction where the death occurred.
Coronial recommendations: Fatal facts

Case number: VIC.2016.2895
Primary category: Drugs and alcohol
Additional categories: Mental illness and health
Fatal facts edition: 60 – cases closed between January and March 2019

Case summary
An adult female died due to drug toxicity.

The adult was residing in a peer recovery community operated by a mental health service and had become distressed when told that their children could not visit. The adult began to consume alcohol and misuse medication, some of which had been obtained from other residents within the community.

The adult was found deceased in their room after a period of being unable to be contacted.

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

The coroner found that the support of the adult by the mental health service staff was suboptimal and did not meet the standards and procedures the mental health service had in place at the time.

The coroner also noted that while the completed and planned improvements identified by the mental health service should improve the safety of residents to an extent by ensuring their medications are securely stored, the implementation of further prevention strategies was warranted.

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

- That an assessment of a resident’s capacity to safely self-administer medications be incorporated into the Peer Recovery Community admission process.
- That [mental health service] consider referring those residents who do have a capacity to safely self-medicate to the Medicare funded Domiciliary Medication Management Review.

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Coronial recommendations: Fatal facts

Case summary

A young female died as a result of drug toxicity.

The young person was identified by a psychologist as highly stressed by a difficult family dynamic and school examinations.

The young person presented to hospital following the intentional ingestion of multiple medications that were not prescribed to them. Emergency staff followed advice provided by the NSW Poisons Information Centre, which although based on a current handbook, were not based on recent research. The young person passed away in hospital.

Coronial findings

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

The coroner determined that although the young person consumed various medications prescribed to their parent in an attempt to end their life, it was that evident that they changed their mind regarding their wish to die.

The coroner found that although the advice provided in relation to toxicity by the NSW Poisons Information Centre was not based on the most up-to-date literature, it was based on current guidelines and that the medical care and treatment provided appeared to have been reasonable in the circumstances.

Coronial recommendations

The coroner made the following recommendations related to this case:

- The Australian Commission on Safety and Quality in Healthcare assist clinical experts in developing National Poisons Information Guidelines.
Coronial recommendations: Fatal facts

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<tr>
<th>Case number</th>
<th>VIC.2017.376</th>
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<tr>
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<td>Fatal facts edition</td>
<td>60 – cases closed between January and March 2019</td>
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Case summary
A middle aged male died while participating in a drag racing event at a motorsport venue. The adult had been involved with cars and motor racing for many years. They were participating in a timed drag event in which they were the only driver. They were wearing a neck brace, helmet and racing harness. The vehicle appeared to lose traction near the end of the track and collided with the concrete barriers at speed. The adult died at the scene.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that there were no mechanical faults with the vehicle. The coroner found that the inspection undertaken by the technical officer prior to the event was inadequate, as it did not identify failures in the track barriers.

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

That Australian National Drag Racing Association (ANDRA):

- obtain structural engineering advice in relation to the minimum requirements for reinforcing safety barriers to provide sufficient support and structural integrity;
- update the 2004 specifications and associated documents, to prescribe the above engineer-approved structural integrity requirements as minimum standard for all ANDRA-sanctioned race tracks;
- communicate the amended specifications and safety inspection information to all ANDRA-sanctioned track owners and users and make the information available on its website; and
- undertake to assess and/or re-assess all ANDRA-sanctioned tracks within 12 months of the commencement of the new specifications, to ensure that all tracks meet the new minimum standard for safety barriers.

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Coronial recommendations: Fatal facts

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<td>60 – cases closed between January and March 2019</td>
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Case summary

An older male died due to complications following a fall. The adult resided in an aged care facility and was at high risk of falls. The adult suffered a fall while on a supervised outing. They were transported to hospital and underwent surgery. Their condition deteriorated following the surgery and they were palliated and passed away several days later.

Coronial findings

The coroner found that the death was unintentional. The coroner found that the facility’s falls risk and management strategies were of an acceptable standard whilst within the facility, but care of the adult during the outing was not appropriate for their level of risk.

Coronial recommendations

The coroner made the following recommendations related to this case:

- Prior to the outing an assessment was undertaken regarding the suitability of the venue and [the deceased]'s functional ability and behaviour, with all information recorded on a [aged care facility] form titled 'Daily Bus Outing Form'. [Aged care facility]'s root cause analysis (RCA) indicated that each resident’s risks were assessed prior to the outing to the [venue] on [date of incident], however the risks were not considered collectively as a group. If the cumulative risks of the group had been considered, the need for additional support staff would have been identified. I therefore recommend that [aged care facility] residents are risk assessed both individually and cumulatively for all future outings, with this information being recorded on the 'Daily Bus Outing Form'.

- Following the RCA, [aged care facility] implemented changes to assessment forms completed prior to an outing. The forms specify how families are to be notified of planned outings. I recommend that [aged care facility] undertake ongoing audits of these forms to ensure compliance.

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Coronial recommendations: Fatal facts

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<td>Fatal facts edition</td>
<td>60 – cases closed between January and March 2019</td>
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Case summary
A middle aged male died as a result of a vehicle incident in which they were a motorcyclist.

The adult was riding their motorcycle in the early hours of the morning when they collided with a truck parked on the side of the road. The adult was declared deceased on arrival of paramedics.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the rear of the truck’s trailer was painted black and was dirty, obscuring the rear reflective surfaces. The coroner found that it was likely that the adult had not seen the parked truck.

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

• I recommend the Australian Government Department of Infrastructure, Regional Development and Cities consider amending vehicle standards to mandate the use of conspicuity markings for heavy vehicles and trailers in line with international standards to improve road safety for all Australian road users.

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Coronial recommendations: Fatal facts

Case number: VIC.2017.5990
Primary category: Work related
Fatal facts edition: 60 – cases closed between January and March 2019

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

The adult was an experienced construction worker and competent in the use of a chainsaw but was not a qualified arborist. The adult attended a property to cut down a tree with the assistance of a cherry picker. They cut the head off the tree and the branches struck them as they fell. The property owner discovered the adult hanging out of the cherry picker basket and contacted emergency services. They were transported to hospital but did not recover and passed away several days later.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the WorkSafe Victoria guidance in relation to working with trees did not provide information or advice on the risk of falling trees and limbs when undertaking tree work.

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

- That WorkSafe Victoria review its guidance note on Working Safely with Trees to make specific note of the risks of injury from falling objects such as branches and provide recommendations on suggested control measures to reduce the risk of injury or death.
- That WorkSafe Victoria consider developing safety checklists for persons engaged in tree lopping and gardening services to assist workers and employers with identifying risks and hazards of tree trimming and removal work and implementing appropriate risk control measures.
- That WorkSafe Victoria consider implementing a safety action plan for tree work such as that initiated in New South Wales to promote safe work practices.

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Coronial recommendations: Fatal facts

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Case summary

An older female died as a result of a vehicle incident in which they were a passenger.

The adult was a passenger in a vehicle driven by their spouse. Their vehicle collided with another vehicle that was attempting to turn off the highway. The adult was transported to hospital where their condition deteriorated and they later passed away.

Coronial findings

The coroner found that the death was unintentional.

The coroner was unable to determine the cause of the collision. The coroner noted that the spouse had conditions imposed on their driver's licence shortly after the incident.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That VicRoads conduct a Road Safety Audit of [highway], between [locations] to establish whether it is eligible for nomination as a "Black Spot" and the associated funding, and
- That VicRoads implement safer overtaking opportunities for road users on the [highway] between [locations], and
- That VicRoads consider dedicated turning lanes at popular tourist destinations directly accessed by the [highway] between [locations].

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Coronial recommendations: Fatal facts

Case number
VIC.2018.3061
Primary category
Transport and traffic related
Fatal facts edition
60 – cases closed between January and March 2019

Case summary
An adult male died due to a motor vehicle incident in which they were a driver.

The incident occurred when the adult drove their van through an intersection and collided with a semi-trailer.

Coronial findings
The coroner found that the death was unintentional.

The coroner noted that the adult was an inexperienced driver in relatively unfamiliar territory and that the truck driver had never travelled the route prior to the incident.

The coroner determined that the direct cause of the incident was the adult’s failure to stop at the intersection, as per the traffic signage. It was also considered possible that better visibility of the intersection from either direction may have prevented the incident or at least decreased the severity of it.

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

- That [local council] review the safety of the intersection of [road] and [road] in light of the circumstances of this collision and the comments above.

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WESTERN AUSTRALIA

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

The following 13 summaries refer to similar incidents that occurred in the same region over several years.

Case summary - WA.2012.1880

A young indigenous male took their own life by hanging.

The young person was drinking to excess and engaging in drug use in the period before their death. This had an adverse impact on their mental state and ability to secure employment. The young person was not in contact with mental health or counselling services.

The young person was with friends at a cattle station where some of the friends worked the day prior to their death. They were witnessed behaving erratically and threatening self-harm. They were discovered deceased the following day.

Coronial findings

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

The coroner found that it was possible the young person was experiencing a drug-induced psychotic episode at the time of the incident but was satisfied the young person was able to form intent and understand the consequences of their actions.

Case summary - WA.2013.57

An indigenous female child took their own life by hanging.

The child had a disrupted home life and witnessed domestic violence incidents. They spent periods of time living with extended family members under informal arrangements that did not involve child protective services. They were noted to have good school attendance and were described positively by their teacher. The child had expressed suicidal ideation to select persons, but this did not result in any contact with mental health or counselling services.
The child was discovered unresponsive in their home. They were unable to be revived.

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

The coroner found that despite multiple reports being made to child protective services regarding the child’s wellbeing, the department did not undertake an assessment of the child. The coroner found that an assessment would possibly have helped the child.

Case summary - WA.2013.304
An indigenous female child took their own life by hanging.

The child had a disrupted childhood and witnessed alcohol abuse and domestic violence in their home. The community where they lived was closed, which forced the child’s family to move to another town. The community closure had a significant effect on the parents.

The child began to experiment with drugs and alcohol and avoided attending school upon moving to the town. They were frequently found by police to be wandering the streets unsupervised at night time, and several instances resulted in reports to child protective services. None of these reports resulted in contact between the department and the family. They were identified as being at-risk but various referrals were not followed up by the appropriate agencies. They had expressed suicidal ideation and had been referred to mental health services but had not been seen by a clinician prior to their death.

The child left their home after an argument on the night of the incident. Police attended to conduct a curfew check and intended to visit other addresses to verify the child’s whereabouts, but this did not occur. The child was discovered deceased in a public area the following day.

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

The coroner found that at the time of their death the child had an increased need for support and intervention for their substance use, personal welfare and mental wellbeing issues. The coroner found that despite the child engaging in at-risk behaviours, child protection services did not undertake a thorough assessment of the child’s wellbeing, health and safety. The coroner found that there were missed opportunities to provide the child with adequate support and engage with the family in a holistic way.

Case summary - WA.2014.50
A young indigenous male took their own life by hanging.

The young person had a disrupted childhood and witnessed alcohol abuse and domestic violence in their home. They had moved between various communities throughout their life
and lived with various family members under informal arrangements facilitated by child protective services. There was a recent history of suicide within the young person’s family.

The young person was a victim of sexual assault, and a plan was put in place to relocate them to boarding school and away from the risk of further sexual harm. They had engaged with mental health and drug services and were supportive of the idea to attend boarding school, as they hoped this would help them move away from substance abuse.

The young person was discovered deceased in their home before the boarding school arrangement came into effect.

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

The coroner found that the collective trauma of experiencing multiple family suicides had a profound and lasting effect on the young person’s mental well-being.

The coroner found that despite the high level of intoxication at the time of their death, the young person was able to form intent and understand the consequences of their actions.

Case summary - WA.2014.77
An indigenous male child took their own life by hanging.

The child resided with their parents and siblings. There were incidents of domestic violence between the parents, but child protective services were never formally involved. The child had no known history of drug or alcohol use, and no known incidents of suicidal ideation or mental ill health. They were to attend a boarding school in another state within weeks of their death.

The child became upset following an incident involving family members and the police. They spent the night at home alone and were discovered deceased the following day.

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

The coroner found that the child was known to behave impulsively but found that their actions showed a degree of planning and deliberateness. The coroner found that the child understood the consequences of their actions.

Case summary - WA.2014.1561
An indigenous male child died by hanging.

The child had a disrupted childhood and witnessed alcohol abuse and domestic violence in their home. They spent periods of time living with extended family members under informal
National Coronial Information System

arrangements that did not involve child protective services. They also experienced several incidents of domestic violence resulting in relocation to refuge centres.

The child was not known to engage in risk-taking behaviours and had not expressed suicidal ideation. There was no record of them attending mental health or counselling services. Their engagement with school had steadily declined in the lead up to their death.

Coronial findings

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

The coroner noted that students in the child’s school peer group were engaging in a highly dangerous behaviour they considered to be a game. Evidence was given about the dangers of the game and the unintended risk of death. There was no direct evidence of the child partaking in the dangerous behaviour.

The coroner found that had the child engaged in the behaviour prior to their death, it was possible the death was by way of misadventure. If the child had not engaged in the behaviour, the coroner found that it was likely the death was by way of suicide. As there was no way to be certain of the child’s engagement with the dangerous behaviour prior to their death, the coroner made an open finding as to the child’s intent.

Case summary - WA.2014.2095

A young indigenous male took their own life by hanging.

The young person spent much of their childhood living with extended family members under informal arrangements in various locations. Numerous concerns were raised with child protective services during this time, but no protective orders were made.

The child did not have consistent guidance from a parental figure, and in the lead up to their death they were lacking boundaries and were vulnerable to risk-taking behaviours. They did not have any engagement with mental health or counselling services. They expressed suicidal ideation in the days prior to their death and had acquired material for self-harm which was taken by family members.

They were discovered unresponsive in their home and were unable to be revived.

Coronial findings

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

The coroner found that despite the high level of intoxication at the time of their death, the young person was able to form intent and understand the consequences of their actions.
Case summary - WA.2015.175

A young indigenous male took their own life by hanging.

The young person had been in a troubled relationship for several years. There was also a history of domestic violence incidents concerning the young person’s parents, many of which the young person witnessed. They had expressed suicidal ideation on numerous occasions from a young age but did not engage with mental health or counselling services and had not been referred to these services by family.

The young person was found self-harming by their partner on a disrupted vehicle journey with family back to their community. The partner attempted to assist and ran for help, but when they returned the young person was floating face down in a river that had rapidly risen in the rain. Police had informed the family they were unable to attend that night and the family transported the young person back to the community. They were airlifted out of the community to hospital the following day where they were officially declared deceased.

Coronial findings

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

The coroner found that there was significant flooding at the time of the incident that caused the journey to be disrupted. The coroner noted the possibility of further harm to the family as they transported the young person back to the community in dangerous flooding. The family were repeatedly denied assistance in being evacuated from the community despite their trauma and low supplies. The coroner found that a more cohesive approach and better communication between various departments would maximise the opportunities for a rescue in similar circumstances and remove the reallocation of responsibilities for evacuation between agencies.

Case summary - WA.2015.556

A young indigenous male took their own life by hanging.

The young person spent their childhood in the care of extended family members under informal arrangements that did not involve child protective services. It was suspected the young person had foetal alcohol spectrum disorder (FASD) but no diagnosis was ever made. They were allegedly a victim of sexual assault as a young child and subsequently moved in with family in a different community. When they were a young teenager, the family expressed concerns about the young person’s welfare due to drug use. The family requested the Department of Child Protection and Family Support remove the young person from the community, but this did not occur.

The young person moved to live with family in a larger town where their self-harming behaviour and drug use escalated. They were taken to hospital and discharged with a referral
to drug and mental health services. The young person was discovered deceased in a public area a few days later.

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

The coroner found that the sexual assault had a lasting and traumatic effect on the young person, and they suffered sustained neglect throughout their childhood that severely compromised their ability to manage their emotions and develop coping strategies.

The coroner found that child protective services failed to undertake assessments of the young person’s wellbeing, despite multiple reports to the department. The coroner found that there were missed opportunities to refer the young person to mental health services which could have potentially helped them.

The coroner found that despite the high level of intoxication at the time of their death, the young person was able to form intent and understand the consequences of their actions.

Case summary - WA.2015.763
A young indigenous male took their own life by hanging.

The young person spent part of their childhood in the care of extended family members under informal arrangements that did not involve child protective services. They were involved in a troubled relationship for several years prior to their death. They had expressed suicidal intent on a number of occasions throughout their life, including shortly prior to their death.

The young person only had one presentation for mental health issues in their life, during which they admitted to thoughts of self-harm. They had several interactions with the justice system and risk factors for self-harm were recorded. Despite this, the young person did not receive any mental health or counselling services beyond the single presentation.

The young person was discovered unresponsive in a relative’s home following an argument with their partner. They were unable to be revived.

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

The coroner found that despite the high level of intoxication at the time of their death, the young person was able to form intent and understand the consequences of their actions.

Case summary - WA.2015.848
A young indigenous male took their own life by hanging.
The young person resided with their parents and extended family until their community was closed which forced them to move. They resided in various places with extended family throughout their childhood. The young person’s parents died prior to the community closing. The young person was residing with their partner at the time of their death, with whom they had a history of domestic violence.

The young person’s sibling had died by suicide several years earlier, which had a lasting impact on the young person. Despite this, they did not receive any mental health or counselling treatment. They were known to abuse alcohol and would often speak of suicide when drinking.

The young person was drinking heavily and voicing suicidal ideation on the night of the incident. They left the house after an argument with their partner, and the partner called the police when they were unable to locate the young person. The police located the young person deceased in bushland near their home.

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

The coroner found that the deaths of their parents and their sibling had a profound and lasting effect on the young person’s mental well-being. The young person was abusing alcohol and taking risks with their health and safety in response to the trauma they experienced.

The coroner found that despite the high level of intoxication at the time of their death, the young person was able to form intent and understand the consequences of their actions.

Case summary - WA.2016.379
An indigenous female child took their own life by hanging.

The child had a disrupted childhood and witnessed alcohol abuse and domestic violence in their parents’ home. They spent much of their childhood in the care of extended family members under informal arrangements that involved consultation with child protective services. The child had poor attendance rates at school, but mental health concerns were not considered, and they were not reported to display at-risk behaviours.

The child disclosed to a social worker a few years prior to their death that their sibling had died by suicide. Despite this, the child was not participating in any mental health or counselling, and no person had referred them to any such services.

The child was discovered deceased in their home. They had not displayed unusual or concerning behaviour prior to the incident.

Coronial findings
The coroner found that the death was due to intentional self-harm.
The coroner found that the child was exposed to alcohol abuse and domestic violence at a young age which would have had a traumatising and lasting effect. The coroner was unable to determine if the child had a complete understanding that their sibling died by suicide, but nonetheless found that their death would have had a significant impact on their mental state.

The coroner found that the child’s actions were impulsive and possibly an intention of going to an after-life where they would see their sibling. The coroner found that these matters did not negate a suicide.

The coroner found that reports were made to child protective services after the child’s disclosure about their sibling’s suicide, and after alleged family violence being experienced by the child. The coroner found that child protective services failed to undertake assessments of the child’s wellbeing, despite multiple reports to the department. The coroner found that there were missed opportunities to engage the child with mental health services and assess their wellbeing on an ongoing basis.

Case summary - WA.2016.476

A young indigenous male took their own life by hanging.

The young person had resided with extended family since the death of their parent when they were a young child. They had experienced the deaths of several family members throughout their life, including by suicide. These deaths caused the young person to experience ongoing grief and distress, which elevated their own risk of self-harm.

The young person had expressed suicidal ideation in the past and had presented to hospital in times of crisis. The young person did not attend their appointments with mental health services and further attempts at contact were unsuccessful.

The young person was discovered unresponsive in their home. They were unable to be revived.

Coronial findings

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

The coroner found that the deaths of family members had a profound and lasting effect on the young person, but that the young person chose not to engage with the mental health treatment and counselling support offered to them.

The coroner found that despite the high level of intoxication at the time of their death, the young person was able to form intent and understand the consequences of their actions.

Coronial recommendations

The coroner made the following recommendations related to these cases:
**Recommendation one:**
- that there be universal screening for foetal alcohol spectrum disorder (FASD) at the following points: during infant health assessments and upon a child entering into the child protection system or justice system for the first time;
- that all children identified as at risk of neurodevelopmental impairment on the basis of antenatal exposure to alcohol or early life trauma be assessed by a paediatrician for developmental and behavioural impairments at the age of one year and in the year prior to school entry;
- in respect of a child entering the child protection system for the first time in addition to FASD universal screening:
  - that preliminary assessments and screening be undertaken by Department of Communities’ district psychologists;
  - that referrals be made for comprehensive IQ and functional capacity assessments where and when required by presentation and behaviours; and
  - that there be referrals to other treatment and therapy services for trauma-related developmental and behavioural issues, including mental health issues, impulsivity, and harmful sexual behaviours, that may or may not include cognitive impairments and neuro-disabilities such as FASD.

**Recommendation two:**
- that neurodevelopmental impairment (an umbrella term which includes behavioural, developmental and cognitive impairments) incorporating the criteria defined in the Australian Guide to the diagnosis of FASD be recognised as a disability within the National Disability Insurance Scheme (NDIS);
- that where FASD has actually been diagnosed at the appropriate level of severity, it is separately recognised as a disability within the NDIS.

**Recommendation three:**
- That consideration be given to whether appropriate Medicare Benefits Scheme item numbers ought to be allocated for FASD.

**Recommendation four:**
- That consideration be given to additional funding for primary care services in areas with a high burden of neurodevelopmental impairment to increase diagnostic capacity for complex conditions including FASD, and to respond to the diagnosis by way of therapeutic services for children and young people diagnosed with FASD.

**Recommendation five:**
- That there be Government funding to extend to other regional centres in the [region] the “Making FASD History” project that ran in [other region], adapted as appropriate to the prevailing circumstances of those communities.
**Recommendation six:**
- That education campaigns be conducted in all secondary schools in Western Australia to alert students to:
  - the dangers of consuming alcohol during pregnancy and
  - the prevalence of FASD (with a culturally relevant education campaign for Aboriginal children).

**Recommendation seven:**
- That the State Government appoints a person who is a Special Advisor on matters concerning Aboriginal children and young persons or considers appointing an additional Commissioner for Aboriginal children and young persons.

**Recommendation eight:**
- That there be restrictions on the purchase of take away alcohol across the entire [region], but that such restrictions be formulated after there has been consultation with key stakeholders, including affected local Aboriginal communities.

**Recommendation nine:**
- That the Western Australian Government considers and/or assesses the feasibility of a Banned Drinker Register that is modelled on therapeutic support for those who are placed on it. If the matter progresses to an assessment, that consideration be given to community consultation.

**Recommendation ten:**
- That in light of the passage of the *Liquor Control Amendment Act 2018* relating to the proscription on "sly grogging", that police be properly resourced to enforce it.

**Recommendation eleven:**
- That there be recurrent, or more long-term funding to the various town-based patrols in the [region] for the provision of diversionary services to those who are abusing alcohol.

**Recommendation twelve:**
- That there be the appointment of Local Area Co-ordinators or local Family Advocates in the [region] who can assist families in need of accessing service providers and that all efforts be made to have such roles filled by an Aboriginal person.

**Recommendation thirteen:**
- That there be consideration of the funding for, and assessment of the feasibility of, the construction of culturally appropriate short-term accommodation in [town] for Aboriginal persons visiting [part of the region].
Recommendation fourteen:
• That the Transitional Housing Project be continued in [four towns in the region] and be extended to other town sites in the [region].

Recommendation fifteen:
• That Aboriginal persons living in the [region] in public and/or transitional housing are not disadvantaged regarding accommodation in the event of their household exceeding the income threshold for eligibility.

Recommendation sixteen:
• That the Yiriman Project or a model akin to the Yiriman Project be extended across the [region], and that consideration be given to the following matters in connection with the extension:
  o That the Western Australian government through its various health and justice branches should explore opportunities for the implementation of models akin to the Yiriman Project in other remote parts of Western Australia with priority given to those areas with high rates of Aboriginal youth suicide.
  o That funding providers for the Yiriman Project and other programs akin to the Yiriman Project should acknowledge the need for key performance indicators that are flexible and reflect the difficulty such organisations have in providing quantitative and qualitative data on the success of individual interventions with at-risk clients.
  o That the Western Australian government should consider guaranteed funding for the Yiriman Project on a longer-term basis, whether through funding provided by the Department for Corrective Services for diversionary programs, through Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) funding, or through funding co-ordinated through the Mental Health Commission.

Recommendation seventeen:
• That the Government and its service providers continue to ensure that the strategies for addressing Aboriginal suicide be implemented in consultation with appropriate representatives from the Aboriginal community, that the representatives which are appropriate to consult are identified on an ongoing basis, and that such representatives be provided with an opportunity for involvement in the co-design of such strategies.

Recommendation eighteen:
• That measures be introduced aimed at increasing the prospects of complaints of domestic violence being reported and maintained; and
  • As part of such measures, that the State Government consider introducing legislation allowing for visually recorded statements taken from victims of domestic violence to be admitted as evidence-in-chief at a court hearing.
Recommendation nineteen:
• That cultural competency training given to service providers who interact with Aboriginal persons is co-designed with Aboriginal persons and delivered in a culturally relevant manner with emphasis on the effect of intergenerational trauma and FASD, and on the importance of cultural wellbeing, and that all service providers be required to be trained and that it be funded.
• Further, wherever possible, that cultural competency training be delivered by involving local Aboriginal people.

Recommendation twenty:
• That Department of Communities’ child protection workers and school teaching staff (in the public and private sectors) who have regular contact with Aboriginal children receive appropriate training in suicide intervention and prevention, and that such training be provided at appropriately regular intervals.

Recommendation twenty-one:
• That efforts continue to be made to employ Aboriginal persons in health (including mental health), education, child protection and police and, where necessary or desirable, that consideration be given to introducing bridging courses and cadet programs and/or locally accessible training courses to assist prospective employees to obtain the necessary qualifications.

Recommendation twenty-two:
• That consideration be given to extending an offer of a voluntary cashless debit card program to include the entire [region].

Recommendation twenty-three:
• That the use of video-conferencing for mental health assessments be expanded throughout the [region], including an after-hours service.

Recommendation twenty-four:
• That mental health treatment plans for Aboriginal persons offer the option of the inclusion of traditional cultural healing, and where that option is accepted, that all efforts be made to work collaboratively for the benefit of the patient.

Recommendation twenty-five:
• That there be funding by Government for the development of cultural healing projects in the [region] such as the one being developed by [Aboriginal centre] in [town].
Recommendation twenty-six:
• That the care or treatment that is provided by service providers to Aboriginal children and young persons in the [region] operate in a trauma informed model, and that service providers take account of the need for trauma-specific care where possible.

Recommendation twenty-seven:
• That all health service clinicians in the [region] have the necessary skills to screen for and facilitate care for patients with alcohol, drugs and mental health issues;
• Further, that all health service clinicians in the [region] have access to training in the assessment and management of alcohol, drugs and mental health issues.

Recommendation twenty-eight:
• That a facility be built in [part of the region] which incorporates the co-morbid treatment of mental health, alcohol and drug abuse problems, or alternatively that a feasibility study be undertaken with a view to considering the need for, and impact of, such a facility.

Recommendation twenty-nine:
• That peri-natal and infant care by health service providers in the [region] incorporates the treatment of mental health issues and that those clinicians be made aware of the role and resources developed by the WA Peri-natal Mental Health Unit.

Recommendation thirty:
• That the development or refurbishment of facilities for young persons to meet and engage in activities be undertaken in the [region], in consultation with local Aboriginal communities.

Recommendation thirty-one:
• That there be a mental health clinician permanently based in [town], or alternatively, that there be an increase in the visiting capacity of mental health clinicians for [town].

Recommendation thirty-two:
• That police stations in the [region] consider undertaking activities similar to the “Adopt-A-Cop” program in [town], ensuring these programs are developed in consultation with senior members of the Aboriginal community and that those police efforts be supported.

Recommendation thirty-three:
• That the Elders Reference Group presently in operation in [town] be extended to other [region] town sites and that this work be Community Development Program (CDP) recognised, and that current police efforts continue and be supported.
Recommendation thirty-four:
• That facilities be developed and funded in the [region] that specifically cater for the rehabilitation of children and young persons with addiction to drugs and/or alcohol, with step down processes. The development of these facilities should be informed by the principles of self-determination, cultural continuity and empowerment.

Recommendation thirty-five:
• That early education programs such as Kindylink be maintained for the [region], with consideration for funding beyond the period of the pilot, and that programs be developed in consultation with the local Aboriginal communities.

Recommendation thirty-six:
• That schools within the [region] be encouraged and resourced to introduce re-engagement classrooms at a primary school level.

Recommendation thirty-seven:
• That high schools in the [region] be provided with facilities that enable non-academic female and male students to engage in vocational programs.

Recommendation thirty-eight:
• That the Department of Education introduce or continue to expand the teaching of Aboriginal languages in its [region] schools, in consultation with the local Aboriginal communities.

Recommendation thirty-nine:
• That the Yiriman Project or a model akin to the Yiriman Project be linked to schools within the [region].

Recommendation forty:
• That consideration be given to residential facilities being built for school aged students in the [region], after consultation with local Aboriginal communities, and that any such colleges be co-designed and informed by the principles of self-determination, cultural continuity and empowerment.
• Further that admission is voluntary, with the consent of the parents and/or caregivers, and the consent of the child.

Recommendation forty-one:
• That a policy be introduced that ensures those who appropriately act as CEOs [Chief Executive Officers] of their Aboriginal communities are either remunerated for their efforts or, at the very least, reimbursed for expenses incurred in executing that role.
Recommendation forty-two:

- The principles of self-determination and empowerment be given emphasis in initiatives, policies and programs relating to Aboriginal people in Western Australia and that the Western Australian Government introduce measures to enable Aboriginal people and organisations to be involved in setting and formulating policy that affects their communities;

- That in developing such measures, consideration be given to negotiating mutually agreed outcomes, with service delivery responsibilities as between the Western Australian Government and Aboriginal people and organisations; and

- The Western Australian Government develop a state-wide Aboriginal cultural policy that recognises the importance of cultural continuity and cultural security to the wellbeing of Aboriginal people in this State.
Coronial recommendations: Fatal facts

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

The adult was an experienced motorcyclist and was riding alone on the day of the incident. They failed to negotiate a bend in the road and entered a stormwater drain, where they were ejected from the motorcycle and struck the ground. The adult was found by passing motorists and was transported to hospital. They were found to have sustained severe spinal injuries and later passed away.

Coronial findings
The coroner found that the death was unintentional.

The coroner found that the safety of the road for motorcyclists had been improved since the adult’s death.

The coroner found that the helmet being worn by the adult was non-compliant with safety standards, and that had a compliant helmet been worn, the adult’s injuries may have been reduced and the fatal outcome prevented.

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

- That the Honourable Minister for Road Safety consider implementing regulations to require retailers of motorcycle helmets in Western Australia to provide written information to any purchaser as to whether the helmet purchased complies with the relevant approved standard for use as a protective helmet when riding a motorcycle on a public road in Western Australia.

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Coronial recommendations: Fatal facts

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</table>

Case summary

A young male died due to complications of heat stroke.

The young person was participating in rugby training on a hot day when they were overcome with heat stroke. They were provided with first aid and conveyed to hospital. The young person's condition deteriorated and they passed away a few days later.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adults responsible for the young person's care acted responsibly, but that due to the training they had received, they were not equipped to readily recognise and appropriately treat heat stroke. The coroner found that the young person may have survived had those responsible been appropriately equipped.

The coroner found that the training provided to sports trainers and other first responders should be altered to incorporating recent approaches to treating heat-related illness.

Coronial recommendations

The coroner made the following recommendations related to this case:

- Sports Medicine Australia, St John Ambulance and all registered training organisations who provide the nationally accredited course Provide First Aid HLTAID003 consider and, if appropriate, incorporate the principles in [professor of emergency medicine’s] guide into the knowledge content of the training they deliver with respect to providing first aid for hyperthermia.

This Fatal facts summary has been produced by the National Coronial Information System Unit and is released with the approval of the relevant State or Chief Coroner. We acknowledge that this content may be distressing. If you or someone you care for is in need of assistance, support services are available.
Coronal recommendations: Fatal facts

Case number | WA.2015.316
Primary category | Drugs and alcohol
Additional categories | Mental illness and health
Fatal facts edition | 60 – cases closed between January and March 2019

Case summary
An adult male died due to drug toxicity.

The adult was an involuntary mental health patient and was being treated in hospital at the time of their death. The adult exhibited agitated and delusional behaviour during their admission, and required regular observation.

The adult was found unresponsive in their room by a nurse. A medical emergency was called and the adult was found to have passed away.

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

The coroner was unable to determine how the methadone found in the adult’s blood reached fatally sedating levels.

The coroner found that improvements could be made to patient observation practices.

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

- The Hospital’s safe and supportive observation charts (AKMR147.2 - AKMR147.5) (the charts) should be amended to make it clear that as required by the policy "Observations: Safe and Supportive", when a patient appears to be asleep, respiration rates must be recorded on the relevant chart and further, a column should be included on the charts for that purpose.

- When visual observations are ordered by medical staff or where the frequency of those observations is increased by nursing staff, the reason for the order (or the change in frequency observations) should be documented in the patient’s progress notes (MR55A) and on the patient’s safe and supportive observation chart (AKMR147.2 - AKMR147.5). A notation that merely indicates the frequency at which observations are to be made should not be regarded as sufficient.
The [hospital’s] zuclopenthixol acetate chart (AKMR170.7) should be amended to make it clear that the vital signs observations prescribed by the Zuclopenthixol Acetate (Clopixol Acuphase) Guidelines must be recorded on the patient’s adult observation and response chart (AKMR140.3), and nowhere else.
## 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 effects from 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 death</td>
</tr>
<tr>
<td>Child and infant death</td>
<td>Any case involving a child or infant</td>
</tr>
<tr>
<td>Domestic incident</td>
<td>Incidents as a result of a domestic injury or event</td>
</tr>
<tr>
<td>Drugs and alcohol</td>
<td>Deaths where drugs or alcohol or both made a primary or secondary contribution</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 death, such as a remote location</td>
</tr>
<tr>
<td>Homicide and assault</td>
<td>Deaths due to interpersonal violence</td>
</tr>
<tr>
<td>Indigenous</td>
<td>Cases where the indigenous status of a person was relevant to the circumstances of death</td>
</tr>
<tr>
<td>Intentional self-harm</td>
<td>Deaths determined by a coroner to be due to intentional self-harm</td>
</tr>
<tr>
<td>Law enforcement</td>
<td>Includes police pursuits, deaths in custody, legal or court issues and coronial investigation or police 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>Cases where mental health issues or their management were relevant to the death, whether diagnosed or anecdotal</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 was 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. Includes cases of pedestrians impacted by transport vehicles</td>
</tr>
<tr>
<td>Water related</td>
<td>Includes swimming, scuba, snorkelling, boating, fishing and all water-based 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>Cases where a work incident 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>