Fatal facts

A summary of cases and recommendations made between October and December 2021

Edition 70

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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.

This edition of *Fatal facts* includes case summaries and recommendations for cases closed between October and December 2021.

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.2019.86
Primary category	Falls
Additional categories	Transport and traffic related
Fatal facts edition	70 – cases closed between July and September 2021

Case summary

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

The adult had been travelling home via bus. The bus stopped at the adult's driveway, at which point the adult fell backwards from the bus through the open doorway. The adult sustained a head injury and was conveyed to hospital where they later passed away.

Coronial findings

The coroner found that the death was unintentional.

The bus was operated by a private organisation providing support services to the community.

The coroner found that improved safety measures had been implemented by the bus operator following the incident. However, the coroner noted that the use of a seat located on an elevated step adjacent to the opening side door of the bus presented a serious risk to passengers with mobility issues.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend [bus operator] and [transport service operator] periodically and jointly conduct risk assessments to address risks associated with the service. In the first instance that should include the risk of passengers falling due to existence of the step and the passenger door. The two organisations should also jointly consider and implement any necessary controls to mitigate those risks. Such controls may, for example, involve the adoption of protocols by [bus operator] and modifications to the bus by [transport service operator].

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.2017.2973
Primary category	Intentional self-harm
Additional categories	Law enforcement, Mental illness and health
Fatal facts edition	70 – cases closed between July and September 2021

Case summary

A young male took their own life by hanging. The young person was being held on remand at the time of their death, prior to which they had been an inpatient at a mental health facility. They had a history of mental health issues, include chronic schizophrenia and substance use disorder.

The young person was last seen alive in their cell. The following morning, their cellmate raised the alarm that the young person had self-harmed. Officers attended the cell and resuscitation attempts were commenced. The young person was unable to be revived.

Coronial findings

The coroner found that the death was due to intentional self-harm. The young person had recently attended court and had been advised that a family member wished to cease contact with them. The coroner found there was a compelling argument for the development of a renewed model of care for Justice Health clients.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the CEO, Justice Health and Forensic Mental Health Network:

- That consideration be given to developing health care plans for patients at [correctional centre] who suffer from chronic and major mental health illness with such a health care plan being updated as necessary by the care coordinator/case manager and including, amongst other relevant matters: diagnosis, medication; cell placement; target frequency of review; early warning signs of deterioration or relapse; target interventions including metabolic monitoring, psychology, employment, other psychosocial supports; risk management and recovery plan; and, the wishes of the patient and family.

TASMANIA

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

Coronial recommendations: Fatal facts

Case number	TAS.2018.352
Primary category	Work related
Additional categories	Transport and traffic related
Fatal facts edition	70 – cases closed between July and September 2021

Case summary

An older male died due to injuries sustained in a tractor incident. The adult resided on a farm and was experienced in using tractors.

The adult was assisting a neighbour with feeding cattle using a tractor with a hay bale attached. When the hay bale was unable to be removed, the adult dismounted the tractor and attempted to remove it manually with the neighbour. A short time later, the neighbour witnessed the tractor running over the adult. Emergency services were called to the scene; however, the adult was unable to be revived.

Coronial findings

The coroner found that the death was unintentional.

The coroner found that the incident likely occurred due to unexpected motion of the tractor while the adult was getting on or off the tractor.

The coroner commented that owners of tractors should consider retrofitting STAP (safe tractor access platform) devices to their tractor to provide added safety.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That all operators of tractors comply with the recommendations of Worksafe Tasmania as to the safe use of tractors.

Coronial recommendations: Fatal facts

Case number	TAS.2019.203
Primary category	Water related
Additional categories	Transport and traffic related
Fatal facts edition	70 – cases closed between July and September 2021

Case summary

An older female died due to drowning following a vehicle incident.

The adult was not a confident driver and was described as having poor driving skills.

The adult was driving their vehicle along a wharf when it mounted the wharf's ledge and rolled into the water. The vehicle was located the next morning and the adult was found deceased.

Coronial findings

The coroner found that the death was unintentional.

The coroner noted that the wharf was poorly signed and provided no indication that the road was coming to an end. The weather conditions were poor at the time of the incident.

The coroner concluded that the adult did not realise the road had ended at the wharf until it was too late to take evasive action.

A concept plan was developed by the local council following the incident, and included proposed line markings and signage leading up to the wharf area.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the [local council] undertake the proposed works as outlined in the concept plan attached to this finding.

Coronial recommendations: Fatal facts

Case number	TAS.2020.225
Primary category	Adverse medical effects
Fatal facts edition	70 – cases closed between July and September 2021

Case summary

An older female died due to complications of intercostal catheter insertion.

The adult was in hospital where they underwent an intercostal catheter insertion. The catheter was erroneously inserted into the adult's liver during the procedure, causing fatal injuries.

Coronial findings

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

The coroner noted that there were several difficulties associated with appropriate placement of the catheter, including the adult's weight, age and issues with their chest wall.

The coroner found that if an ultrasound had been used to assist in the placement of the intercostal tube, it was highly unlikely the incident would have occurred.

Coronial recommendations

The coroner made the following recommendations related to this case:

- The circumstances of [the deceased's] death lead me to conclude that it is appropriate to recommend the use of ultrasound to guide the correct placement of intercostal catheters.

Coronial recommendations: Fatal facts

Case number	TAS.2020.380
Primary category	Water related
Additional categories	Work related, Transport and traffic related
Fatal facts edition	70 – cases closed between July and September 2021

Case summary

A middle aged male died due to drowning as a result of a fishing incident.

The adult worked as a commercial fisher. The adult went fishing in their vessel on the day of the incident. Passers by located the adult's unattended vessel and a search for the adult was commenced. The adult's body was located in the water by rescue crews; despite attempts at resuscitation, the adult was unable to be revived.

Coronial findings

The coroner found that the death was unintentional.

The coroner was unable to determine the cause of the adult's fall into the water.

The coroner noted that the adult was not wearing a floatation device at the time of the incident, and that it was unlikely they would have drowned had they been wearing one.

Coronial recommendations

The coroner made the following recommendations related to this case:

- [I recommend] that all domestic commercial vessel operators, operating "single-handed" wear an appropriate PFD [personal floatation device] and carry an appropriate PLB [personal locator beacon] on their person at all times when outside the wheelhouse or superstructure of the vessel.
- I recommend that the appropriate regulatory authorities give consideration to making such a requirement mandatory.

VICTORIA

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

Coronial recommendations: Fatal facts

Case number	VIC.2016.5596
Primary category	Intentional self-harm
Additional categories	Mental illness and health, Law enforcement, Falls
Fatal facts edition	70 – cases closed between July and September 2021

Case summary

An adult male took their own life in an intentional fall.

The adult had a complex medical history, including admissions as a mental health patient.

The adult had contact with police in the days before their death and had been witnessed behaving strangely. Their family believed them to be in a state of crisis; however, police did not detain the adult.

The adult was witnessed climbing over and jumping from a bridge the following day.

Coronial findings

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

The coroner found that there was no assessment or treatment order in force at the time of police contact with the adult that would have empowered them to apprehend the adult under the *Mental Health Act*.

The coroner found that more options were required to assist family, police and ambulance services in managing challenging mental health situations.

The coroner noted that a number of recommendations made as part of the Royal Commission into Victoria's Mental Health System were relevant to this case.

Coronial recommendations

The coroner made the following recommendations related to this case:

I make the following recommendation connected with the death to Mental Health Reform Victoria:

- That recommendations 8, 9 and 10 arising from the Royal Commission into Victoria's Mental Health System be prioritised and implemented in their entirety as recommended by the Royal Commission.

I make the following recommendation connected with the death to the Department of Health:

- That the current power provided pursuant to s351 *Mental Health Act*, however it is to be drafted into the new *Mental Health and Wellbeing Act*, and or the supporting documentation, provides clear and practical guidance on the role of the family, if any, in informing the use of police powers in circumstances requiring a community based crisis response.

Coronial recommendations: Fatal facts

Case number	VIC.2016.6096
Primary category	Adverse medical effects
Additional categories	Child and infant death
Fatal facts edition	70 – cases closed between July and September 2021

Case summary

A male child died due to complications of airway obstruction.

The child was born premature and spent significant time in intensive care following their birth. They were residing in foster care at the time of their death and were nightly attended by staff from a nursing care agency.

The child was fed via their percutaneous endoscopic gastrostomy (PEG) tube and was later found gasping for breath. Resuscitation was attempted and paramedics were called to the scene. The child was conveyed to hospital where they were found to have sustained fatal brain injuries.

Coronial findings

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

The coroner found that there were deficiencies in the management of the child's respiratory arrest and that the nurse was not competent in emergency tracheostomy management, which precluded an opportunity to prevent the fatal outcome.

The coroner found that miscommunication between the hospital, the department responsible for the child's care placement and the nursing agency compromised the care provided.

Coronial recommendations

The coroner made the following recommendations related to this case:

To the [hospital]:

- Where the [hospital] provides advice as to the healthcare needs of a child subject to Children's Court orders, that advice should be communicated in writing to the Department of Families, Fairness and Housing and recorded in the Department of Families, Fairness and Housing's [DFF&H] CRIS [Client Relationship Information System] system and provided in writing to those people providing for the immediate care and welfare of the child, as well as to the Children's court, the parties and their legal representatives, including where relevant, the Court appointed independent children's lawyer.

To the [hospital], the Department of Families, Fairness and Housing and the Department of Health:

- That the [hospital], Department of Families, Fairness and Housing, and the Department of Health consider, develop and expand models for the embedding of healthcare knowledge within Child Protection, including a wider roll out of the Vulnerable Children's Health Project.

To the [hospital] and the Department of Families, Fairness and Housing:

- To review the current memorandum of understanding in place between the two organisations in light of this Finding to strengthen relationships and clarify ambiguities, particularly to ensure it reflects the importance in discharge planning to delineate each of the roles and responsibilities of care between DFF&H and [hospital] where a third party agency is involved in care provision. This should be sufficient to clarify, if a similar situation were to arise in the future, for example, whose responsibility it is to ensure adequate training for staff caring for a patient with a tracheostomy at home, and whose responsibility it is to ascertain the capacity of attending staff to assess and manage an evolving tracheostomy emergency in the setting of a home environment.

Coronial recommendations: Fatal facts

Case number	VIC.2016.6146
Primary category	Homicide and assault
Additional categories	Law enforcement
Fatal facts edition	70 – cases closed between July and September 2021

Case summary

An adult male died due to an assault.

The adult was residing with their partner, with whom they had a history of family violence. An argument arose on the day of the incident, during which neighbours heard a disturbance coming from the residence. Neighbours contacted police, who attended the couple's home.

The adult was found deceased upon police arrival and the partner confirmed they had caused the adult's injuries.

Coronial findings

The coroner found that the death was due to assault.

The coroner found that both the adult and their partner were subject to Community Corrections Orders, and that failure to take earlier action through proactive monitoring of their compliance was a missed opportunity to intervene in the circumstances leading to the adult's death.

The coroner noted that a previous inquest indicated that Corrections Victoria was heavily reliant on paper fields and that an overhaul of the paper-based system with appropriate prompts for compliance would greatly improve the case management of Community Corrections Order offenders.

Coronial recommendations

The coroner made the following recommendations related to this case:

Corrections Victoria:

- I endorse the recommendation of [Deputy State Coroner] in her findings into the death of [another person] and recommend that Corrections Victoria introduce an electronic case management system to enhance Community Correctional Services management of an offender's compliance with their Community Corrections Order. The system needs to address issues identified in this case such as the lack of awareness of non-compliance, lack of supervision and the supervisors' awareness of non-compliance, and the ability to

address non-compliance early. The system should allow case managers the ability to create a schedule outlining how each condition will be completed and contain key milestones that must be reached. This will ensure that starting at induction, case managers and offenders will have a clear case plan to complete and comply with conditions. The system should also allow supervisors the ability to oversee the management of serious offenders with an automated overview of their compliance which allows early interventions to occur when non-compliances are logged.

Coronial recommendations: Fatal facts

Case number	VIC.2017.2483
Primary category	Homicide and assault
Additional categories	Law enforcement
Fatal facts edition	70 – cases closed between July and September 2021

Case summary

An adult male died due to an assault.

The adult had commenced a relationship with a person who had an existing partner. The adult was invited to the couple's home to engage in sexual activity. The three engaged in consensual intimate activity, following which the partner became jealous and attacked the adult.

The couple disposed of the adult's body following which it was found by a local council worker.

Coronial findings

The coroner found that the death was due to assault.

The coroner found that the partner was the subject of a Community Corrections Order at the time of the incident and had previously spent time in prison. The coroner noted failures in the case management of the offender which posed a risk to the community.

The coroner noted that a previous inquest indicated that Corrections Victoria was heavily reliant on paper files and that an overhaul of the paper-based system with appropriate prompts for compliance would greatly improve the case management of Community Corrections Order offenders.

Coronial recommendations

The coroner made the following recommendations related to this case:

Corrections Victoria:

- I endorse the recommendation of [Deputy State Coroner] in her findings into the death of [another person] and recommend that Corrections Victoria introduce an electronic case management system to enhance Community Correctional Services management of an offender's compliance with their Community Corrections Order. The system needs to address issues identified in this case such as the lack of awareness of non-compliance, lack of supervision and the supervisors' awareness of non-compliance, and the ability to address noncompliance early. The system should allow case managers the ability to create a schedule outlining how each condition will be completed and contain key milestones

that must be reached. This will ensure that starting at induction, case managers and offenders will have a clear case plan to complete and comply with conditions. The system should also allow supervisors the ability to oversee the management of serious offenders with an automated overview of their compliance which allows early interventions to occur when non-compliances are logged.

Coronial recommendations: Fatal facts

Case number	VIC.2017.3756
Primary category	Intentional self-harm
Additional categories	Work related
Fatal facts edition	70 – cases closed between July and September 2021

Case summary

A middle aged male took their own life by hanging.

The adult suffered from depression, and had experienced a number of distressing personal events in the years leading up to their death. The adult was employed in a senior position in a large company, and had recently been told they would be performance managed. This caused the adult a great deal of distress. The adult's ex-partner attended the home when they were unable to contact the adult and found them deceased.

Coronial findings

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

The coroner noted that employers should engage in ongoing assessment of their staff management processes and procedures and particularly 'take stock' when such processes and procedures are involved in injury to, or the death of an employee, especially when the employer is aware of the employee having at least experienced workplace stress. The coroner also noted that minimisation of stress associated with difficult employment discussions is especially significant for employees experiencing mental ill-health.

Coronial recommendations

The coroner made the following recommendations related to this case:

- I recommend that the Company assiduously evaluate their internal processes and procedures for dealing with employees who are considered not to be performing up to expectation and explicitly consider strategies for minimising the inevitable stress caused by such processes and procedures particularly in employees with mental ill-health.

Coronial recommendations: Fatal facts

Case number	VIC.2017.4190
Primary category	Homicide and assault
Additional categories	Law enforcement, Weapon
Fatal facts edition	70 – cases closed between July and September 2021

Case summary

An older female died due to an assault.

The adult's partner had a history of mental illness. The partner had previously held a firearms licence which was cancelled as a result of a Family Violence Intervention Order in relation to a previous relationship. The partner's firearms had been seized; however, they had reobtained some of them through friends and acquaintances who acquired the firearms legally.

Family became concerned when the adult did not present to a pre-arranged engagement as planned. They attended the adult's home where they were found deceased. They had sustained fatal gunshot wounds.

Coronial findings

The coroner found that the death was due to assault.

The coroner found that the partner had manipulated both the firearms system and friends and acquaintances to maintain custody of their firearms despite being unlicensed and a prohibited person under the *Firearms Act 1996*.

The coroner found that there was a need for systemic improvements in relation to firearms to help prevent family violence-related deaths and firearms violence in the community.

Coronial recommendations

The coroner made the following recommendations related to this case:

- That Victoria Police make changes to their information technology system so that when a member is searching the serial number of a firearm to obtain information about previously registered owners that the search results provide information about all previous registered owners of that firearm. Where it is not possible to change any relevant system, Victoria Police should mandate that police members must contact the Licencing and Regulation Division (LRD) to obtain this information when they are conducting any such search.
- That Victoria Police (LRD) when assessing for approval an Application for Permit to Acquire Firearms be required to establish whether:

  - the person witnessing the Application was ever previously the registered owner of the firearm and if so, enquiries must then made about their interest in the firearm;
  - the person witnessing the Application is a prohibited person and if so, enquiries must then be made about their interest in the firearm;
  - the person providing a reference for or evidence of a matter relevant to the Application (for example, the property owner where the firearm is to be used,) is a prohibited person and if so, enquiries must then made of their interest in the firearm;
  - the proposed storage address listed is common to a prohibited person or person whose firearms licence has been cancelled and if so, the Permit should not be granted and an investigation commenced.
- That Victoria Police update their policies and procedures so that upon notification of a change of postal, residential or storage address by a licence holder, LRD must establish whether the proposed address listed is common to a prohibited person or person whose firearms licence has been cancelled and if so an investigation should be commenced.
- That Victoria Police update their policies and procedures to confirm that upon identification of missing or unregistered firearms or the commencement of an investigation involving the same, police members are required to notify LRD (unless circumstances prohibit such notification) immediately. LRD must then provide the investigating member any and all relevant intelligence contained in the LARS records and any other assistance and information available in the investigation (unless circumstances prohibit the provision of such information). These updates should be promulgated to police members via the necessary information sharing, policy documents and training to ensure compliance.
- That Victoria Police consider an update to the firearms safety courses for new firearms licence holders to include education about the licence holders' responsibilities and offences under the *Firearms Act 1996*. New licence holders must be able to demonstrate an understanding of those responsibilities and offences in order to successfully complete the firearms safety course.
- That Victoria Police consider providing an information brochure about license holder's responsibilities and highlighting common offences under the *Firearms Act 1996* with every license renewal and upon issuing a new permit to acquire a firearm.
- That the Victorian Attorney-General consider requesting a review of the sentencing outcomes and practices under the *Firearms Act 1996* by the Sentencing Advisory Council to provide feedback on the effectiveness of sanctions imposed on offenders found guilty of offences under this Act.
- That the Royal Australian and New Zealand College of Psychiatrists mandate that of the 50 hours per year of continuing medical education (as required by the Medical Board of Australia) that Fellows complete, not less than four hours of training and education within a two-year period relate to Family Violence (including but not limited to identification, risk assessment or understanding of the relevant frameworks) (four hours out of 100 hours.)

Coronial recommendations: Fatal facts

Case number	The coroner held a joint investigation into the following deaths which resulted from the same incident: VIC.2017.6347, VIC.2017.6350
Primary category	Domestic incident
Fatal facts edition	70 – cases closed between July and September 2021

Case summary

An adult female and a middle aged female died due to a balcony collapse incident.

The two adults were attending a party at the residence of a colleague. The party group were gathered on a balcony when the balcony collapsed, causing many of the group to fall.

Emergency services were called to the scene. Despite resuscitation attempts, the middle aged person was unable to be revived. The adult was conveyed to hospital where they later passed away.

Coronial findings

The coroner found that the deaths were unintentional.

The coroner found that there were structural failures in the balcony and that this, in combination with poor maintenance, resulted in the collapse. Compliance with the system in place at the time of construction of the home and balcony should have revealed that the as-built balcony did not accord with the plans and building approval issued by the council, and that the balcony was inadequately supported by reference to standards applicable at the time.

Neither at the time of construction, nor at the time of collapse, was there was any legislative or regulatory requirement for certification of balconies as to maximum load capacity; for periodic inspection of balconies for structural integrity; or for prescribed or recommended maintenance of the structural members of balconies.

Coronial recommendations

The coroner made the following recommendations related to these cases:

- That the Victorian Building Authority promotes among registered builders and building surveyors a practice of ensuring that balconies associated with residential premises are subject to mandatory inspections at either the frame stage or at the final stage and that the inspection is specifically directed to the compliance of the balcony with currently applicable standards.

- That the Victorian Building Authority continues its efforts to improve public awareness of the need for regular inspections and competent maintenance of balconies, particularly where they are of timber construction or have timber structural members and considers partnering with Local Government in furtherance of this recommendation.
- That the Victorian Building Authority continues its efforts to develop a specific standard addressing the design and durability of exposed structures in response to the 2018 paper referred to it by the Chair of the Building Regulations Advisory Committee.
- That the Victorian Building Authority considers developing a system for:
  - the certification of newly constructed balconies as to their maximum distributed load capacity; and
  - requiring an alert to all users of newly constructed balconies in the form of signage to be permanently affixed to the balcony with an appropriately worded alert to owners and occupiers not to exceed that capacity and to be mindful of the need for regular inspection and competent maintenance.

APPENDIX A: FATAL FACTS SEARCH TOOL CATEGORY TAGS

Category tags	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
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

Category tags	Description
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