# Coronial recommendations: Fatal facts

## A summary of cases and recommendations made between July and September 2020

Edition 66

## National Coronial Information System

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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 July and September 2020.

Access Fatal facts to see previous case summaries and recommendations.

## AUSTRALIAN CAPITAL TERRITORY

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

# Coronial recommendations: Fatal facts

| | |
|---|---|
| **Case number** | ACT.2017.249 |
| **Primary category** | Law enforcement |
| **Additional categories** | Weapon |
| **Fatal facts edition** | 66 – cases closed between July and September 2020 |

## Case summary

A middle aged male died during the course of a police operation.

The adult had a history of illicit drug use and mental ill health. Police were called to the adult's home due to concerns raised by a neighbour. The adult was found injured and self-harming and was tasered by police ensure police and ambulance services could safely enter the home. They went into cardiac arrest shortly after being tasered and were unable to be revived.

## Coronial findings

The coroner found that the death was due to legal intervention. The coroner found that police use of the taser was justified given the circumstances. The coroner found that police governance and training in relation to taser use should be reviewed to enhance identifying and understanding various risks and protocols, including use in relation to vulnerable persons.

## Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the [Australian Federal Police (AFP)] review the governance and training it provides in relation to taser usage and to report back to me within 12 months as to what changes have been made. The [family] submissions on the review of [Commissioner's Order on Operational Safety (CO 3)] and use of tasers should be considered by the AFP.
- I recommend that standard reporting should occur in all cases involving the use of force and that ad hoc exceptions to that requirement should not be allowed under any circumstances.
- I recommend that the AFP conduct a review or audit of the communications response on that day to identify whether any systemic issues arise from the apparent failure of process and report back to me within 12 months.

# Coronial recommendations: Fatal facts

| | |
|---|---|
| **Case number** | ACT.2018.95 |
| **Primary category** | Transport and traffic related |
| **Fatal facts edition** | 66 – cases closed between July and September 2020 |

## Case summary

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

The adult was cycling with their partner when they collided with a utility vehicle and its attached trailer after exiting an off-road bicycle path. They were assisted by bystanders and conveyed to hospital. The adult was found to have sustained significant brain injuries and later passed away.

## Coronial findings

The coroner found that the death was unintentional.

The coroner found that the state of the bicycle path on which the adult was riding contributed to the collision, and that steps had since been taken to improve cyclist safety in the area.

## Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that, if no such program presently exists, the ACT Government institute a regular audit program for its off-road bicycle paths to ensure that they are appropriately maintained and there are no obstructions or risk of obstruction from the surrounding environment (such as gravel, dirt or trees). If such a program exists, I recommend it be reviewed to ensure that inspections occur at sufficient frequency so as to minimise the risk that a path becomes and remains obstructed to a level that may be dangerous to persons using the path.

# Coronial recommendations: Fatal facts

| | |
|---|---|
| **Case number** | ACT.2019.170 |
| **Primary category** | Natural cause death |
| **Additional categories** | Mental illness and health |
| **Fatal facts edition** | 66 – cases closed between July and September 2020 |

## Case summary

An adult female died due to complications of anorexia nervosa.

The adult had a lengthy history of an eating disorder and was under a Community Treatment Order at the time of their death. The adult was found unresponsive in their home by family and was conveyed to hospital. Despite attempts at resuscitation, they were unable to be revived.

## Coronial findings

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

The coroner found that recent work had been done and was intended to be done by the ACT Government in relation to specialist beds for eating disorder patients.

## Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that ACT Health explore with NSW Health ways of improving access, and pathways, to inpatient specialist public beds for ACT patients with severe eating disorders, where necessary.

## NEW SOUTH WALES

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

# Coronial recommendations: Fatal facts

| | |
|---|---|
| **Case number** | NSW.2015.5530 |
| **Primary category** | Law enforcement |
| **Additional categories** | Falls, Drugs and alcohol |
| **Fatal facts edition** | 66 – cases closed between July and September 2020 |

## Case summary

A middle aged male died due to injuries sustained in a fall. They were a sentenced prisoner at the time of their death and suffered from chronic alcoholism.

The adult had been sentenced to imprisonment and entered into custody later that evening. The adult fell the following morning while trying to get out of their cell bed and suffered a head injury. The adult's cellmate advised correctional officers of the fall via intercom; however, the officers did not summon medical help or report the fall to officers in the relevant area. Upon interacting with the adult later that morning, officers asked if the adult required an ambulance. The adult declined and indicated they would wait to see the nurse.

A Justice Health nurse attended the adult's cell later that morning and found them unresponsive. An ambulance was called, and the adult was conveyed to hospital where they later passed away.

## Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult died due to trauma sustained in the fall in the context of serious health problems and alcohol withdrawal.

The coroner found it had been recommended that the adult be detoxed upon entry into custody and that they undergo treatment for alcoholism; however, the adult did not receive assessment or treatment for alcohol withdrawal upon reception into the correctional centre.

## Coronial recommendations

The coroner made the following recommendations related to this case:

To NSW Commissioner for Corrective Services;
To General Manager, Court Escort and Security Unit, Corrective Services NSW;

- The Court Escort and Security Unit should ensure that all staff involved in the reception and screening of inmates receive training and guidance on the use of the After Hours

Nurse Manager within the Remote/Offsite/Afterhours Medical Service ("ROAMS") of Justice Health, and the requirement for that service to be contacted where an unscreened inmate is received into custody detoxing from drugs or alcohol where no Justice Health staff member is physically present, in accordance with the Custodial Operations Policy and Procedures ("COPP") manual, section 1.1 at paragraph 4.7-4.8 and section 6.1 at paragraph 2.1.

- Corrective Services NSW should consider adopting a practice that, where a recommendation regarding medical assessment or treatment is made by a judicial officer on a warrant, and the recommendation cannot be carried out, that fact should be immediately brought to the attention of the General Manager of the Correctional Centre (or in the absence of the General Manager the next most senior officer) where the inmate is received.

# Coronial recommendations: Fatal facts

| | |
|---|---|
| **Case number** | NSW.2017.4854 |
| **Primary category** | Intentional self-harm |
| **Additional categories** | Law enforcement; Mental illness and health |
| **Fatal facts edition** | 66 – cases closed between July and September 2020 |

## Case summary

A young Aboriginal male took their own life by hanging. They were a prisoner on remand at the time of their death.

The young person had been incarcerated for much of their life and was recognised as a clear risk of self-harm. The young person had previously tried to take their own life multiple times, and was diagnosed with severe depression and anxiety disorders and drug addiction. While incarcerated, the young person did not receive sustained psychological care or drug and alcohol treatment. In addition, the young person did not receive cultural support or meaningful assistance to maintain ties with their community.

The young person was hospitalised for apparent seizures the day before the incident. They had not been diagnosed with epilepsy. The young person did not receive a comprehensive health screen upon their return to the prison and was later found deceased in their cell.

## Coronial findings

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

The coroner found that the medical care provided to the young person in the hospital was adequate. However, the young person should not have been taken back to prison without a discharge summary. The coroner found that, while resources may have been stretched, appropriate ongoing health care could not be provided upon the young person's return to prison without the discharge summary.

The coroner found that the care provided by the prison nurse was cursory and inadequate. The nurse had not properly turned their mind to the potential risks to the young person on returning from hospital, including placing them alone in a cell, without supervision, and not completing a compressive clinical assessment.

The coroner also found that, despite the large proportion of Aboriginal inmates, the prison did not have an Aboriginal health worker or significant programs catering to the health and wellbeing of Aboriginal inmates. The coroner found that improvement of such programs would likely have improved mental health care provided to the young person.

## Coronial recommendations

The coroner made the following recommendations related to this case:

To the Commissioner of Corrective Services

- That CSNSW [Corrective Services New South Wales] conduct a comprehensive audit of all cell hanging points at the [prison] and undertake urgent removal of any hanging points identified.
- That CSNSW amend policy to notify the next of kin if an inmate is taken to a hospital in a medical emergency, even if that inmate is not ultimately admitted.
- That CSNSW implement a policy whereby prisoners who have been taken to hospital are not returned to prison without a discharge summary.

To the Commissioner of Corrective Services NSW and Justice Health

- That CSNSW, in consultation with Justice Health (JH), adopt a policy whereby any inmate who has been taken to hospital is placed either two out or in an assessment cell until a comprehensive JH review can take place. In the event that this is not considered suitable or appropriate, any other placement must be documented with reasons recorded.
- That CSNSW and JH actively recruit Aboriginal health workers at [prison]. The provision of Aboriginal health workers must include consideration of expanded culturally appropriate Drug and Alcohol and Mental Health Services and workers with expertise in suicide prevention strategies.

To [hospital]

- That [hospital] provide a copy of a discharge summary to officer escort when a custodial patient is discharged from [hospital] (including from the Emergency Department).

To the Chief Executive, Nursing and Midwifery Board of Australia

- I recommend that, pursuant to *section 151A(2)* of the *Health Practitioner Regulation National Law (NSW) no 86a*, the transcript of the evidence of [nurse unit manager] be forwarded to the Chief Executive, Nursing and Midwifery Board of Australia for consideration of whether the professional conduct of [nurse unit manager] on [date of hospital admission] should be the subject of review.

# Coronial recommendations: Fatal facts

| | |
|---|---|
| **Case number** | NSW.2019.1255 |
| **Primary category** | Homicide and assault |
| **Fatal facts edition** | 66 – cases closed between July and September 2020 |

## Case summary

An adult male disappeared in suspicious circumstances.

The adult had a lengthy criminal history and was known to be involved with criminal gang members. The adult was last seen driving an associate's car. Police believed the adult was killed as part of a reprisal attack involving underworld crime syndicates.

## Coronial findings

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

The coroner found that the adult was closely associated with unlawful activities and criminal figures at the time of their disappearance. The coroner found that the adult likely died around the time of their disappearance.

## Coronial recommendations

The coroner made the following recommendations related to this case:

To the New South Wales Commissioner of Police:

- I recommend that the death of [the deceased] be referred to the NSW Police Unsolved Homicide Unit for ongoing investigation

## SOUTH AUSTRALIA

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

# Coronial recommendations: Fatal facts

| | |
|---|---|
| **Case number** | SA.2015.1762 |
| **Primary category** | Mental illness and health |
| **Fatal facts edition** | 66 – cases closed between July and September 2020 |

## Case summary

A middle aged male died due to complications of choking.

The adult was detained as an inpatient of a psychiatric facility. The adult was being held in a seclusion room at the time of the incident. They were served food and were later found unresponsive in the seclusion room. Resuscitation was commenced and they adult was conveyed to hospital; however, they were unable to be revived.

## Coronial findings

The coroner found that the death was unintentional.

The coroner found that changes had been made to seclusion rooms at the facility since the incident that enabled continuous observation of secluded patients.

An investigation was carried out under the *Health Care Act 2008* in relation to the adult's death, which resulted in the following recommendations:

- [local health network mental health service] develop a clinical guideline and education strategy for Physical Health Assessments (inclusive of nutritional assessment) within an inpatient mental health facility.
- [local health network mental health service] undertake a review of current nursing observation practice, procedure and auditing process.
- [local health network mental health service] develop and implement auditing processes against the SA Health Seclusion and Restraint Policy.
- Undertake a review of the physical environment for wards in which the adverse event occurred.

## Coronial recommendations

The coroner made the following recommendations related to this case:

To the Chief Executive, SA Health:

- The Court recommends that the recommended measures be employed in all psychiatric intensive care units in South Australia.

- The Court recommends that in considering whether a secluded patient should be provided with food, that nursing and other staff need to take into consideration the matters identified by [Specialist Consultant Psychiatrist] in [their] report, including the medication that the patient has been administered, the state of agitation of the patient and the state of dentition of the patient. Consideration should also be given to the question as to whether in all of the circumstances if the patient is capable of safely consuming food at that point, the reality may be that the patient is suitable to be released from seclusion.

## TASMANIA

The following case summaries and recommendations relate to deaths reported to a coroner in Tasmania.

# Coronial recommendations: Fatal facts

| | |
|---|---|
| **Case number** | TAS.2017.562 |
| **Primary category** | Intentional self-harm |
| **Additional categories** | Physical health |
| **Fatal facts edition** | 66 – cases closed between July and September 2020 |

## Case summary

An adult female died due to drug toxicity and substance inhalation.

The adult suffered from multiple sclerosis and had recently become significantly incapacitated as a result of their condition. They had previously expressed their desire to end their own life to their partner.

The adult's partner returned home on the day of the incident and found the adult unconscious and barely breathing. Emergency services were contacted, and the adult was conveyed to hospital. Attempts were made to resuscitate the adult, but they later passed away.

## Coronial findings

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

The coroner found that the adult had put in place an *Advanced Care Directive for Care at End of Life (Tasmania)* (ACD) with their general practitioner which expressly requested that they not be resuscitated in certain circumstances.

The coroner found it was important that individuals who complete an ACD make their wishes known to both loved ones and treating doctors, and that health professionals be alerted to the existence of an ACD and give effect to the patient's wishes expressed within it.

## Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that all hospitals in this state take any necessary steps to ensure that a patient's [*Advanced Care Directive for Care at End of Life (Tasmania)*] is readily accessible within the patient's medical records so that timely compliance with a patient's wishes as expressed in this document can be achieved when the circumstances arise.

# Coronial recommendations: Fatal facts

| | |
|---|---|
| **Case number** | TAS.2018.43 |
| **Primary category** | Work related |
| **Fatal facts edition** | 66 – cases closed between July and September 2020 |

## Case summary

An older male died in a tree felling accident.

The adult was felling trees with two others when a branch broke unexpectedly, falling on the adult. The adult was wearing a safety hat, however the impact to their head was fatal.

## Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult's safety hat appeared damaged and did not comply with the applicable Australian Standard. It was also found that unsafe chainsaw practices for tree falling were used. The coroner found that compliance to appropriate standards and practices may have prevented the adult's death.

## Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the responsible agency considers regulatory reform directed at preventing deaths and injuries arising from the use of chainsaws by members of the community.

# Coronial recommendations: Fatal facts

| | |
|---|---|
| **Case number** | TAS.2019.111 |
| **Primary category** | Natural cause death |
| **Fatal facts edition** | 66 – cases closed between July and September 2020 |

## Case summary

An older male passed away from heart disease.

The adult presented to the hospital after feeling dizzy and sick. The adult left without seeing a doctor after waiting for several hours. A doctor called the adult and arranged an appointment the following morning. The adult did not attend the appointment, and they were found deceased in their home several days later.

## Coronial findings

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

The coroner found that if the adult had waited at the hospital for a full assessment and treatment, their death might have been prevented. The coroner was also satisfied that the adult was of sound mind and made their own decision to leave the hospital instead of waiting, and that if they had continued to wait, they would have received treatment eventually.

The coroner also found, from hospital records, that staff were uncertain of the adult's whereabouts within the hospital while they waited for assessment.

## Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the [hospital] review the adequacy of its procedures for monitoring the whereabouts of triaged patients waiting to be assessed and treated in the Emergency Department.
- I recommend that the [hospital] also review the adequacy of its processes for documenting significant interactions with triaged patients waiting to be assessed and treated in the Emergency Department.

# Coronial recommendations: Fatal facts

| | |
|---|---|
| **Case number** | TAS.2019.171 |
| **Primary category** | Work related |
| **Fatal facts edition** | 66 – cases closed between July and September 2020 |

## Case summary

An adult male died due to a tree felling incident.

The adult was cutting down trees for firewood alone at a property when their chainsaw became lodged in the trunk of a tree. The tree fell on top of the adult while they were attempting to free the chainsaw. The adult worked in the forestry industry. Though they did not work as a tree feller, they had experience with using chainsaws.

## Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult had deficient felling techniques which caused them to become trapped under the tree. The coroner also found that although the adult had experience with chainsaws, they were not licensed or trained in using them to cut down trees.

## Coronial recommendations

The coroner made the following recommendations related to this case:

- That the responsible agency considers regulatory reform directed at preventing deaths and injuries arising from the use of chainsaws by members of the community.

# Coronial recommendations: Fatal facts

| | |
|---|---|
| **Case number** | TAS.2019.278 |
| **Primary category** | Fire related |
| **Fatal facts edition** | 66 – cases closed between July and September 2020 |

## Case summary

An older female died due to injuries sustained in a house fire.

The adult lived independently and had limited mobility. A neighbour heard the sound of breaking glass and went outside to find the adult's residence on fire. Emergency services attended and found the adult deceased in their home.

## Coronial findings

The coroner found that the death was unintentional.

The investigation revealed that the adult had been heating wheat packs in a microwave and stacking them on a chair. Due to being piled, the wheat packs were unable to release heat and self-ignited, starting the fire that caused that adult's death. The adult's close proximity to the fire and limited mobility resulted in them sustaining fatal injuries.

## Coronial recommendations

The coroner made the following recommendations related to this case:

- That individuals in possession of wheat packs without instructions as to their use immediately cease use of such wheat packs.
- That members of the public familiarise themselves with the Fact Sheet prepared by Tasmania Fire Service prior to using wheat packs.

## VICTORIA

The following case summaries and recommendations relate to deaths reported to a coroner in Victoria.

# Coronial recommendations: Fatal facts

| | |
|---|---|
| **Case number** | VIC.2015.2720 |
| **Primary category** | Homicide and assault |
| **Fatal facts edition** | 66 – cases closed between July and September 2020 |

## Case summary

A young female died due to injuries sustained in an assault. The perpetrator was their intimate partner.

The young person had children with previous partners. After experiencing homelessness and drug dependence, the young person met and quickly moved in with their partner. The pair lived together in a car at the time of the incident. The perpetrator became jealous, which led to the attack that resulted in the young person's death.

## Coronial findings

The coroner found that the death was due to assault.

The coroner found that there had been previous incidents of family violence involving the couple, but that police had failed to conduct investigations with sufficient depth or record witnesses' accounts.

The coroner found that if police had followed through with investigation of these incidents, witness statements would have been considered while completing a risk assessment.

The coroner found that the young person should have been considered 'high risk' as a victim of family violence, and the perpetrator was 'highly likely' to commit acts of family violence again.

The coroner found that the perpetrator had previously been assessed as 'nil risk of harm to self or others' on multiple occasions during their prior contact with the criminal justice system and subsequent Youth Justice. Failure of communication between Youth Justice and the police resulted in inaccurate risk assessments which may have prevented the young person's death.

## Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the Victoria Police and the Victorian Department of Justice and Community Safety update their policies and procedures for information sharing to ensure that when an offender under the supervision of Youth Justice is arrested or is the subject of a family violence investigation, Victoria Police provide this information to Youth Justice

so that current and accurate risk assessments of offenders under the supervision of Youth Justice can be completed. This system should replicate the efficiencies and effectiveness of the L17 referral notification process and should provide for timely sharing of relevant information for all agencies to assess risks. It would be preferable that this be achieved through the development of an automated system to ensure a reduction in data entry errors and increase the efficiency of information flow between the relevant agencies.

- I recommend that the Victorian Department of Justice and Community Safety review their policies and procedures to ensure that Youth Justice offenders who attend counselling programs funded or operated by Youth Justice or Justice Health accurately record and utilise an appropriate family violence risk assessment tool when assessing a youth offender's current or future risk of harm to self or others. These assessments should draw upon relevant family violence information shared within the CISS [Child Information Sharing Scheme] and FVISS [Family Violence Information Sharing Scheme] to enhance the assessment of risk.
- I recommend that the Victorian Department of Justice and Community Safety should also review the training and professional development of mental health practitioners who staff any programs funded or operated by Youth Justice or Justice Health to ensure they are adequately trained to identify and manage family violence risk for their clients.

# Coronial recommendations: Fatal facts

| | |
|---|---|
| **Case number** | VIC.2017.2771 |
| **Primary category** | Drugs and alcohol |
| **Fatal facts edition** | 66 – cases closed between July and September 2020 |

## Case summary

An adult male died due to mixed drug toxicity.

The adult had a history of drug abuse and had recently recommenced taking methadone as part of an opioid replacement therapy program under the supervision of their doctor.

The adult was feeling unwell on the morning of their death. They went to sleep for several hours and their partner noted they were snoring and unable to be moved when checked upon. The adult was later found unresponsive by their partner, who contacted emergency services. They were unable to be revived.

## Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult died due to consumption of methadone in combination with other prescription medications.

The coroner found that had the adult's partner received education regarding how to correctly recognise signs of drug overdose, they may have taken steps earlier to intervene and potentially prevent the death. The coroner reiterated a recommendation made by another coroner in a similar case regarding overdose education.

## Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend the Department of Health and Human Services consider expanding its heroin focussed overdose education and naloxone programs to those, including their immediate family members prescribed strong opioids such as methadone, physeptone and similar drugs and their families.

# Coronial recommendations: Fatal facts

| | |
|---|---|
| **Case number** | VIC.2017.5188 |
| **Primary category** | Transport and traffic related |
| **Additional categories** | Physical health |
| **Fatal facts edition** | 66 – cases closed between July and September 2020 |

## Case summary

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

The collision occurred when an older person became disoriented and lost while driving. The older person turned across two lanes of traffic and collided with the adult's motorcycle.

## Coronial findings

The coroner found that the death was unintentional.

The coroner found that the older person's general practitioner classified them as 'fit and healthy', and therefore capable of driving. Following the accident, the older person was noted to be suffering from cognitive decline.

The coroner also found that the adult was under the influence of drugs at the time of the incident, however, this was not the sole cause of the incident.

## Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that consideration be given by the Secretary of the Department of Transport to adopting a framework requiring mandatory reporting to VicRoads when a medical practitioner forms an opinion that a person with a permanent or long-term injury or illness, is not or may not be medically fit to drive.

# Coronial recommendations: Fatal facts

| | |
|---|---|
| **Case number** | VIC.2017.5513 |
| **Primary category** | Water related |
| **Fatal facts edition** | 66 – cases closed between July and September 2020 |

## Case summary

An adult male died following an ocean drowning incident.

The adult was an overseas tourist visiting family at the time. The adult was swimming at a beach with a relative and got into difficulty returning to shore. Surfers paddled out to the adult and returned them to the beach. Resuscitation efforts were commenced; however, the adult showed no signs of life. They were determined to have passed away at the scene.

## Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult was a strong swimmer, considered fit and healthy and had no underlying health issues.

The coroner found that the area of coast was unpatrolled by lifesavers, there was a lack of signage at the access point and ocean conditions were rough.

## Coronial recommendations

The coroner made the following recommendations related to this case:

- That the [coastal management body] ensure adequate risk measures (including but not limited to signage and public awareness messaging for tourists) are undertaken in relation to the coastline it manages to address the potential for drowning in public spaces.
- That these measures should be re-assessed at appropriate intervals to ensure that they remain best practice and in line with relevant standards.
- That water safety measures be undertaken in consultation with industry experts/stakeholders, such as Life Saving Victoria (the recognised peak water safety agency in Victoria), and form part of the Coastal and Marine Management Plans required to be prepared under the *Coastal and Marine Policy 2020*.

# Coronial recommendations: Fatal facts

| | |
|---|---|
| **Case number** | VIC.2018.609 |
| **Primary category** | Electrocution |
| **Additional categories** | Work related, Transport and traffic related |
| **Fatal facts edition** | 66 – cases closed between July and September 2020 |

## Case summary

A middle aged male died when the trailer they were driving contacted overhead powerlines, causing electrocution.

The adult was very experienced within the truck driving industry and had completed jobs at the site of the incident in the past. The overhead power lines had not been drawn to the attention of the adult on this occasion or previously. Emergency services pronounced the adult deceased at the scene.

## Coronial findings

The coroner found that the death was unintentional.

The coroner found that previous drivers had also not been warned of the overhead power lines. Commonplace procedure at this site was for management to verbally inform workers of hazards. The coroner notes that this practice had since been reviewed and reformed.

## Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend WorkSafe distribute an industry-wide release setting out the lessons learnt, and the initiatives undertaken by the employer and the [property] owner in this case, in order to reduce the risk of electrocution by overhead power lines.

# Coronial recommendations: Fatal facts

| | |
|---|---|
| **Case number** | VIC.2018.4185 |
| **Primary category** | Transport and traffic related |
| **Fatal facts edition** | 66 – cases closed between July and September 2020 |

## Case summary

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

The young person was driving a car they were unfamiliar with when they failed to negotiate a bend in the road. The young person's vehicle impacted a tree on the driver's side. Witnesses called emergency services to the scene, but they were unable to resuscitate the young person.

## Coronial findings

The coroner found that the death was unintentional.

The young person regularly drove on this road and the road was in good condition. The coroner concluded that the young person overshot the bend at considerable speed and overcorrected, causing the accident and the young person's death.

## Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that [local council] erect signage in both directions of [road], advising of the upcoming sweeping bend and mandating a reduction in speed.
- I recommend that [local council] review the statistical data associated with this stretch of road in light of the death of [the deceased] and consider reducing the speed limit along the length of [road], from 100 km/h to 80km/h.

# Coronial recommendations: Fatal facts

| | |
|---|---|
| **Case number** | VIC.2018.5494 |
| **Primary category** | Water related |
| **Additional categories** | Child and infant death |
| **Fatal facts edition** | 66 – cases closed between July and September 2020 |

## Case summary

A male child died when they fell into a swimming pool. They were able to be resuscitated; however, they did not recover.

The child was unattended when they accessed their home's swimming pool through a pool gate and back door, which were both unlocked.

## Coronial findings

The coroner found that the death was unintentional.

It was found that the pool gate was in a weathered condition and would not self-latch without additional pressure. It was found that the gate did not comply with pool gate safety standards, due to evidence of disrepair, rather than failure of design or construction.

The coroner found that if stricter regulations existed and were enforced, the child's death would have been prevented.

## Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that Committee CS-034, Safety of Private Swimming Pools, of Standards Australia consider whether amendments should be made to Australian Standard 1926.1 to ensure that pool gate hinges are resistant to degradation over time, particularly in conditions of disuse, by requiring either:
  - that certain grades of materials be used in spring-based self-closing hinges; or
  - that self-closing gate hinges employ a prescribed class of mechanisms.

# Coronial recommendations: Fatal facts

| | |
|---|---|
| **Case number** | VIC.2018.6184 |
| **Primary category** | Adverse medical effects |
| **Fatal facts edition** | 66 – cases closed between July and September 2020 |

## Case summary

An older male died due to complications from anaesthetic induction during surgery.

The adult was undergoing emergency hernia surgery and was administered an anaesthetic induction agent, following which they went into cardiac arrest. The adult was revived, and their surgery completed. They were transferred to an intensive care unit. Their condition worsened following surgery, and they received palliative care until the time of their death.

## Coronial findings

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

The adult was found to have suffered an anaphylactic reaction to the anaesthetic induction agent.

According to the records of their general practitioner, the adult was known to be allergic to two other neuromuscular blocking agents. The adult's referral to the hospital did not include recently updated allergy information. The coroner found that a template referral form containing allergy information would assist in the capture of relevant details.

## Coronial recommendations

The coroner made the following recommendations related to this case:

- [Health service] consider amending their '[health service] Outpatient Referral Form' template to include a specific field for allergies (or an alternate measure) to increase the likelihood of the template capturing all essential information when [general practitioner] clinic patient summaries are imported.

# Coronial recommendations: Fatal facts

| | |
|---|---|
| **Case number** | VIC.2019.5449 |
| **Primary category** | Drugs and alcohol |
| **Fatal facts edition** | 66 – cases closed between July and September 2020 |

## Case summary

A middle aged male died due to drug toxicity.

The adult was under the influence of synthetic cannabinoids at the time of death. Shortly after boarding a train, fellow passengers observed the adult appearing unwell. The adult was struggling to breathe before losing consciousness. Resuscitation attempts were commenced; however, the adult was unable to be revived and they were declared deceased at the scene.

## Coronial findings

The coroner found that the death was unintentional.

The coroner found that the adult's death was caused by a naturally occurring disease in the context of illicit drug use. It was unknown if the adult was aware of the risks and dangers associated with illicit synthetic drugs, especially given the lack of public awareness and policy.

## Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the Victorian Department of Health and Human Services review how education regarding synthetic cannabinoids is disseminated to health services and, if deemed appropriate and necessary, develop a training package or similar resource for clinicians to equip them to have conversations with patients about synthetic cannabinoid risks and harm reduction.

## WESTERN AUSTRALIA

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

# Coronial recommendations: Fatal facts

| | |
|---|---|
| **Case number** | WA.2015.676 |
| **Primary category** | Adverse medical effects |
| **Additional categories** | Drugs and alcohol |
| **Fatal facts edition** | 66 – cases closed between July and September 2020 |

## Case summary

An adult male died due to complications related to prescribed medication. The adult had schizophrenia and was detained as an involuntary patient. They were prescribed clozapine, and experienced side-effects that had not been identified. The adult was also under the influence of a synthetic cannabinoid. The adult died from gastrointestinal complications contributed to by this medication.

## Coronial findings

The coroner found that the death was due to complications of medical or surgical care. The coroner found that the adult's clozapine treatment contributed to their death, and that the synthetic cannabinoid likely had a sedative effect, further complicating treatment. The coroner found that the adult's supervision, treatment and care was appropriate for their needs and of a proper standard regarding the dangers of clozapine known at the time it was prescribed.

## Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that Department of Health amend its guidelines for the Safe and Quality Use of Clozapine Therapy in the Western Australian Health System to include reference to clozapine induced gastrointestinal hypomotility as a serious side effect to the use of clozapine and recommend gastrointestinal monitoring in accordance with the draft "Guidelines for Managing Specific High Risk Medications Relevant to the Organisation".
- I recommend that [pharmaceutical companies], in consultation with the Therapeutic Goods Administration, consider highlighting the risk of clozapine-induced gastrointestinal hypomotility in the boxed warning that appears at the beginning of their Product Information, and that if so altered, that it appears in the MIMS [Monthly Index of Medical Specialties] Full Prescribing Information and the Consumer Medicine Information.

# Coronial recommendations: Fatal facts

| | |
|---|---|
| **Case number** | WA.2017.696 |
| **Primary category** | Intentional self-harm |
| **Additional categories** | Indigenous |
| **Fatal facts edition** | 66 – cases closed between July and September 2020 |

## Case summary

A young Aboriginal female took their own life by hanging.

The young person experienced consistent neglect, physical, emotional and sexual abuse by family members and others throughout their life. They had severe alcohol dependence, and were placed in multiple foster-care homes with their siblings, however none provided long-term security for the young person.

The young person was placed in a secure care centre as a 'placement of last resort' on multiple occasions. During their final placement at the centre, the young person took their own life.

## Coronial findings

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

The coroner found that the young person suffered from complex developmental trauma and needed comprehensive services to address their medical, psychological, emotional, behavioural and cultural needs. The coroner found that the 21-day standard stay at the centre did not allow enough time to achieve their therapeutic aims.

In addition, the centred failed to appropriately address the cultural needs for the young person. The coroner also found that once a child was discharged from the centre there was a lack of options for further services, which evidently impacted the young person.

## Coronial recommendations

The coroner made the following recommendations related to this case:

- [I recommend] the Department should consider whether the *Children and Community Services Act 2004* WA, should be amended to provide for a maximum secure care placement of greater than 42-days.
- [I recommend] in order to adequately address the needs of young people with complex/extremely complex needs, including those transitioning from secure care, the Department should fast-track the implementation of its proposed complex community care service (the Service). Given the obvious and urgent need for the Service, the current

endorsed commencement date, namely the last quarter of 2023, is manifestly inadequate as is the Department's "accelerated" start date of July 2022 which is currently under consideration.

- [I recommend] in order to ensure the cultural safety of children and staff at [the Centre] and provide staff with access to a high level of cultural competence the Department should, as a matter of urgency, endorse the business case submitted by the Director, Secure Care on 24 January 2020 and take all necessary steps to employ a cultural therapeutic specialist at [the Centre].

# Coronial recommendations: Fatal facts

| | |
|---|---|
| **Case number** | WA.2017.2094 |
| **Primary category** | Sports related |
| **Additional category** | Physical health |
| **Fatal facts edition** | 66 – cases closed between July and September 2020 |

## Case summary

A young female died from dehydration and overheating while training for a combat sport competition.

The young person collapsed after trying to cut their weight to be eligible to fight the following day. The young person dehydrated themselves and over-trained in an attempt to reach the required weight, as they had for previous competitions. The young person collapsed while training and was hospitalised with major organ failure and dehydration. They were unable to recover.

## Coronial findings

The coroner found that the death was unintentional.

The coroner found that the practice of water loading and cutting is very dangerous. The coroner also found that dangerous weight loss techniques and ideals are commonplace and expected within combat sports. The coroner found that the young person received pressure from other gym patrons and trainers to 'make weight' for their competition. The coroner found that despite warning signs of extreme dehydration and exhaustion, family and other athletes did not appreciate the mortal danger that the young person was in.

Despite dangerous methods, the coroner found there was no effective regulation or monitoring of the health and safety of athletes.

## Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the Honourable Minister for Sport and Recreation give consideration to amending the *Combat Sports Act 1987* (WA) and *Combat Sports Regulations 2004* (WA) to empower the Commission to undertake a greater role in regulating the trainers and gyms responsible for training combat sports contestants, outside of contests, to improve the safety of combat sports in Western Australia. Any additional resources required by the Commission to then carry out that regulatory role should be funded by the State Government.

- I recommend that the Combat Sports Commission consider implementing a scheme that requires contestants to provide their weight at the time of registration (at least 7 days out from the contest) in addition to the present system of formal weigh-in on the day prior and the day of the contest. The Commission staff can then take that information into account at an early stage in determining whether a contest is safe to be sanctioned, prior to the formal weigh-in process commencing. This would likely require legislative amendment to the regulations, which would be an element to be considered in implementing [the first recommendation].

## APPENDIX A: FATAL FACTS WEB TOOL CATEGORY TAGS

| Category | Description |
|---|---|
| Adverse medical effects | Adverse effects from medical or surgical treatment, failure to comply with medical advice |
| Aged care | Incidents that occurred in an aged care or assisted living facility or residence, including a retirement village |
| Animal | Incidents where an animal was involved in the death |
| Child and infant death | Any case involving a child or infant |
| Domestic incident | Incidents as a result of a domestic injury or event |
| Drugs and alcohol | Deaths where drugs or alcohol or both made a primary or secondary contribution |
| Electrocution | Cases where electrocution contributed to death |
| Falls | Incidents where a fall was involved in the circumstances or cause of death |
| Fire related | Incidents where a fire was involved in the circumstances or cause of death |
| Geographic | Cases where the geographic region is significant to the death, such as a remote location |
| Homicide and assault | Deaths due to interpersonal violence |
| Indigenous | Cases where the indigenous status of a person was relevant to the circumstances of death |
| Intentional self-harm | Deaths determined by a coroner to be due to intentional self-harm |
| Law enforcement | Includes police pursuits, deaths in custody, legal or court issues and coronial investigation or police procedures |
| Leisure activity | Any leisure activity that directly influenced the circumstances of death |

| Category | Description |
|---|---|
| Location | Cases where the location type of either the incident or the discovery of the body is of significance. Does not refer to geographic location |
| Mental illness and health | Cases where mental health issues or their management were relevant to the death, whether diagnosed or anecdotal |
| Misadventure | Risk-taking behaviour such as train surfing |
| Natural cause death | Cases where the death was due to natural causes |
| Older persons | Cases where the agedness of a person was a factor in the death |
| Physical health | Cases where the existing physical health of the person contributed but was not necessarily the cause of death |
| Sports related | Cases where a sporting incident contributed to death |
| Transport and traffic related | Cases involving road, water and air vehicle incidents, motorised or naturally powered. Includes cases of pedestrians impacted by transport vehicles |
| Water related | Includes swimming, scuba, snorkelling, boating, fishing and all water-based activities in either a recreational or commercial context |
| Weather related | Cases where the environmental conditions such as heatwave or storm conditions contributed to death |
| Work related | Cases where a work incident is related to the death |
| Weapon | Cases where the involvement of a weapon is significant |
| Youth | Cases where the youth of a person was a factor in the death |