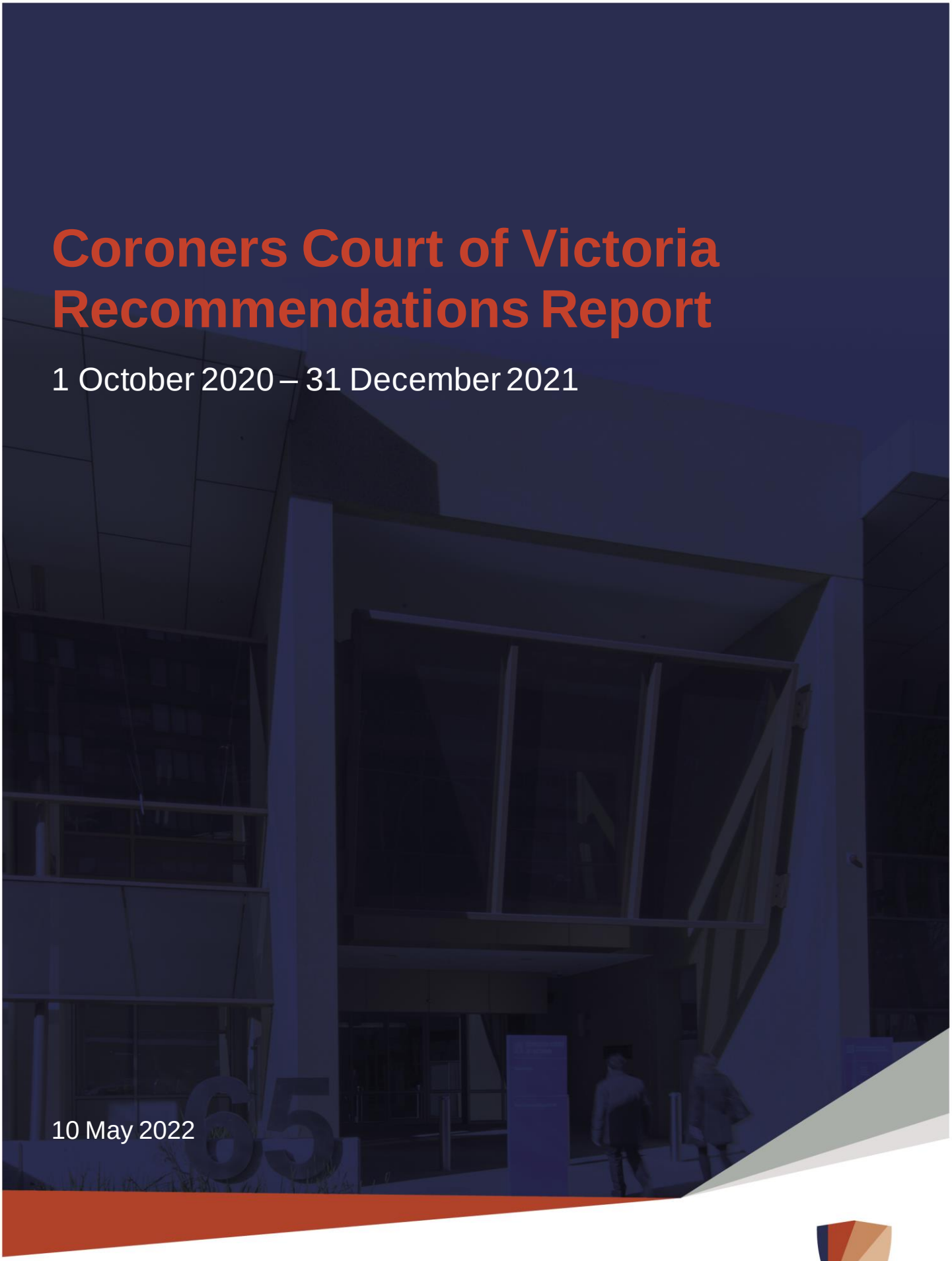
Coroners Court of Victoria Recommendations Report

1 October 2020 – 31 December 2021



10 May 2022

Coroners Court of Victoria

Coroners Court of Victoria

Warning

Aboriginal and Torres Strait Islander peoples are respectfully warned that the following report includes names and information associated with deceased persons from events that have occurred in Victoria. The sensitive nature of the information is associated with the commencement of dreaming for many Aboriginal people and may be distressing for some readers.

Acknowledgement

The Coroners Court of Victoria (CCOV) acknowledges the traditional owners of the land on which it is located, the Wurundjeri and Boon Wurrung Peoples. Furthermore, the CCOV respectfully acknowledges all traditional owners across Victoria and pay respect to all Elders, past, present and emerging. We acknowledge all families and communities who have been impacted by the loss of a loved one and provide our deepest of condolences and respect at this time.

The wellbeing of the community is central to the work of the Coroners Court of Victoria. Through recommendations coroners drive reforms that reduce the number of preventable deaths and strengthen public health and safety responses.

The Court plays a unique and important role in protecting the Victorian community. Each year the Court independently investigates around 7000 cases of sudden or unexpected deaths, deaths of people in care or custody, and fires – to reveal when, where, how and why the incidents occurred.

Throughout their investigations, coroners seek to identify if the event was preventable and make recommendations to stop similar incidents happening in the future.

Where prevention measures are found, the coroner will make recommendations to any relevant minister, public statutory authority or entity. Any matter connected with a death may be included, such as recommendations relating to public health and safety or the administration of justice. A coroner may also report to the Attorney-General in relation to a death or fire they have investigated.

Any public statutory authority or entity to whom a recommendation is directed must respond, in writing, within three months stating what action, if any, has or will be taken. The Court publishes all responses to recommendations on coronerscourt.vic.gov.au.

The *Coroners Court of Victoria Recommendations Report* is a quarterly publication collating all recommendations made in a twelve-month period and the status of responses.

This third edition covers the period from 1 October 2020 to 31 December 2021. During this period, coroners made 257 recommendations across 114 findings. F

Following these recommendations, the Court received:

- 159 responses stating the recommendation was accepted in full
- 28 responses stating the recommendation was accepted in part or an alternative was proposed
- 65 responses stating the recommendation remains under consideration
- 21 responses where the recommendation was not accepted

In addition to these:

- 8 responses are still being prepared within the required three-month time frame or have been granted an extension (awaiting a response)
- 15 responses have not been received within the required time frame (overdue)

The report also contains a chapter on overdue responses reported since the first edition of this publication that remain outstanding. There are currently 5 responses overdue across 9 recommendations in this category.

Please note, a coroner may direct a recommendation to multiple parties. As such, the number of responses required may exceed the number of recommendations made.

All findings and responses can be accessed via the hyperlinks in each case entry of the report.

The status of responses received is accurate at 3 May 2022.

Contents

Suicide

Finding into death of Mr O

Keywords: Suicide, Victoria Police, collateral information, mental health, ligature

Recommendation	Response	Response outcome
BHS develop a specific policy or procedure to address the importance of actively engaging family and responding to family concerns, consistent with the Victorian Chief Psychiatrist's guideline "Working together with families and carers", published in August 2018.	Ballarat Health Services was expected to respond by 10 February 2022	Overdue
BHS ensure that their procedure entitled "Persons who are difficult to engage" incorporates information about the important skills that are required for these patients and ensure that staff are afforded training opportunities to improve their confidence and skills when working with difficult-to-engage patients, noting the work undertaken by Orygen in this area.	Ballarat Health Services was expected to respond by 10 February 2022	Overdue

Finding into death of Mr A

Keywords: Suicide, ligature, disability, family violence, FVIO, recent separation, Victoria Police, family violence services

Recommendation	Response	Response outcome
With the aim of promoting public health and safety, preventing deaths and supporting medical practitioners to address family violence, I recommend that the RACGP consider reviewing the White Book with reference to more up-to-date state and territory integrated, multi-agency service response frameworks and common risk assessment tools, such as Victoria's MARAM Framework.	Response from Royal Australian College of General Practitioners (RACGP)	Accepted in full
With the aim of promoting public health and safety, preventing deaths and supporting medical practitioners to address family violence, I recommend that the RACGP consider mandating that GPs attend a fixed amount of continuing medical education (as required by the Medical Board of Australia) per year which includes at least four hours of training and education within a two-year period related to Family Violence (including but not limited to identification, risk assessment or understanding of the relevant frameworks).	Response from Royal Australian College of General Practitioners (RACGP)	Accepted in part

Finding into death of GAMcM

Keywords: suicide, ligature, mental health, workplace stress

Recommendation	Response	Response outcome
With the aim of promoting public health and safety, 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.	Response from 'The Company'	Accepted in full

Finding into death of Edward Espino

Keywords: suicide, ligature, mental health, medical non-compliance; psychosis, violent behaviour, bail conditions

Recommendation	Response	Response outcome
That the Chief Commissioner of Police provide training for recruits, and instructions for extant members, making clear that police members have no power to relieve those who have entered into undertakings of bail fixed by a court of their obligation to comply by preemptively agreeing not to prosecute the breach of any such obligation.	Response from Victoria Police	Accepted in full

Finding into death of Garry Wise

Keywords: mental health, alcohol, chronic health issues, suicidal ideation, ligature

Recommendation	Response	Response outcome
To improve the safety of clients of the Bolton Clarke Homeless Persons Program and provide the program nurse clear and appropriate contact points for early escalation of concerns, the HPP develop and document a plan with clients as part of assessment that: i. provides the client with a documented list of contacts for situations in which they feel unsafe or at increased risk; ii. identify people the client agrees to have contacted by the Program nurse in case of an increase in concerns for the client's safety; and, iii. the plan is reviewed regularly and updated when circumstances change	Homeless Persons Program was expected to respond by 26 November 2021	Overdue

Finding into death of Brendon Crippen

Keywords: Transfer of care, absconding, mental health, fire, interstate transfer

Recommendation	Response	Response outcome
For the Chief Psychiatrist of Victoria to work with the Chief Civil Psychiatrist of Tasmania to review the need for a cross-border agreement relevant to the Mental Health Acts of both states.	The Office of the Chief Psychiatrist was expected to respond by 6 December 2021	Overdue
For the Chief Psychiatrist of Victoria to raise awareness of the expectation of contemporary clinical practice in arranging for follow-up and/or transfer of care with mental health services of a client known to be in the other state.	The Office of the Chief Psychiatrist was expected to respond by 6 December 2021	Overdue

Finding into death of Adam Laufer

Keywords: mental health, complex medical history, fall from height

Recommendation	Response	Response outcome
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.	Response from Department of Health Response from Privacy and Integrity Branch, Regulatory, Risk, Integrity and Legal Division, Department of Health	Accepted in full
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.	Response from Department of Health	Accepted in full

Finding into death of Michelle Williams

Keywords: hypoxic brain injury, suicide, risk assessment

Recommendation	Response	Response outcome
That Bendigo Health formalise the inclusion of plastic bags in their regular ligature audit.	Response from Bendigo Health Bendigo Health Attachment 1 Bendigo Health Attachment 2	Accepted in full
That Bendigo Health amend their Searches of Patients and Visitors in Psychiatry Inpatient and Residential Units protocol to include that when a patient is found with a prohibited item, all reasonable efforts are made to identify how the patient accessed the item, that steps be taken to prevent future access to such items in similar circumstances, and that such steps be documented in the patient's medical record.	Response from Bendigo Health Bendigo Health Attachment 1 Bendigo Health Attachment 2	Accepted in full

Finding into death of Mirek Juda

Keywords: suicide, ligature, major depression, medication compliance

Recommendation	Response	Response outcome
To ensure there is appropriate monitoring of patients with a treatment plan for major depression which is essentially pharmacological, I recommend that Monash Health CATT affirm that medication compliance is a regular part of their clinical reviews, along with assessments of mental state, current situation and clinical risk.	Response from Monash Health	Accepted in full

Finding into death of Kent Thomas

Keywords: tinnitus, mental health, suicide, ligature

Recommendation	Response	Response outcome
The Royal Australian College of General Practitioners work with Hearing Australia to develop a guideline for general practitioners to screen for and treat tinnitus related distress in 1) newly diagnosed cases of tinnitus in which investigations are still ongoing and 2) cases of tinnitus where investigations do not identify a cause and treatment does not adequately alleviate symptoms. Such a guideline should include a suicide risk assessment and appropriate treatment options for those identified as experiencing tinnitus-related distress.	Response from the Royal Australian College of General Practitioners	Accepted in part
The Royal Australian College of General Practitioners promote awareness to general practitioners of the significant psychosocial impacts of tinnitus and tinnitus related distress, including associated risks and the risk of suicide.	Response from the Royal Australian College of General Practitioners	Accepted in full

Finding into death of Mr BB

Keywords: suicide, mental health, mental health services, collateral information

Recommendation	Response	Response outcome
To improve the safety of patients who are discharged from an emergency department following an assessment for suicide risk, I recommend that North Western Mental Health update relevant guidelines to include a requirement for contact with a family member or carer (where possible) prior to the patient being discharged in situations where a risk has been identified that the patient may be minimizing their suicide risk and/or where conflicting information has been provided regarding their suicidality.	Response from North Western Mental Health	Accepted in full

Finding into death of Christopher Ritson

Keywords: hypoxic ischaemic encephalopathy, suicide, mental health

Recommendation	Response	Response outcome
I recommend that Maroondah Hospital clearly assess the utility of mental health assessments being undertaken by telephone, vis-à-vis face-to-face, and limit the use of such contact to circumstances when contact by telephone has been identified to be adequate.	Response from Eastern Health Attachment 1 Psychiatric Phone Triage Guideline Attachment 2 State-wide Mental Health Triage Scale	Rejected in full
Further I recommend that Maroondah Hospital investigate whether in this case the period of time that elapsed between 7 March and 12 March 2020 was a result of the systematic failure to which Dr Starke referred and if that is found to be the case that it take the steps necessary to prevent a repetition of that systematic failure. I also recommend that if such an investigation does not reveal a systematic failure and that the reason identified for the 5 day delay between 7 march and 12 March 2020 be clearly and practically addressed by the hospital so as to ensure that such a delay does not occur again.	Response from Eastern Health Attachment 1 Psychiatric Phone Triage Guideline Attachment 2 State-wide Mental Health Triage Scale	Accepted in full

Finding into death of Mitchell James Dowling

Keywords: suicide, mental health

Recommendation	Response	Response outcome
That the Australian Psychological Society (APS) and other peak bodies representing psychologists, including the Australian Clinical Psychology Association (ACPA) and the Australian Association of Psychologists (AAP) advise their members that when treating young adults, unless clear reasons contraindicate such action, they provide the patient with written information relevant to the diagnosis which can be provided to the patient's family, friends and/or supports. In particular the information should include information about future symptoms which may indicate a relapse and the need for further therapy.	Response from The Australian Clinical Psychology Association Response from Australian Association of Psychologists Inc Response from Australian Psychological Society	Accepted in full Accepted in full Accepted in full
That the APS, ACPA and AAP advise their members that when treating young adults in relation to self-harm and suicide issues that, unless clear reasons contraindicate such actions, management should include exploring the option for the patient approving/consenting for the psychologist to directly consult with the patient's parent or a parent or partner about the patient's condition and that which may be needed to support the patient.	Response from The Australian Clinical Psychology Association Response from Australian Association of Psychologists Inc Response from Australian Psychological Society	Accepted in full Accepted in full Accepted in full
That the APS, ACPA and AAP advise their members that when treating young adults, unless clear reasons contraindicate such action, management should include establishing whether the patient has discussed the subject of treatment and any diagnosis with family, friends and/or supports and, if not, encourage and potentially provide strategy for such discussion with a view to such	Response from The Australian Clinical Psychology Association Response from Australian Association of Psychologists Inc Response from	Accepted in full Accepted in full Accepted in full

supports aiding treatment.	Australian Psychological Society	
That the APS, ACPA and AAP advise their members that when treating young adults, if the involvement of psychiatric care is considered appropriate, clear advice is provided as to how to access such care and the patient's general practitioner is promptly notified regarding the recommendation in order to further facilitate access to such care.	Response from The Australian Clinical Psychology Association Response from Australian Association of Psychologists Inc Response from Australian Psychological Society	Accepted in full Accepted in full Accepted in full
That the APS, ACPA and AAP remind their members that, regardless of their ongoing duty of confidentiality to deceased patients, that there is a specific exemption contained in Health Privacy Principle 2.4 of the Health Records Act 2001 (Vic) which states that: "a health service provider may disclose health information about an individual to an immediate family member of the individual if: (ii) the disclosure is made for compassionate grounds.	Response from The Australian Clinical Psychology Association Response from Australian Association of Psychologists Inc Response from Australian Psychological Society	Accepted in full Accepted in full Accepted in full

Finding into death of Brett McDonnell

Keywords: suicide

Recommendation	Response	Response outcome
I recommend that the Corrections Victoria obtain detailed relevant professional advice about the adequacy and effectiveness of the "Suicide and Self-harm Risk Screening Suite" together with the qualifications and training of those who administer it as well as the manner in which it is administered with a view to improving insight into the state of mind of those upon whom the Screening Suite is conducted specifically in relation to the likelihood of proximate suicide and self-harm risk. Such advice ought to contemplate the best way to maximise effectiveness and efficiency and consider the utility of recommending a minimum time-period over which the Screening Suite ought to be administered and periodic 'refresher' training.	Response from Department of Justice and Community Safety	Accepted in full

Finding into death of Jack David Watson

Keywords: suicide, asphyxiation, mental health, inert gas

Recommendation	Response	Response outcome
I recommend that Ballarat Health Services amend the section "Transfer between another Area Mental Health Services - Community Services" of the Patient Transfer Protocol to explicitly require that the referral discussion address a recommended timeframe for the receiving service to see the patient, including the relative urgency of a face-to-face interview as opposed to telephone contact. These matters should also be documented in the information sent to the receiving health service.	Response from Ballarat Health Services	Accepted in full

Finding into death of Stanley Weaver

Keywords: suicide, family violence, mental health

Recommendation	Response	Response outcome
I recommend that Victoria Police review the relevant Victoria Police Manual and Guidelines to ensure that there is clear and consistent guidance regarding suspect welfare management in relation to family violence perpetrators. Suspect welfare management should be considered in all interactions between Victoria Police and family violence perpetrators, including during the service of family violence related documentation. This guidance should be included in the updated Code of Practice for the investigation of Family Violence and be reflective of the advice already provided in the Code of Practice for the investigation of Sexual Crime.	Response from Victoria Police	Accepted in full

Finding into death of Nguyen Pham Dinh Le

Keywords: suicide, international student, mental health, support

Recommendation	Response	Response outcome
With the aim of promoting public health and safety and preventing like deaths, I recommend that the Victorian Department of Health and Human Services takes on the role of leading and coordinating efforts to support mental health and wellbeing of international students studying in Victoria, and to ensure international students can access mental health treatment.	Response from Department of Health	Accepted in full

Finding into death of Daniel Patrick Frawley

Keywords: motor vehicle collision, CTE, mental health, head trauma, suicide

Recommendation	Response	Response outcome
That the Australian Football League actively encourages players and, their legal representatives after their death, to donate their brains to the Australian Sports Brain Bank in order to make a meaningful contribution to research into Chronic Traumatic Encephalopathy and thereby improve the safety of future generations of footballers and others engaged in contact sports.	Response from Australian Football League	Accepted in full
That the Australian Football League Players' Association actively encourages players and, their legal representatives after their death, to donate their brains to the Australian Sports Brain Bank in order to make a meaningful contribution to research into Chronic Traumatic Encephalopathy and thereby improve the safety of future generations of footballers and others engaged in contact sports.	Response from Australian Football League Players' Association	Accepted in full

That, in order to enhance research into CTE, the State Coroner and the Director of the Victorian Institute of Forensic Medicine, ensure that, as far as possible, coronial processes and practices: (i) Recognise that currently, CTE can only be diagnosed at autopsy and requires a careful brain examination and sampling of the appropriate areas of the brain for histological and immunohistochemical assessment to determine whether the pathological changes ascribed to CTE are present. (ii) Improve timely identification of cases in which there is a history of head trauma, be that major trauma or minor repetitive trauma, such as may be sustained in sporting activities, so that consideration of the need for an autopsy can be appropriately informed. (iii) While brain examination and tissue sampling needs to be adequate for CTE assessment and this is ideally achieved by retention of the brain for examination in an appropriate centre, such as the Australian Sports Brain Bank, this option may not be acceptable to the senior next of kin. Therefore, a histological brain sampling protocol should be developed to ensure that appropriate sections are available to allow adequate assessment for the presence or absence of CTE changes without the need for long term retention of the whole brain.	Response from Coroners Court of Victoria Response from Victorian Institute of Forensic Medicine	Accepted in full Accepted in full

Finding into death of Julie Ann Lindsay

Keywords: mental health, suicide, firearm, mental health services, general practitioners, rural

Recommendation	Response	Response outcome
Given the increased access to firearms in regional and rural areas, and their lethality as a means of suicide, I recommend that the College of General Practitioners targets promotion of their comprehensive website education about suicide prevention to General Practitioners who treat patients in regional and rural areas.	Response from Royal Australian College of General Practitioners	Accepted in full

Finding into the death of Mr P

Keywords: suicide, firearms licence, clinical guidelines, gun ownership, mental health

Recommendation	Response	Response outcome
Victoria Police develop a framework for determining whether a person with a history of or current mental illness and suicidality is a fit and proper person to hold a firearm licence under the Firearms Act, in consultation with the Royal Australian and New Zealand College of Psychiatrists and the Royal Australian College of General Practitioners; and	Response from Royal Australian College of General Practitioners Response from Royal Australian and New Zealand College of Psychiatrists Response from Victoria Police	Rejected in full Under consideration Accepted in full
As part of the development of that framework, the Royal Australian and New Zealand College of Psychiatrists and the Royal Australian College of General Practitioners develop a set of clinical guidelines regarding assessing fitness to own a firearms licence and firearms in people with a history of or current mental illness and suicidality.	Response from Royal Australian College of General Practitioners Response from Royal Australian and New Zealand College of Psychiatrists	Rejected in full Under consideration

Deaths in custody

Finding into death of Daniel Richards

Keywords: Mental illness, Victoria police, de-escalation, restraint

Recommendation	Response	Response outcome
To the Secretary of the Department of Health, through the Mental Health and Wellbeing Division: i. Consistent with the recommendation I made in the finding into the death of Adam Laufer, 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. ii. That in implementing Recommendation 10 of the RCVMHS Final Report that where a person is being assessed in the community by a mental health service and police and paramedics are involved, that specific consideration be given to: a. The circumstances in which the mental health service had instigated the involvement of police and paramedics. b. Inter-service planning that ensures a mutual understanding of the onsite response across all onsite services. c. The principles of trauma-informed care. d. Identification of best practice. e. Practical guidance to all	Response from Department of Health	Accepted in full

onsite services.		
To the Secretary of the Department of Health, via the Chief Psychiatrist, that: i. The Chief Psychiatrist alert Area Mental Health Services to the risks associated with restraint of people with a mental illness and cardiovascular, respiratory, and metabolic diseases that in circumstances where a community mental health service involves police and paramedics and where restraint could possibly be used, that an assumption of physical disease is reasonable. In response, mental health services include in their planned response: a. Where possible, identification of physical health risks as part of collateral information gathering, including from family members. b. Communication to police and paramedics prior to engagement with the person any established physical illness risks or if it remains unknown. c. Consideration be given to mitigating strategies by all onsite services if physical illness risks are identified or remain unknown.	Response from Department of Health	Accepted in full

Finding into death of Spiros Boursinos

Keywords: Drug induced psychosis, physical/mechanical restraint, Victoria Police, death in police custody, mandatory inquest, licensed premises, responsible service of alcohol training, mechanical asphyxia, cocaine

Recommendation	Response	Response outcome
Recommendation One: I recommend that the Chief Executive Officer of Victorian Commission for Gambling and Liquor Regulation as part of an awareness campaign, arrange for the production of a Safety Alert/Guidance Note explaining the risks and dangers associated with managing people who experience mental health episodes and aggressive type behaviours, and the risks associated with the apprehension and physical restraint of these types of people, and arrange for its distribution to all licenced bar owners to alert them of these issues.	Response from the Victorian Commission for Gambling and Liquor Regulation	Accepted in full
Recommendation Two: I recommend the Secretary of the Department of Justice and Community Safety arrange to amend the Responsible Service of Alcohol Training to include information about how to recognise and manage: a. person who may be experiencing a mental health or drug-related episode; and b. the dangers and risks associated with physical restraint.	Response from the Department of Justice and Community Safety	Accepted in principle

Finding into death of Gary Hietanen

Keywords: death in custody, Aboriginal and Torres Strait Islander passing, combined drug toxicity

Recommendation	Response	Response outcome
G4S commission independent research into the safest efficient way to dispense medication to prisoners in the Borrowdale Unit of Port Phillip Prison incorporating consideration of: a) 'Trap-to-trap' dispensation and alternatives including but not limited opening cell doors to dispense medication, b) Dispensing medication directly to prisoners form a central point in the Unit; and c) Whether different dispensation methods ought to be used for different prisoners taking into account the nature of the medication being dispensed and each prisoner's history of medication and drug use and abuse.	Response from Port Phillip Prison	Alternative adopted
G4S reiterate to staff undertaking the 'lock-down' of the Borrowdale Unit that a verbal, spoken response must be obtained from each and every prisoner. If such a response is not forthcoming from an enquiry made through the 'trap', the cell door is to be opened and a verbal response then obtained from the prisoner.	Response from Port Phillip Prison	Accepted in full

Deaths in care

Finding into death of NB

Keywords: premature birth, subglottis stenosis, emergency tracheostomy, chronic lung disease, foster care, 24-hour care needs, child protection, adequacy of training

Recommendation	Response	Response outcome
To the Royal Children's Hospital: Where the Royal Children's 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 CRIS 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.	Response from Royal Children's Hospital Response from the Department of Families, Fairness and Housing	Accepted in full Accepted in full
To the Royal Children's Hospital, the Department of Families, Fairness and Housing and the Department of Health: That the Royal Children's 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.	Response from Royal Children's Hospital Response from Department of Families, Fairness and Housing Response from Department of Health	Accepted in full Accepted in full Accepted in full
To the Royal Children's 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	Response from Royal Children's Hospital Response from Department of Families, Fairness and Housing	Accepted in full Accepted in full

to ensure it reflects the importance in discharge planning to delineate each of the roles and responsibilities of care between DFF&H and RCH 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.		

Finding into death of Christopher Dewhurst

Keywords: Suicide, struck by train, compulsory patient, Mental health Act, substance abuse, risk assessment, death in care

Recommendation	Response	Response outcome
1. With the aim of promoting public health and safety and preventing like deaths, I recommend that the Chief Psychiatrist review the Guidelines related to Leave (Leave of absence from a mental health inpatient unit guidelines) to specifically reference Family Meetings and recommend that the patient's leave entitlements be suspended until a review of the patient's risk to taking leave – escorted, unescorted, on grounds, off grounds; by the patient's Consultant Psychiatrist can be made.	Response from Chief Psychiatrist	Rejected in full
2. With the aim of promoting public health and safety and preventing like deaths, I recommend that Mercy Health review its own policies and procedures related to Leave to specifically reference Family Meetings and require that the patient's leave entitlements be suspended until a review of the patient's risk to taking leave – escorted, unescorted, on grounds, off grounds; by the patient's Consultant Psychiatrist can be made.	Response from Mercy Health Attachment to Mercy Health response	Under consideration
3. With the aim of promoting public health and safety and encouraging best practice in the clinical setting, I recommend that Mercy Mental Health take steps to discourage the practice of completing retrospective documentation particularly in respect of risk assessments by providing training, that is repeated periodically, on the principles that contemporaneous documentation in the health care setting should be an effective means of communication, should act as an aide memoire to the	Response from Mercy Health Attachment to Mercy Health response	Accepted in full

clinician of the contemporaneous circumstances and of their importance emphasised as they are a legal document.		

Finding into death of Anthony Churches

Keywords: cyanide toxicity, poisoning, absconding

Recommendation	Response	Response outcome
That St Vincent's Health conduct a review of training programs (induction training for new ED staff and periodic training for ongoing ED staff) and any associated materials (hard copy and online) to ensure that they include comprehensive guidance about the response required in the event that a compulsory psychiatric patient absconds and highlights the importance, purpose and use of the MHA124 form when notifying police.	Response from St Vincent's Hospital	Accepted in full
That St Vincent's Health consider the introduction of measures to improve observation of patients at risk of absconding from the ED during the afternoon change of shift (2pm-4pm).	Response from St Vincent's Hospital	Under consideration
That St Vincent's Health provide an update about implementation of its mental health crisis hub including a comment on anticipated (or actual) improvements to patient supervision, absconding risk minimisation or other aspects of mental health management in the emergency department, and how these will be monitored and evaluated.	Response from St Vincent's Hospital	Under consideration

Family violence

Finding into death of Simone Quinlan

Keywords: Intimate partner homicide, family violence, risk assessment, Victoria Police

Recommendation	Response	Response outcome
I recommend that Victoria Police update the Code of Practice and relevant family violence policies and procedures to include advice recommending that police members do not contact alleged family violence perpetrators by telephone prior to the service of a family violence safety notice or intervention order. The advice should highlight the vulnerability of affected family members when a safety notice or intervention order is not yet in effect and the potential evasion of service by an alleged perpetrator upon notification that a family violence allegation has been made against them.	Response from Chief Commissioner of Police, Victoria Police	Accepted in part
I endorse the recommendation of Deputy State Coroner English in her findings into the death of Kylie Cay 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	Response from Department of Justice and Community Safety Response from Justice Service, Corrections Victoria	Accepted in part Under consideration

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.		
I also recommend Corrections Victoria implement training for all Community Correctional Services staff state-wide who are involved in preparation of Judicial Monitoring reports, regarding their composition and contents to improve the quality and accuracy of these reports.	Response from Department of Justice and Community Safety	Accepted in full

Finding into death of VT

Keywords: Family violence, Homicide, sharp object, Culturally and Linguistically Diverse persons (CALD), mental health, Victoria Police, health services

Recommendation	Response	Response outcome
In light of the comprehensive nature of the Royal Commission's work in this regard, I support the recommendations put forward, specifically in this case as they relate to the issue of assisting third parties to educate and assist both perpetrators and victims of family violence. I recommend that the Victorian Government and Family Safety Victoria develop a research-based strategy, in consultation with victim survivors, informal supporters and priority communities, to provide targeted information and services to informal supporters assisting persons affected by family violence.	Response from Family Safety Victoria	Accepted in full

Finding into death of MWJ

Keywords: Intimate partner homicide, family violence, community corrections order

Recommendation	Response	Response outcome
Corrections Victoria: I endorse the recommendation of Deputy State Coroner English in her findings into the death of Kylie Cay 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.	Response from Minister for Corrections Response from Department of Justice and Community Safety	Under consideration Under consideration

Finding into death of Marilyn Burdon

Keywords: Intimate partner homicide; family violence; firearm, suicide

Recommendation	Response	Response outcome
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.	Response from Victoria Police	Rejected in full
That Victoria Police (LRD) when assessing for approval an Application for Permit to Acquire Firearms be required to establish whether: a. 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; b. the person witnessing the Application is a prohibited person and if so, enquiries must then be made about their interest in the firearm; c. 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; d. the proposed storage address listed is common to a prohibited person or person whose firearms licence has been cancelled and if so,	Response from Victoria Police	Rejected in full

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.	Response from Victoria Police	Rejected in full
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.	Response from Victoria Police	Accepted in full
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.	Response from Victoria Police	Accepted in full
That Victoria Police consider providing an information brochure about license holder's responsibilities and highlighting common offences	Response from Victoria Police	Accepted in full

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.	The Victorian Attorney General's office was expected to respond by 21 December 2021	Overdue
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.)	Response from the Royal Australian College of General Practitioners	Alternative adopted

Finding into death of Kylie Cay

Keywords: family violence, Ambulance Victoria, ambulance dispatch policy, triage guidelines, recent hospital attendance, vulnerable patients, community corrections order

Recommendation	Response	Response outcome
To Ambulance Victoria: to ensure clinicians and referral service triage practitioners are able to access all information taken by ESTA call operators, including the ProQA codes and their descriptions in the Computer Aided Dispatch system.	Response from Ambulance Victoria	Accepted in full
To Ambulance Victoria: to conduct an internal review to ensure all staff have received the training and education about the nature and effects of injuries and harm caused by family violence, as outlined in the Pro Ops 273 (approved on 29 July 2020), to enhance their understanding of patients suffering from and at risk of family violence, recognising their particular difficulties and acute vulnerability in the community.	Response from Ambulance Victoria	Accepted in full
To Ambulance Victoria: To use this Finding and in particular, the transcript of the call between Ms Cay and the referral service triage practitioner, (Exhibit 20), for staff education and training purposes regarding the meaning of and effects of family violence, as well as learnings about active and empathetic listening.	Response from Ambulance Victoria	Accepted in full
To Ambulance Victoria: To audit its policies and work instructions to ensure alignment between policies and actual internal compliance, to identify and address discrepancies so policies are meaningful and are reflected in actual process and practice.	Response from Ambulance Victoria	Accepted in full
To Corrections Victoria: To introduce	Response from	Under consideration

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.	Department of Justice and Community Safety	
To Corrections Victoria: To implement training for all Community Correctional Services staff state-wide who are involved in preparation of Judicial Monitoring reports, regarding their composition and contents to improve the quality and accuracy of these reports.	Response from Department of Justice and Community Safety	Accepted in full

Finding into death of Aisha Beck
Finding into death of Aziza Beck

Keywords: mental health, suicide, filicide, family violence, firearm

Recommendation	Response	Response outcome
1. I recommend-that the RACGP consider issuing or updating practice guidelines to GPs treating patients who are prescribed psychotropic medication to incorporate a flag or alert in their patient management software systems to prompt a follow-up for patients who require a repeat script or mental health review.	Response from the Royal Australian College of General Practitioners	Accepted in full
2. I recommend that the Australian Government consider the RACGP proposals to change to the Medicare system to add a specific item number for longer sessions for patients with mental health conditions and funding for telehealth consultations for patients who have been prescribed psychotropic medication.	Response from Minister for Health and Aged Care	Accepted in full

Finding into death of Jason Smith

Keywords: homicide, firearm, family violence, mental health, firearm licensing

Recommendation	Response	Response outcome
1) That Victoria Police review their current policies and procedures regarding firearms license applications and renewal applications. Specifically, that if an applicant declares that they are currently being treated for a medical issue (including mental health), the medical evidence provided to support such an application must be current and less than 3 months old. It must also be provided in the form of Appendix One to the Quick Guide: The Role of Health Professionals in the Firearms Licensing Process to ensure that health professionals understand why the medical report is being provided with respect to the suitability of an individual to hold a firearms license.	Response from Victoria Police	Accepted in full
2) That if a firearms license holder is being treated for a condition that is subject to change as indicated in a medical report supporting their continual access to firearms, Victoria Police should consider implementing a variable period of review for such firearms license holders to ensure that they continue to provide regular advice as to the appropriateness of the individual being licensed to possess and use a firearm.	Response from Victoria Police	Accepted in full

Finding into death of Ms ZT

Keywords: homicide, sharp force injuries, family violence

Recommendation	Response	Response outcome
Recommendation One: That the Department of Health update the Maternal and Child Health Service guidelines and the Additional Family Violence Consultation-Practice Note for Maternal and Child Health Nurses to indicate the family violence enquiries must be asked whilst the mother is alone as a matter of standard procedure and what strategies are best adopted to achieve this. Appropriate training must also be provided to staff performing these tasks.	Response from Department of Health	Accepted in full
Recommendation Two: That the Department of Health also review the Maternal and Child Health Service guidelines, Maternal and Child Health Services practice guidelines 2009 and the Additional Family Violence Consultation- Practice Note for Maternal and Child Health Nurses with a view to update these guidelines to provide staff with guidance on how to arrange a family violence consultation with a mother, to manage instances in which the partner declines to leave the mother alone and how to manage suspected perpetrators of violence.	Response from Department of Health	Accepted in full
Recommendation Three: That the Department of Health update the current policies and procedures governing the practice of MCH staff to reflect the guidelines provided in the Department of Families, Fairness and Housing's Language Services Policy, specifically that family members are not to be used as interpreters in a health service setting.	Response from Department of Health	Accepted in full
Recommendation Four: That	Response from the	Accepted in full

Services Australia consider requiring all contractors who provide social services funded programs adopt a Child Safety Policy across all locations that they operate. This policy should be State specific, refer to child clients as well as children of clients, and provide greater guidance to staff on the signs and symptoms of child abuse and neglect. This should be supported by training for stagg in recognising child abuse and neglect and how to staff may respond in these instances.	National Office for Child Safety	
Recommendation Five: That Victoria Police consider updating guidance to indicate that police members should consider undertaking a welfare check on residents in instances where there are repeated incidents reported to emergency services requesting police attendance and where incidents are described as "violent or possibly family violence related". This should also be considered as part of the training and guidance for police members when assessing whether a welfare check is required or not.	Response from Victoria Police	Accepted in full
Recommendation Six: I reiterate my previous recommendation in the coronial findings in the cases of the deaths of Mrs FS and Mrs K. I recommend that the Victorian Government and Family Safety Victoria develop a research-based strategy, in consultation with victim survivors, informal supporters and priority communities, to provide targeted information and services to informal supporters assisting persons affected by family violence.	Response from Family Safety Victoria Response from Department of Premier and Cabinet	Accepted in full

Finding into death of John Reed

Keywords: family violence, head injury, intimate partner homicide

Recommendation	Response	Response outcome
I reiterate my previous recommendation in the coronial findings in the cases of the deaths of Ms ZT, Mrs FS and Mrs K. I recommend that the Victoria Government and Family Safety Victoria develop a research-based strategy, in consultation with victim survivors, informal supporters and priority communities, to provide targeted information and services to informal supporters assisting persons affected by family violence.	Response from Family Safety Victoria	Accepted in full

Finding into death of Teresa Mancuso

Keywords: family violence, FVIO, police response

Recommendation	Response	Response outcome
Victoria Police amend the current Code of Practice for the Investigation of Family Violence and the current Victoria Police Manual Policy Rules - Family Violence to provide clear instructions to Victoria Police members responding to reports of family violence incidents received via telephone and make a reference to updated VPM - Crime and events reporting.	Response from Victoria Police	Accepted in full

Finding into death of Mrs K

Keywords: Family violence, homicide, non-accidental injuries

Recommendation	Response	Response outcome
I recommend that the Victorian Government and Family Safety Victoria develop a research-based strategy, in consultation with victim survivors, informal supporters and priority communities, to provide targeted information and services to informal supporters assisting persons affected by family violence.	Response from Family Safety Victoria	Accepted in full

Finding into death of Baby S

Keywords: Child homicide, family violence, non-accidental injuries, fatal head injuries

Recommendation	Response	Response outcome
I recommend that the Secretary of the Department of Health and Human Services conduct a review and audit of the updated Child Protection policies and procedures listed above in paragraphs 86 to 89, to determine whether these changes have effectively improved Child Protection's response to and management of high-risk infants. In addition I recommend that the Secretary of Department of Health and Human Services conduct a compliance audit to ensure that staff are complying with the policies and procedures listed in paragraph 86 and 89. The review and audit should be completed no later than 30th June 2021.	Response from Department of Families, Fairness and Housing	Accepted in full

Finding into death of Mrs A

Keywords: Family violence, homicide, non-accidental injuries

Recommendation	Response	Response outcome
I recommend that the Victorian Government and Family Safety Victoria develop a research-based strategy, in consultation with victim survivors, informal supporters and priority communities, to provide targeted information and services to informal supporters assisting persons affected by family violence.	Response from Family Safety Victoria	Accepted in full

Overdose and poisoning

Finding into death of AH

Keywords: overdose, mixed drug toxicity, emergency department, prescription drugs, inadequate care

Recommendation	Response	Response outcome
LRH continue to conduct ongoing education for all levels of staff regarding the management of opiate toxicity, particularly as it applies to long acting formulations.	Response from LaTrobe Regional Hospital	Accepted in full

Finding into death of Yunjie Zhang

Keywords: malnutrition, nitrous oxide inhalation

Recommendation	Response	Response outcome
I recommend the Department of Health consider whether a kit similar to the previously published Responsible Sale of Solvents: A Retailer's Kit is needed for retailers of cream whipper bulbs and other nitrous oxide sources to alert them to the requirement that they must have a reasonable belief the nitrous oxide will not be inhaled. The risk of drawing further attention to nitrous oxide inhalation, and the risk that nitrous oxide users might switch from the relatively safe and pure nitrous oxide in cream whipper bulbs to sources with potentially toxic contaminants will naturally form part of the Department's considerations about whether this resource would be helpful for reducing deaths related to recreational inhalation of nitrous oxide.	Response from Department of Health	Alternative adopted
I recommend the Department of Health consider developing an education resource for recreational users of nitrous oxide, outlining the dangers of the drug in general as well as the specific elevated risks associated with practices such as using tubes and masks. I also recommend the Department consider distributing this resource to all Australian online retailers of cream whipping nitrous oxide bulbs and request that they incorporate the material into their websites in such a way that it is visible to any person seeking to purchase these bulbs.	Response from Department of Health	Accepted in full
I also recommend the Department consider distributing this resource to	Response from Department of	Accepted in full

all Australian online retailers of cream whipping nitrous oxide bulbs and request that they incorporate the material into their websites in such a way that it is visible to any person seeking to purchase these bulbs.	Health	

Finding into death of HG

Keywords: mixed drug toxicity, heroin, naloxone, custodial health, prisoner health, health information sharing

Recommendation	Response	Response outcome
That the Victorian Department of Health and the Victorian Department of Justice and Community Safety work together to convene a formal advisory group to guide the identification, prioritisation, implementation and evaluation of policies and programs to reduce drug-related mortality among people who are released from prison. This advisory group should include representatives from government departments and non-government organisations whose work intersects with support of people leaving prison, as well as academic experts. This advisory group should have the necessary capacity and authority to address health information sharing, including any applicable requirements of the Health Records Act 2001.	Response from the Victorian Department of Health Response from the Victorian Department of Justice and Community Safety	Accepted in full Accepted in full
That the Victorian Department of Justice and Community Safety should expand its pilot naloxone program state-wide to all Victorian prisoners.	Response from the Victorian Department of Justice and Community Safety	Accepted in full

Finding into death of Samantha Leech

Keywords: Pregabalin, over-prescribing, false identity, SafeScript, prescription drug abuse

Recommendation	Response	Response outcome
I recommend that the Victorian Department of Health review the circumstances of Ms Leech's death including but not necessarily limited to the apparent ease with which she presented to multiple clinics, registered as a patient under her maiden surname and altered date of birth and was prescribed significant quantities of pregabalin, implicated in her death.	Response from Department of Health	Accepted in full
I recommend that the Victorian Department of Health's review should be expedited and aimed at including pregabalin to the list of medicines monitored through the SafeScript system and any other measures that could enhance patient safety in this regard.	Response from Department of Health	Accepted in full

Finding into death of DA

Keywords: Mental health, addiction, opioid analgesics, benzodiazepines, depression, anxiety, doctor shopping, Tourette syndrome, Victoria Police, SafeScript

Recommendation	Response	Response outcome
I recommend that the Department of Health review and amend the SafeScript training modules for health professionals to include additional advice and training about: a) exploring with patients the effect of other medications not recorded in SafeScript which affect the central nervous system, for example antidepressants and antipsychotics, that in combination increase the risk of harm; b) discussing with patients who are prescribed quetiapine the details of its use, time of dosing and risks when taken in combination with other medicines; c) educate patients about the potential for accidental overdose with dosing routines and combinations of high risk medicines even if prescribed; and d) educate patients using multiple sedating medications about the implications of alcohol use due to the central nervous system depressive effect.	Response from Department of Health	Accepted in full
I recommend that the Department of Health review and amend the SafeScript educational materials for patients and their families to include information about the potential for accidental overdose and the implications of alcohol use when taking multiple sedating medications.	Response from Department of Health	Alternative adopted

Finding into death of Anson;
Finding into death of Ilker;
Finding into death of Jordan;
Finding into death of James;
Finding into death of Jason

Keywords: novel psychoactive substances, drug toxicity, overdose

Recommendation	Response	Response outcome
1. That the Department of Health, as the appropriate arm of Victorian Government, implements a drug checking service in the State of Victoria as a matter of urgency, to reduce the number of preventable deaths (and other lesser harms) associated with the use of drugs obtained from unregulated drug markets.	Response from Department of Health	Under consideration
2. That the Department of Health, as the appropriate arm of Victorian Government, implements a drug early warning network in the State of Victoria as a matter of urgency, to reduce the number of preventable deaths (and other lesser harms) associated with the use of drugs obtained from unregulated drug markets.	Response from Department of Health	Under consideration

Finding into death of Sharni Connolly

Keywords: pregabalin, multiple drug toxicity, hypoxic brain injury

Recommendation	Response	Response outcome
In order to reduce the risk of harm associated with pregabalin, the Victorian Department of Health and Human Services consider the inclusion of pregabalin in the scope of drugs monitored in the Safe Script real-time prescription monitoring scheme.	Response from Department of Health	Accepted in full

Finding into death of Michael Woodhouse

Keywords: supraventricular tachycardia, mental health, coronary artery disease, myocardial fibrosis, synthetic cannabinoids

Recommendation	Response	Response outcome
With the aim of promoting public health and safety and preventing like deaths, I recommend that the Victorian Department of Health develop a training package or similar resource for primary health care providers to support them in educating patients with existing heart conditions on the cardiac effects of synthetic cannabinoids and the risks associated with their use.	Response from Department of Health Further response from Department of Health	Under consideration.

Finding into death of Diane Maria Hillgrove

Keywords: mixed drug toxicity, chronic pain, SafeScript

Recommendation	Response	Response outcome
In order to reduce the risk of harm associated with pregabalin, the Victorian Department of Health and Human Services consider the inclusion of pregabalin in the scope of drugs monitored in the Safe Script real-time prescription monitoring scheme.	Response from Minister for Health	Accepted in full

Finding into death of Shae Harry Paszkiewicz

Keywords: combined drug toxicity, heroin, naloxone, custodial health, prisoner health

Recommendation	Response	Response outcome
That the Victorian Department of Health adopt formal responsibility for improving health outcomes and reducing drug-related mortality among people who are released from prison.	Response from Department of Health	Alternative Adopted
That the Victorian Department of Health convene a formal advisory group to guide the identification, prioritisation, implementation and evaluation of policies and programs to reduce drug-related mortality among people who are released from prison. This advisory group should include representatives from government departments and nongovernment organisations whose work intersects with support of people leaving prison, as well as academic experts.	Response from Department of Health	Accepted in full
That the Victorian Department of Health collaborate with the Victorian Department of Justice and Community Safety to link information they hold on all people who enter Victoria's prison system, with a view to producing accurate and timely information on these people and their health outcomes including death within 10 years of release from prison. This information should be collated in consultation with the advisory group (see Recommendation Two) and should be publicly reported on (at least) an annual basis, as well as being made available to researchers who are engaged in efforts to improve these health outcomes.	Response from Department of Health Response from Department of Justice and Community Safety	Accepted in full Accepted in part
That the Victorian Department of Justice and Community Safety should immediately introduce a take-home naloxone program (including training in	Response from Department of Justice and Community Safety	Accepted in part

overdose awareness and naloxone administration) to be made available to all people in Victorian prisons who have a history of opioid use and who are preparing to exit prison.		

Finding into death of AAC

Keywords: combined drug toxicity, pregabalin, dihydrocodeine, tramadol, temazepam, lorazepam, obesity, accidental overdose

Recommendation	Response	Response outcome
I acknowledge the Department's response to Coroner Gebert's recommendation. I trust that the Department and the SafeScript Expert Advisory Group are abreast of coroners' concerns about pregabalin given its now established and ongoing contribution to Victorian overdose deaths. Nevertheless, given my obligation as a coroner to contribute to a reduction in the number of preventable deaths in Victoria, I recommend that the Victorian Department of Health review the circumstances of Mr AAC's death, and particularly the apparent ease with which he presented to multiple clinics, registered as a patient under false names and was prescribed significant quantities of drugs implicated in his death - pregabalin, tramadol, temazepam and lorazepam. Such review should include a re-consideration of the case for adding pregabalin to the list of medicines monitored through the SafeScript system and any other measures that could enhance patient safety in this regard.	Response from Department of Health	Accepted in full

Missing persons

Finding into death of Barry Scott Collins

Keywords: missing person, search, Victoria Police, work stressors, Warrnambool

Recommendation	Response	Response outcome
I recommend that the Chief Commissioner of Police considers introducing a system of regular auditing and oversight of the investigation of long-term missing persons cases to ensure that they are being progressed in as timely and thorough manner as possible and that they are referred to the Coroners Court as suspected deaths as soon as it is appropriate to do so.	Response from Victoria Police	Under consideration

Medical

Finding into death of Geoffrey Locks

Keywords: Ambulance Victoria, resuscitation, haemorrhage, tracheostomy, external service providers (MePACS); cardiorespiratory arrest

Recommendation	Response	Response outcome
I recommend that MePACS (Peninsula Health) develop a policy and procedure specifically for non-verbal clients. The policy should require a client's preferences regarding communication and the steps to be taken in a medical emergency to be recorded in their file and considered when MePACS responds to a medical emergency alert.	Response from Peninsula Health	Accepted in full

Finding into death of Peta Hickey

Keywords: Anaphylaxis, inadequate treatment, delayed treatment, contrast medium, radiology, cardiac CT, workplace health screening, medical imaging

Recommendation	Response	Response outcome
That the Royal Australian and New Zealand College of Radiologists (RANZCR) implement a mandatory requirement that radiologists working in settings where contrast is administered without other expert medical support undertake specific training in the recognition and management of severe contrast reactions and anaphylaxis every 3 years.	Response from Royal Australian and New Zealand College of Radiologists	Accepted in full
That RANZCR [Royal Australian and New Zealand College of Radiologists], the Australasian Society of Clinical Immunology and Allergy (ASCIA) and the Australian Resuscitation Council (ARC) develop and implement 151 a comprehensive training and certification programme for radiologists in the recognition and management of severe contrast reactions and anaphylaxis and the provision of CPR and basic life support including airway management with equipment available in radiology practices.	Response from Royal Australian and New Zealand College of Radiologists Response from Australasian Society of Clinical Immunology and Allergy Response from Australian Resuscitation Council	Rejected in full Under consideration Alternative adopted
That RANZCR [Royal Australian and New Zealand College of Radiologists] implement a register of severe contrast reactions, their management and outcomes to enable an assessment of the effectiveness of training and compliance with guidelines.	Response from Royal Australian and New Zealand College of Radiologists	Rejected in full
That RANZCR [Royal Australian and New Zealand College of Radiologists] amend its contrast reaction management guidelines for display in rooms where contrast is	Response from Royal Australian and New Zealand College of	Under consideration

administered to specifically highlight: (a) that adrenaline is potentially life-saving and must be used promptly. Withholding adrenaline due to misplaced concerns of possible adverse effects can result in deterioration and death of the patient. (b) the role of glucagon in reactions in patients undergoing cardiac CT who have received beta-blocking medication.	Radiologists	
That RANZCR [Royal Australian and New Zealand College of Radiologists] amend their Standard 5.3.2 with regard to requests for nonemergency and invasive investigations or procedures, or procedures including administration of contrast dye, so that referrals containing no or inadequate clinical information regarding the test or procedure are rejected or referred back to the requesting doctor if that doctor cannot be directly contacted to provide their clinical indication for requesting the test or procedure.	Response from Royal Australian and New Zealand College of Radiologists	Under consideration
That RANZCR [Royal Australian and New Zealand College of Radiologists] prepare a joint position statement with the Cardiac Society of Australia and New Zealand regarding when 'screening' is an acceptable indicator for a CT angiogram or other invasive cardiac tests.	Response from Royal Australian and New Zealand College of Radiologists Response from Cardiac Society of Australia and New Zealand	Under consideration Rejected in full
That RANZCR [Royal Australian and New Zealand College of Radiologists] prepare joint position statements with other relevant bodies on when 'screening' is an acceptable indicator for other imaging procedures.	Response from Royal Australian and New Zealand College of Radiologists	Alternative adopted

That, after these statements are prepared, RANZCR [Royal Australian and New Zealand College of Radiologists] update its standards and guidelines regarding both clinical requests and consent procedures to address the increasing prevalence of 'screening' requests, and to ensure that imaging procedures are not performed for 'screening' when lower-risk alternatives might achieve the same end.	Response from Royal Australian and New Zealand College of Radiologists	Under consideration
That the Medical Radiation Practice Board (MRPB) review and update its set of Professional Capabilities for Medical Radiation Practitioners to ensure that emergency response is adequately addressed within them, including both proficiency in recognition of reactions, administration of necessary treatments, and playing an active role in emergency response, including raising issues with more senior staff when required.	Response from Australian Society of Medical Imaging and Radiation Therapy Response from Medical Radiation Practice Board	Under consideration Accepted in full
That the MRPB [Medical Radiation Practice Board] update their CPD guidelines to require that all radiographers who work with contrast media ensure they are consistently trained in emergency response to severe reactions and anaphylaxis.	Response from Australian Society of Medical Imaging and Radiation Therapy Response from Medical Radiation Practice Board	Under consideration Under consideration
That RANZCR [Royal Australian and New Zealand College of Radiologists], ASCIA [Australasian Society of Clinical Immunology and Allergy], Australian Resuscitation Council and the Australian Society of Medical Imaging and Radiation Therapy (ASMIRT) develop and	Response from Royal Australian and New Zealand College of Radiologists Response from Australian Society	Rejected in full Accepted in full

implement a training and certification programme for radiographers in the recognition and management of severe contrast reactions and anaphylaxis, CPR and Basic Life support with a triannual recertification requirement, including: (a) the ability to administer adrenaline via autoinjector when encountering a patient experiencing a severe reaction; and (b) playing an active role in emergency response, including raising issues with more senior staff when required.	of Medical Imaging and Radiation Therapy Response from Australasian Society of Clinical Immunology and Allergy Response from Australian Resuscitation Council	Under consideration Under consideration
That the MRPB [The Medical Radiation Practice Board], RANZCR [The Royal Australian and New Zealand College of Radiologists] and ASMIRT [Australian Society of Medical Imaging and Radiation Therapy] consider expanding radiographers' scope of practice to include training in the preparation and administration of medications appropriate to their practice, including drugs used to treat medical emergencies encountered in radiology, either under the supervision of a medical practitioner or, in emergencies, without the supervision of a medical practitioner.	Response from Royal Australian and New Zealand College of Radiologists Response from Australian Society of Medical Imaging and Radiation Therapy Response from Medical Radiation Practice Board	Rejected in full Under consideration Rejected in full
That FMIG [Future Medical Imaging Group] stock adrenaline auto-injectors (in addition to vials of adrenaline) as a means to enable the rapid administration of an accurate dose of adrenaline by the correct route.	Response from Future Medical Imaging Group (FMIG)	Accepted in full
That FMIG [Future Medical Imaging Group] revise their consent process to include a consent form for CTCA and other contrast procedures that is clearly identified as a consent	Response from Future Medical Imaging Group (FMIG)	Accepted in full

form requiring witnessing by an appropriate person (radiographer or radiologist) and which includes 153 specific reference to items in the RANZCR guideline including radiation risk and alternatives appropriate to their individual circumstances.		
That RANZCR [The Royal Australian and New Zealand College of Radiologists] update its standards regarding radiology practices to ensure: (a) That adrenaline auto-injectors (in addition to vials of adrenaline) are accessible in every room where contrast medium is injected as part of a diagnostic imaging procedure. (b) That policies and procedures for responding to inappropriate requests specify that the response must occur promptly after receipt of the request. (c) That the information required to be given to patients during consent procedures include alternatives which may be appropriate to their individual circumstances. (d) That all radiographers are trained in the recognition and management of anaphylaxis and severe contrast reactions. (e) That practice staff, including but not limited to radiographers, are trained and empowered to play an active role in emergency response, including raising issues with more senior staff when required. (f) That practices have	Response from Royal Australian and New Zealand College of Radiologists	Under consideration

onboarding systems for new radiologists which include an orientation with regard to the location of emergency equipment as well as an assurance of the recency of training with respect to recognition and management of severe contrast reactions and anaphylaxis. (g) That all rooms where contrast medium is administered are to have a contrast reaction treatment guideline prominently displayed.		
That the Diagnostic Imaging Accreditation Scheme (DIAS) Advisory Committee review the current DIAS Practice Accreditation Standards and propose revised standards, or means of applying the current standards, that ensure: (a) That adrenaline auto-injectors (in addition to vials of adrenaline) are accessible in every room where contrast medium is injected as part of a diagnostic imaging procedure. (b) That policies and procedures for responding to inappropriate requests, as required in Standard 2.1, specify that the response must occur promptly after receipt of the request. (c) That the information required to be given to patients under Standard 2.2 include alternatives which may be appropriate to their individual circumstances. (d) That Standard 2.4 requires that all radiographers are trained in the recognition and management of anaphylaxis	Response from Diagnostic Imaging Accreditation Scheme was expected by 22 February 2022	Overdue

and severe contrast reactions. (e) That Standard 2.4 requires that practice staff, including but not limited to radiographers, are trained and empowered to play an active role in emergency response, including raising issues with more senior staff when required. (f) That practices have onboarding systems for new radiologists which include an orientation with regard to the location of emergency equipment as well as an assurance of the recency of training with respect to recognition and management of severe contrast reactions and anaphylaxis. (g) That all rooms where contrast medium is administered are to have a contrast reaction treatment guideline prominently displayed. *Recommendations regarding private diagnostic imaging practices		
That RANZCR [The Royal Australian and New Zealand College of Radiologists] and the Diagnostic Imaging Accreditation Scheme Advisory Committee consult each other on the best distribution of efforts to achieve the aims in the previous two recommendations, and that they work together to develop a programme for communicating any changes to radiologists and diagnostic imaging practices.	Response from Royal Australian and New Zealand College of Radiologists	Under consideration
That FMIG [Future Medical Imaging Group] review their compliance with the DIAS [Diagnostic Imaging Accreditation Scheme] Practice	Response from Future Medical Imaging Group	Accepted in full

Accreditation Standards, in particular Standard 2.1.	(FMIG)	
That the Commonwealth Minister for Health undertake an audit of all Australian accredited diagnostic imaging practices regarding their compliance with DIAS Practice Accreditation Standard 2.1.	A response from the Commonwealth Minister for health was expected on 22 February 2022	Awaiting response
That the Commonwealth Minister for Health produce and promulgate standard forms for referrals to diagnostic imaging practices, ensuring that referrals include clinical information and effective contact information, and that the Minister consider whether measures should be taken to mandate the use of such forms.	A response from the Commonwealth Minister for health was expected on 22 February 2022	Awaiting response
That the Australian Competition and Consumer Commission consider whether enforcement action is appropriate against Priority Care Health Solutions, MRI Now or related corporate entities for unconscionable, misleading and/or deceptive conduct in their businesses which: (a) gave clients the impression that the business directly employs medical practitioners, when it does not; and (b) gave the impression to diagnostic imaging practices that a medical practitioner has reviewed a patient before requesting a scan, when they have not. *Recommendations regarding the workplace health industry	Response from ACCC was expected by 22 February 2022	Overdue
That the Royal Australian College of General Practitioners (RACGP) and the Australasian Faculty of Occupational & Environmental Medicine (AFOEM) of the Royal	Response from Royal Australian College of General Practitioners	Accepted in full

Australasian College of Physicians prepare a joint position statement on whether practitioners engaged in workplace health have different obligations to 'clients' or 'candidates', for whom they are undertaking a limited review of information, than they do toward their 'patients', as was suggested by Dr Saad.		
That the RACGP [Royal Australian College of General Practitioners] and the AFOEM [Australasian Faculty of Occupational & Environmental Medicine] prepare a joint position statement on the appropriateness of a practitioner authorising, or otherwise allowing, their signature to be used in referring individuals (whether 'patients', 'clients' or 'candidates') for tests when neither the patient, nor any information specific to the patient, has been reviewed.	Response from Royal Australian College of General Practitioners	Accepted in full
That Ambulance Victoria (AV) issue a practice advisory highlighting that adrenaline be administered as soon as practicable to patients who have acutely deteriorated within a short time of receiving radiological contrast at a radiology clinic.	Response from Ambulance Victoria	Accepted in full
That AV [Ambulance Victoria] issue a practice advisory highlighting the possibility of beta-blocking medication being present in a patient experiencing anaphylaxis to radiological contrast whilst undergoing cardiac CT, and that consideration should be given to administering glucagon in these circumstances if the patient is unresponsive to adrenaline.	Response from Ambulance Victoria	Accepted in full

Finding into death of Mr XH

Keywords: Anaesthetic care, airway management, endotracheal tube placement, hypoxic ischaemic brain injury, surgical complications

Recommendation	Response	Response outcome
I recommend that the Australian and New Zealand College of Anaesthetists consider the establishment of guidelines emphasising the use of End Tidal Carbon Dioxide in Endotracheal Tube placement.	Response from Australian and New Zealand College of Anaesthetists	Under consideration

Finding into death of Eileen Smith

Keywords: head injury, fall, hospital, elder care, fall prevention

Recommendation	Response	Response outcome
I recommend that Mildura Base Hospital provide further education to its nursing and allied health staff on the importance of adhering to patients falls management plans. Such education should be incorporated into its online and in-person orientation and education programs for nursing students.	Response from Mildura Base Hospital was expected by 30 February 2022	Overdue
I recommend that Mildura Base Hospital develop and implement a system to monitor, review and report on compliance with fall prevention practices within the hospital. Such a system may involve regular observational audits and provision of feedback to nursing and allied health staff to increase awareness and to identify areas for improvement in falls prevention practices.	Response from Mildura Base Hospital was expected by 30 February 2022	Overdue

Finding into death of John Flynn

Keywords: Emergency airway management, hypoxic ischaemic brain injury, pseudoaneurysm rupture and haemorrhage

Recommendation	Response	Response outcome
Melbourne Health consider whether this case constitutes a sentinel event and, if determined to be a sentinel event, make a report to Safer Care Victoria in accordance with its obligations.	Response from The Royal Melbourne Hospital	Accepted in full

Finding into death of Carlene Salveson

Keywords: inpatient death, electronic medical records (EMR), pulmonary embolism, deep vein thrombosis, acute renal failure, oncology

Recommendation	Response	Response outcome
In the interests of public health and safety and to prevent like deaths, I recommend that the Chief Digital Health Officer of Victoria coordinate with clinical and safety leaders in Victoria and nationally, including Safer Care Victoria, the Australian Commission on Safety and Quality in Health Care and Therapeutic Goods Administration, to review how Electronic Medical Records and Electronic Medication Management systems present and manage high risk medicines.	Response from Department of Health was expected by 1 February 2022	Overdue

Finding into death of Michael Anderson

Keywords: Anaesthetic care, dental procedure, complication dental root canal, cardiorespiratory arrest, borderline cardiomegaly

Recommendation	Response	Response outcome
With the aim of promoting public health and safety through addressing the increased risks to health by obesity, I recommend that the Australian and New Zealand College of Anaesthetists develop guidelines around the use of conscious sedation/anaesthesia, including but not necessarily limited to Propofol, in the dental practice setting on patients within WHO Class II and Class III obesity.	Response from Australian and New Zealand College of Anaesthetists	Under consideration
With the aim of promoting public health and safety through ongoing professional development of its members, I recommend that the Australian and New Zealand College of Anaesthetists use the circumstances surrounding the death of Michael Peter Anderson as an educational tool for emphasising the importance of documenting vital signs following the administration of anaesthetic.	Response from Australian and New Zealand College of Anaesthetists	Under consideration

Finding into death of Barry Brown

Keywords: Diagnostic error, laparoscopic cholecystectomy, internal haemorrhage, post-operative management, internal bleeding, post-surgical complications

Recommendation	Response	Response outcome
The Western Hospital: Provide specific periodic training to nursing staff reinforcing the significance of strict compliance with the 'escalation algorithm' first referred to in paragraph 58 above and the circumstances under which various 'codes' including 'code blue' ought to be 'called'.	Response from Western Health	Alternative adopted
The Western Hospital: To the extent that it is not currently explicitly part of Hospital procedure and protocols, explicitly include in relevant procedure and protocols the requirement that a surgeon who has operated on a patient be immediately notified if that patient experiences post-operative hypotension and that in such circumstances the surgeon (or a nominee) be required to go to the Hospital and assess the patient as soon as is possible.	Response from Western Health	Accepted in full
The Western Hospital: Formulate and promulgate written policy setting-out when 'on-call' physicians, consultant physicians, specialist physicians admitting physicians and otherwise relevant physicians, or other senior treating physicians, or all or any of a combination of them, are treating one patient they should; (i) Speak directly to each other, rather than managing a patient's treatment indirectly through more junior physicians, or remotely by technology. For example, if one or other of such medical specialists proposes treatment or a management plan with which	Response from Western Health	Accepted in full

another has reservations, or if the patient's condition precipitously changes and there is uncertainty about aetiology or treatment. (ii)Themselves go to the hospital and assess a patient.		
The Australian Medical Council include in the syllabus for training those who wish to practise as physicians (and to the extent that it is included highlight) explicit and detail material analysing 'confirmation bias', its nature, manifestation and potentially fatal effects.	Response from The Australian Medical Council	Rejected in full

Finding into death of Robena Lloyd

Keywords: intellectual and cognitive disability, mental illness, 24-hour home care, deteriorating health, urinary tract infection, enterococcus faecalis sepsis, acute renal failure

Recommendation	Response	Response outcome
I recommend the Secretary of the Victorian Department of Health gives consideration to formulate an action plan to mandate skills training for health professionals in the private and public health care sectors about the health needs of people with intellectual and other cognitive disabilities to address the lack of specific content around the health needs of people with intellectual disability in nursing and medical courses in this State, given Professor Troller's evidence at paragraph 256 that a recent audit revealed over 20 years there had been no improvement in content, and in some instances it had gone backwards.	Response from Department of Health	Under consideration
I recommend the Victorian Health Minister give consideration to the establishment of a 15- bed facility (possibly as part of the Victorian Dual Disability Service), for in-patient services for people with dual disabilities, including intellectually disabled adults like Robena, along the lines originally announced so that their medical needs can be addressed when they are ill.	The Minister for Health was expected to respond by 3 December 2021	Overdue

Finding into death of Christian Joy

Keywords: Aortic dissection, hemopericardium, missed diagnosis, emergency department, cardiac tamponade

Recommendation	Response	Response outcome
I recommend that St Vincent's Hospital expedites the implementation of the three major recommendations of the RCA.	Response from St Vincent's Hospital (Melbourne)	Accepted in full
I recommend that St Vincent's Hospital implement a change in imaging reporting so that the indication or clinical notes on an imaging request are included on the formal report so that the reviewing doctor (who may not be the requesting doctor) can correlate the relevance of the request to the findings in the report.	Response from St Vincent's Hospital (Melbourne)	Accepted in part
I recommend that St Vincent's Hospital review their triage processes regarding patients with recurrent symptoms or concerns returning to the ED on the advice of ED clinicians following a recent admission, particularly with significant symptoms such as chest pain. Such a recommendation could include that a doctor review the patient's previous notes and results and speak to the patient prior to the patient leaving.	Response from St Vincent's Hospital (Melbourne)	Rejected in full
I recommend that St Vincent's Hospital undertake open disclosure with Mr Joy's family in accordance with the Australian Open Disclosure Framework.	Response from St Vincent's Hospital (Melbourne)	Under consideration

Finding into death of PT

Keywords: Haemopericardium complicating aortic dissection, untreated hypertension, aortic dissection

Recommendation	Response	Response outcome
That Safer Care Victoria promote a wider awareness of the risk factors, presentations and the limitations of clinical signs in ruling out aortic dissection.	Response from Safer Care Victoria	Accepted in full
That the Australasian College of Emergency Medicine promote a wider awareness of the risk factors, presentations and the limitations of clinical signs in ruling out aortic dissection.	Response from Australasian College for Emergency Medicine	Under consideration

Finding into death of Phillip Sealey

Keywords: Diabetic ketoacidosis, coronary atherosclerosis, cardiomegaly, missed diagnosis

Recommendation	Response	Response outcome
I recommend that the Royal Australian College of General Practitioners liaise with the Australian Diabetes Society with a view to identifying further opportunities to educate and raise awareness amongst primary care providers about: a. hyperglycaemia emergencies occurring as the first presentation of undiagnosed diabetes; b. identifying and recognising signs and symptoms of an emerging metabolic crises, particularly in patients not known to have diabetes; c. undertaking urgent point-of-care assessment using preferred methods of capillary (finger prick) blood glucose level and capillary blood ketones tests where there are symptoms suggestive of diabetes and/or an emerging metabolic crises; d. adopting best practice standards of care and ensuring they have access to capillary blood glucose and ketone monitoring meters and strips to undertake urgent point-of care assessment; and e. providing education to patients who are under investigation for or suspected to have diabetes (and their families or carers), about the risk factors, signs and symptoms of glycaemic emergencies and the need to obtain urgent medical assessment and management if such symptoms develop.	The Royal Australian College of General Practitioners was expected to respond by 31 November 2021	Overdue

Finding into death of Ian Gould

Keywords: Creutzfeldt-Jakob disease, fall, head injury, bilateral occipital haemorrhage, anticoagulation

Recommendation	Response	Response outcome
I recommend that Ballarat Health Services review their policies relating to the management of head injuries in anticoagulated patients with reference to the comparators footnoted above.	Response from Ballarat Health Services	Accepted in full

Finding into death of Melanie Doherty

Keywords: medication reconciliation, hypoxic brain injury, mixed drug toxicity

Recommendation	Response	Response outcome
Queen Elizabeth Centre review the current processes and clinical staff training for recording and managing medications for residential program participants, that includes best practice best possible medication history steps, medication reconciliation processes and clinical staff responsibilities.	Response from Queen Elizabeth Centre	Accepted in full
In circumstances where a parent needs to stay with their baby at Eastern Health, prior to the baby's discharge, and Eastern Health is aware that the parent has medication requirements, Eastern Health will offer admission to the parent. As a consequence, the parent's assessment and care plan, including medication management as appropriate, will be managed and documented consistently with Eastern Health practices. Should the parent decline admission, they will be unable to stay overnight at Eastern Health.	Response from Eastern Health	Accepted in full

Finding into death of Eoghan Arnold

Keywords: Hypoxic ischaemic brain injury, cardiac arrest, pulmonary embolism, DVT, anticoagulant medication, motor vehicle accident

Recommendation	Response	Response outcome
I recommend Safer Care Victoria develop an evidence-based guideline for venous thromboembolism prophylaxis consistent with the Queensland Health guideline. The guideline could be incorporated into a local standard care pathway to ensure that appropriate consideration of venous thromboembolism prophylaxis is given to all patients according to their level of risk.	Response from Safer Care Victoria	Accepted in full

Finding into death of Pamela Pattison

Keywords: Haemopericardium, dissection of the ascending aorta

Recommendation	Response	Response outcome
That the Royal Australian College of General Practitioners consider highlighting to its Trainees, Fellows and Members the importance of considering the diagnosis of aortic dissection for patients presenting in general practice with chest pain and the nuanced presentations of aortic dissection, particularly in circumstances where ischaemic heart disease has been excluded.	Response from the Royal Australian College of General Practitioners	Accepted in full

Finding into death of Josephine Helen Clarke

Keywords: subdural haemorrhage, fall, inpatient rehabilitation

Recommendation	Response	Response outcome
Monash Health review its falls related guidelines and other supporting documents to clarify ambiguous terms or instructions including, but not limited to, 'constant supervision' and 'N/A'	Response from Monash Health Attachment 2 - Preventing Falls and harm from falls Attachment 3 - Delirium and Dementia Attachment 4 - Medical Falls risk assessment	Accepted in full
Monash Health review its falls related guidelines and other supporting documents so that a patient's cognitive issues are more clearly identified and documented in order to inform the individual risk mitigation and intervention strategies to be put in place	Response from Monash Health Attachment 2 - Preventing Falls and harm from falls Attachment 3 - Delirium and Dementia Attachment 4 - Medical Falls risk assessment	Accepted in full
Monash Health review how the application and implementation of falls prevention mitigation and intervention strategies are recorded for individual patients with a view to providing consistent care	Response from Monash Health Attachment 2 - Preventing Falls and harm from falls Attachment 3 - Delirium and Dementia Attachment 4 - Medical Falls risk assessment	Accepted in full
Monash Health review how consumers	Response from	Accepted in full

and their families are informed of falls prevention mitigation strategies and interventions with a view to reducing ambiguity	Monash Health Attachment 2 - Preventing Falls and harm from falls Attachment 3 - Delirium and Dementia Attachment 4 - Medical Falls risk assessment	

Finding into death of Robert Gerard Dimattina

Keywords: aspiration pneumonia, surgical procedure, colorectal surgery, NGT insertion

Recommendation	Response	Response outcome
That the Royal Australian College of Surgeons (RACS) use a de-identified version of this case as an educative tool to remind its members of the uncommon and unexpected severe risks associated with NGT insertion.	Royal Australian College of Surgeons was expected to respond by 5 May 2021.	Overdue

Finding into death of Ian Fraser

Keywords: retroperitoneal haemorrhage, anticoagulants, congestive heart failure, useability of electronic medical records

Recommendation	Response	Response outcome
1(a) I recommend the Therapeutic Goods Association consider: Reassigning the risk-level assigned to EMRs (specifically, the electronic prescribing component) to a risk level that requires assessment of and compliance with a usability standard. These standards should be developed in conjunction with key stakeholders (for example, the Australian Commission of Safety and Quality in Health, state government health departments, safety departments, and state government digital health officers, and relevant overseas agencies) (b) I recommend the Therapeutic Goods Association consider: developing pathways for users to report adverse events involving software as a medical device (including but not limited to electronic medical records) similar to the publicly accessible pathways that already exist for medical devices, medicines and vaccines c) I recommend the Therapeutic Goods Association consider assessing the EMR vendor improvements in response to incidents for usability and shared with other health services (d) I recommend the Therapeutic Goods Association consider developing promotional material for this pathway similar to those that already exist for medical devices, medicines and vaccines.	Response from the Australian Commission of Safety and Quality in Health Care Response from Therapeutic Goods Administration	Accepted in full Accepted in part
2. I also recommend that Safer Care Victoria promote the Therapeutic Goods Association's reporting pathway to both health-service safety departments and clinicians.	Response from Safer Care Victoria Further response from Safer Care	Accepted in full

	Victoria	

Finding into death of Carl David Waldon

Keywords: medical, hospital, intracerebral haemorrhage

Recommendation	Response	Response outcome
In the interests of public health and safety and preventing like deaths, I recommend that the Monash Clinical Council supports the proposed Hospital-wide anticoagulant stewardship program.	Response from Monash Health	Accepted in full

Finding into death of Mrs L

Keywords: neutropenic sepsis, multiple organ failure, chemotherapy, capecitabine toxicity, availability of antidote

Recommendation	Response	Response outcome
That the Peter MacCallum Cancer Centre and the Medical Oncology Group of Australia make a submission to the Medical Services Advisory Committee to consider the feasibility of finding DPYD testing for all patients prior to commencement of fluoropyrimidines in Australia and to determine the support required to implement a DPYD testing program to remove the major barrier of cost to testing and provide oncologists and patients the choice to undertake DPYD testing when clinically indicated.	Response from Peter MacCallum Cancer Centre Response from Medical Oncology Group of Australia Incorporated	Under consideration Rejected in full

Finding into death of Valerie Fraser

Keywords: palliative care

Recommendation	Response	Response outcome
The Australian Commission on Safety and Quality in Health Care and Safer Care Victoria consider the need for a body external to health organisations to conduct periodic audits within the three-year assessment windows for ongoing compliance with the National Safety and Quality Health Service Standards.	Response from Australian Commission on Safety and Quality in Health Care	Accepted in part

Finding into death of Nicola Deleo

Keywords: surgical complications, surgery, medical, hospital, allergy, anaphylaxis

Recommendation	Response	Response outcome
Austin Health consider amending their 'Austin Health 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 GP clinic patient summaries are imported.	Response from Austin Health	Accepted in full

Transport and Road Safety

Finding into death of Max Loweke

Keywords: flood waters, driving through flood waters, drowning, road safety, road subject to flooding, flooding, road signage, flooded ford, emergency procedures

Recommendation	Response	Response outcome
(a) Victoria Police and Victoria State Emergency Services consider augmenting emergency management training to provide that when an emergency ("The Emergency") is being managed by the provisions of the Emergency Management Act ("the Act") and The Emergency Management Manual ("the Manual") that all organisations and personnel involved be explicitly informed that The Emergency is being managed pursuant to the Acts and The Manual and of: i. Which Organisation is the Control Agency. ii. The names of those appointed to or adopting defined roles for the purposes of managing the Emergency such as the Incident Controller (or in the case of Victoria Police the Police Commander and Police Forward Commander), Incident Emergency Response Team, Incident Emergency Response Coordinator, Municipal Emergency Response Coordinator, the Municipal Emergency Response Officer, etc. iii. At meetings conducted within and across organisations involving those referred to in ii above the meetings be explicitly	Response from Victoria Police is expected by 27 May 2022	Awaiting response

declared as Emergency Management Team Meetings, minuted and that such minutes list the names of people appointed to or adopting the defined roles referred to in ii above.		
(b) Those employees of emergency services who may adopt the role of Incident Controllers, and in the case of Victoria Police those who may fulfil the role of Police Commander and Police Forward Commander undergo formal risk assessment training.	Response from Victoria Police is expected by 27 May 2022	Awaiting response
(c) Victoria Police and Victoria SES and other relevant parties engage in regular practical exercises – mock emergencies, conducted in a realistic fashion and including in regional areas rehearsing the implementation and use of the EMMV management structure in the circumstances of various forms of emergencies.	Response from Victoria Police is expected by 27 May 2022 Response from Victoria State Emergency Services (ESTA) Response from Victoria SES is expected by 27 May 2022	Awaiting response Accepted in full Awaiting response

Finding into death of Arzu Karakoc

Keywords: Cyclist, heavy vehicle safety, driver distraction, collision

Recommendation	Response	Response outcome
I recommend to the Secretary, Department of Transport (Victoria) that consideration be given to the Federation trail being re-directed away from Whitehall Road as a temporary measure until the completion of the crossover bridge.	Response from Department of Transport	Rejected in full
I recommend that Secretary, Department of Transport (Victoria) review the risk and therefore appropriateness of the two sets of electronic messaging systems at the intersection of Whitehall Street and Somerville Road, which apply to pedestrians/people riding bikes and other traffic, given that if both are simultaneously green, the risk for accidents is increased.	Response from Department of Transport	Accepted in full
I recommend that the Secretary, Department of Infrastructure, Transport, Regional Development and Communications (Commonwealth) adopt appropriate vehicle standards to mandate side underrun protection among commercial heavy vehicles in Australia to reduce the incidence of road trauma resulting from side underrun events.	Response from Department of Infrastructure, Transport, Regional Development and Communications **and** Attachment A to response **and** Attachment B to response	Accepted in full
I recommend that the Secretary, Department of Infrastructure, Transport, Regional Development and Communications (Commonwealth) recommend heavy vehicle standards for blind spot technology and for the retro fitting of indirect vision devices and blind spot information systems, such as class 5 mirrors and reversing blind spot cameras.	Response from Department of Infrastructure, Transport, Regional Development and Communications **and** Attachment A to response **and** Attachment B	Accepted in full

	to response	
I recommend to the Secretary, Department of Infrastructure, Transport, Regional Development and Communications (Commonwealth), the Secretary, Department of Transport (Victoria), and the Minister for Local Government (Victoria) that they recommend and pursue changes in government tender processes so that all levels of government prescribe preference in tender specifications for contracts for those transport and logistics companies whose heavy vehicle fleet comply with safety improvements in blind spot technology such as class 5 mirrors and reversing blind spot cameras either directly or through schemes such as CLOCS-A.	Response from Department of Transport Response from Department of Infrastructure, Transport, Regional Development and Communications **and** Attachment A to response **and** Attachment B to response Response from Minister for Local Government (Victoria) was expected by 3 February	Accepted in full Under consideration Overdue
With a view to further increase the safety of commercial heavy vehicles, I recommend that the Secretary, Department of Infrastructure, Transport, Regional Development and Communications (Commonwealth) consider adopting a direct vision standard for trucks such as the London Direct Vision Standard.	Response from Department of Infrastructure, Transport, Regional Development and Communications **and** Attachment A to response **and** Attachment B to response	Under consideration
I recommend that Secretary, Department of Transport (Victoria) mandate vulnerable road user awareness training in driver licensing programs for heavy vehicles. I note two such relevant programs already exist, Sharing Roads Safely program run by the Amy Gillett Foundation and the Driver Delivery program, an initiative of the Victorian Transport Association.	Response from Department of Transport	Alternative adopted

I recommend that Secretary, Department of Transport (Victoria) encourage and support driver behaviour change programs by way of a public campaign to increase heavy vehicle driver awareness to look for bike riders.	Response from Department of Transport	Alternative adopted
I recommend the Secretary, Department of Transport (Victoria) enacts a rule or regulation prohibiting the placement of any stickers or advertising material on door or window glass panels on heavy vehicles which inhibit visibility. I recommend the Secretary, Department of Transport (Victoria) enacts a rule or regulation prohibiting the placement of any stickers or advertising material on door or window glass panels on heavy vehicles which inhibit visibility.	Response from Department of Transport	Accepted in part

Finding into death of Fangzhou Shi

Keywords: head injury, tram, pedestrian, vision impairment

Recommendation	Response	Response outcome
That the Department of Transport conduct a safety review and audit of the Burwood Highway tram tracks in the vicinity of Milford Avenue. The review should: a. consider the feasibility of erecting safety barriers and/or warnings along the sides of the tram tracks to discourage patients from crossing the highway between designated areas; and b. consider the risks posed by planting along the sides of the tram tracks for tram driver visibility, and develop and implement strategies to ensure visibility for tram drivers is not impeded by the growth of bushes planted alongside the tram tracks. Such strategies might include: i. implementing a schedule for regular maintenance checks to ensure the planting is trimmed back as necessary; or ii. replacing tall bushes with planting that is unlikely to grow to heights that may impede visibility	Response from Department of Transport	Under consideration

Finding into death of Robert John Woolcock

Keywords: blunt chest trauma, motor vehicle incident, collision

Recommendation	Response	Response outcome
With the aim of promoting public health and safety and preventing like deaths, I recommend that MRCC [Mildura Rural City Council] continue to examine the traffic patterns and monitor traffic count data at the intersection of Etiwanda Avenue and Seventeenth Street in Mildura to determine whether the intersection is a location that could be considered under the Black Spot Program as a site that has a recurrent problem.	Response from Mildura Rural City Council	Accepted in full

Finding into death of Ingeburg Muller

Keywords: motor vehicle collision, multiple injuries, staphylococcus bacteraemia, elderly driver, fitness to drive, vision impairment

Recommendation	Response	Response outcome
With the aim of promoting public health and safety and preventing like deaths, I recommend that Boroondara City Council continue review the design and layout of the three-way intersection of High Street and Marquis Street in light of the circumstances of this collision and consider improve the existing infrastructures.	Response from Boroondara City Council	Accepted in full
With the aim of promoting public health and safety and preventing like deaths, I recommend that Boroondara City Council replace the existing advisory speed limit sign of 40 kilometres per hour between the hours of 7.00am to 7.00pm along the northbound lane of Marquis Street to a warning sign of 'Raised Intersection' with advisory speed limit of 40 kilometres per hour.	Response from Boroondara City Council	Alternate adopted

Finding into death of Eden Herbert-Allan

Keywords: motor vehicle incident, head injuries, tree collapse

Recommendation	Response	Response outcome
With the aim of promoting public health and safety and prevent like deaths, I recommend that VicRoads consider coordinate with Yarra Range Shire Council in establishing a database system that captures, analyses and stores condition data for roadside hazards as part of its strategy for achieving its roadside management objectives.	Response from Department of Transport Response from Yarra Range Shire Council	Rejected in full Accepted in part
With the aim of promoting public health and safety and prevent like deaths, I recommend that Yarra Range Shire Council review its Nature Strips and Roadside Guidelines and include the responsibility to provide suitable safety precautions after any work of excavations done on the nature strips.	Response from Department of Transport Response from Yarra Range Shire Council	Accepted in part Under consideration

Finding into death of Raymond Thomas

Keywords: Police pursuit, Aboriginal and Torres Strait Islander passing, motor vehicle

Recommendation	Response	Response outcome
I make the following recommendations pursuant to section 72(2) of the Act: a) That the Pursuits Policy mandate that the following requirement must be satisfied before commencing a pursuit: A serious risk to health or safety of a person must exist before the decision to intercept, that is before police involvement. b) Training must ensure there is no scope for interpretation of the above. That the policy means what it says. c) Policy must require neither UDD nor pursuit be conducted unless police are always aware of their speeds. d) In every pursuit, irrespective of outcome, policy require members to record for review, the serious risk which existed before the decision to intercept, that is before police involvement.	Response from the Chief Commissioner of Police	Accepted in part

Finding into death of Kyle Shepherd

Keywords: Motor vehicle incident, pedestrian, shared roads, rural roads

Recommendation	Response	Response outcome
1. With the aim of reducing pedestrian fatalities through education focussing on the safe use of shared roads in rural areas, I recommend that the Department of Transport and Transport Accident Commission work with other relevant state government departments and agencies to specifically develop education campaigns directed at pedestrians in rural areas.	Response from Department of Transport Response from Transport Accident Commission	Accepted in full Accepted in full
2. With the same aim, I recommend that the City of Greater Bendigo consider developing and implementing a local education campaign directed at pedestrians in its catchment area.	Response from City of Greater Bendigo	Accepted in full

Finding into the death of Scott Adams

Keywords: motor vehicle collision, motorised bicycle

Recommendation	Response	Response outcome
VicRoads, The Transport Accident Commission, The Vehicle Safety Standards Bureau, Victoria Police, Bicycle Industries Australia, consider the circumstances in which Scott Adams died as set out in this Finding and individually and together assess the adequacy of the current regulation of the motorisation of bicycles and their use including the ready availability of conversion kits taking into account the actual power provided by such kits vis-à-vis any purported power they provide with a view to improving public safety and the safety of people riding such bicycles.	Response from Victoria Police	Under consideration
	Response from Department of Infrastructure	Under consideration
	Response from Department of Transport	Accepted in full
	Bicycle industries Australia was expected to respond by 2 June 2021	Overdue
	Response from Transport Accident Commission	Accepted in part

Finding into death of Walentyna Huczyk

Keywords: motor vehicle collision, mobility scooter, motorised scooter

Recommendation	Response	Response outcome
I recommend that the Victorian Department of Transport implement a targeted public awareness campaign to highlight the risks associated with motorised mobility scooters as a potential traffic hazard.	Response from the Department of Transport	Alternative adopted

Finding into death of Jason Gilham
Finding into death of Bradley Dobney

Keywords: transport and road safety, barriers, water hazards

Recommendation	Response	Response outcome
Using the risk-based 'safe system approach', the Department of Transport should conduct a review of Victorian roads in the vicinity of 'bodies of water', to identify and consider whether safety barriers should be installed or extended to protect against potential water hazards.	Response from Department of Transport	Alternative adopted

Finding into death of Joshua Luke Ackaoui

Keywords: traumatic haemothorax, motorcycle collision, motor vehicle collision, transport, road safety

Recommendation	Response	Response outcome
In the interest of promoting public safety and preventing like deaths, pending the duplication of Hallam Road, I recommend that VicRoads and the Casey City Council review the circumstances of Mr Ackaoui's death and consider the need for interim remediation of road infrastructure in the vicinity of the collision by: (i) facilitating right turns from Centre Road onto Hallam Road whether by the installation of traffic controls signals or otherwise; or	Response from Casey City Council Response from Department of Transport	Under consideration Under consideration
(ii) converting the broken white dividing line to a single unbroken white line, thus prohibiting U-turns altogether; or	Response from Casey City Council Response from Department of Transport	Accepted in full Accepted in full
(iii) by signage or other means, encouraging drivers intending to turn right from Centre Road onto Hallam Road, to use existing traffic-signal controlled intersections such as the intersection of Hallam Road and Pound Road, to safety negotiate a route north.	Response from Casey City Council Response from Department of Transport	Under consideration Under consideration

Finding into death of Cameron Andrew MacLellan

Keywords: motorcycle, motor vehicle collision, mental health, elderly driver, methylamphetamine

Recommendation	Response	Response outcome
With the aim of promoting public health and safety, I repeat my recommendation 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.	Response from Department of Transport	Under consideration

Finding into the death of Mr R

Keywords: motor vehicle incident, unsecured load

Recommendation	Response	Response outcome
That the Indigo Shire Council consider installing advisory speed sign(s) at an appropriate location at the bend near the intersection of Sandy Creek Road and Reserve Road, Sandy Creek, recommending a maximum speed limit of 80 km/h	Indigo Shire Council was expected to respond by 19 May 2021.	Overdue

Finding into death of Norman MacKenzie

Keywords: pedestrian, had injury, struck by cyclist, road safety, infrastructure

Recommendation	Response	Response outcome
I recommend that submissions from Bicycle Network and Victoria Walks be provided to VicRoads for their consideration when planning road and bicycle lane construction in Melbourne and in particular on Jacka Boulevard, St Kilda.	Response from VicRoads	Accepted in part

Finding into death of AC

Keywords: motor vehicle collision, road safety, speed limit

Recommendation	Response	Response outcome
That VicRoads consider reducing the speed limit on the unsealed section of Kulkyne Way, Colignan, approaching Hattah National Park, to 80 kilometres per hour.	Response from Department of Transport	Alternative adopted

Drowning

Finding into death of Ehren Hyde

Keywords: drowning, sailing accident, recreational activities

Recommendation	Response	Response outcome
I recommend that Transport Safety Victoria engage with Victorian sailing and yacht clubs to promote the 'Prepare to Survive: Know The Five' campaign and encourage boaters or paddlers to enact the five steps, particularly when boating or paddling alone. Such a campaign may be multimodal, utilising where possible, social media, flyers or posters at sailing or yacht clubs, and articles or advertisements in sailing club newsletters.	Response from Transport Safety Victoria	Alternative adopted
I recommend that Transport Safety Victoria liaise with the Department of Economic Development, Jobs, Transport and Resources to explore the possibility and feasibility of legislative amendment to require EPIRBs or PLBs to be carried by the operators of recreational vessels (regardless of the classification of waterway or distance offshore) in high risk situations, including when operating alone.	Response from Transport Safety Victoria	Accepted in full

Finding into death of Mr L

Keywords: drowning, recreation, tourist

Recommendation	Response	Response outcome
That the OCC 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.	Response from Great Ocean Road Coast and Parks Authority	Under consideration
That these measures should be re-assessed at appropriate intervals to ensure that they remain best practice and in line with relevant standards.	Response from Great Ocean Road Coast and Parks Authority	Under consideration
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.	Response from Great Ocean Road Coast and Parks Authority	Rejected in full

Finding into death of Amanda Bourke

Keywords: drowning, beach safety, rough surf, alcohol, methylamphetamine

Recommendation	Response	Response outcome
In order to prevent further instances where the response of emergency services is delayed due to confusion or unawareness of the correct emergency location, I recommend Parks Victoria review the warning signs along the Belfast Coastal Reserve to ensure unique emergency marker codes are included where appropriate.	Response from Parks Victoria	Accepted in full

Recreational Activities

Finding into death of Allan McFarlane

Keywords: cardiac arrest, near drowning, boating accident

Recommendation	Response	Response outcome
For a number of years this Court has made recommendations with regard to prevention opportunities in boating related incidents. Most recently, after the death of Graham Hill, Coroner Michelle Hodgson recommended " ... that Transport Safety Victoria consider introducing requirements that all boats be fitted with a_ manual or electrical pumping mechanism to all bilge areas ... ". I support Coroner Hodgson's recommendation and add that I concur with the Water Police Squad's advocation for all boats fitted with electrical bilge pumps in enclosed bilge areas to have automated switches or floats, or alarms if a manual bilge exists.	Response from Transport Safety Victoria	Under consideration
Since 2010, the Water Police Squad has consistently campaigned for 'seaworthy' inspections at the time of registration and acquisition or transfer of vessel ownership. The absence of a vessel inspection process to Victoria tragically means that old and/or modified vessels are usually only detected as unsafe or unsuitable post incident. My fellow coroners have enduringly supported the implementation of such a system; however, one is yet to be developed. For this reason, I encourage Transport Safety Victoria to explore the possibility of implementing a system of vessel inspections, akin to roadworthy inspections, to improve marine safety.	Response from Transport Safety Victoria	Under consideration

Furthermore, I recommend that as part of seaworthy inspections, builders plates are retrospectively attached which determine the number of people, the conditions for which the vessel is suited and the maximum engine capacity of the vessel.	Response from Transport Safety Victoria	Under consideration

Child/infant deaths

Finding into death of ANG

Keywords: Child, recreational boating, water safety, drowning

Recommendation	Response	Response outcome
Maritime Safety Victoria consider advising boat users of the possible consequences of not being in a fully seated position on a vessel, particularly in a bow rider, in any pamphlets or similar that are provided to registered boat users.	Response from Transport Victoria Maritime Safety Branch	Accepted in full
Maritime Safety Victoria consider reinforcing boat users to practice man overboard procedures and, in particular, the requirement to stop engines, where appropriate to prevent injury, in any pamphlets or similar that are provided to registered boat users.	Response from Transport Victoria Maritime Safety Branch	Accepted in full

Finding into death of Baby A

Keywords: hypoxic brain injury, methylamphetamine, physical trauma

Recommendation	Response	Response outcome
To the Secretary, Department of Health I recommend that consideration be given to establishing positions similar to the initiative at the Child Protection Divisional Office at Footscray of a Royal Children's Hospital Clinical Nurse Coordinator, in each Divisional Child Protection Office linked to the local hospital or major health service	Response from Department of Health	Under consideration
To the Secretary, Department of Families, Fairness and Housing I recommend that consideration be given to the placement of a senior state-wide child protection officer at the Royal Children's Hospital to enhance information sharing and collaborative risk assessment and management.	Response from Department of Families, Fairness and Housing	Accepted in part
To the Secretary, Department of Education and Training I recommend in the interests of enhancing information sharing and collaborative risk assessment and management, that consideration be given to including public hospitals in the group of agencies authorised to use the Child Link database when it becomes operational December 2021	Response from Department of Education and Training	Under consideration

Finding into death of Baby MNL

Keywords: Obstetric care, prolonged labour, neonatal death, hypoxic ischaemic encephalopathy, peri-partum asphyxia

Recommendation	Response	Response outcome
I recommend Werribee Mercy Hospital amend relevant guidelines to require a partogram to be completed for each labour and birth.	Response from Werribee Mercy Hospital	Accepted in full

Finding into death of D2

Keywords: Homicide, child, family violence, neglect, drug dependence, mental health, non-compliance with policies and procedures, inadequate services

Recommendation	Response	Response outcome
Given the ongoing challenges faced by both ACSASS and Child Protection in complying with the Protocol, I recommend that the Department of Families, Fairness and Housing (DFFH) review the current case management systems to ensure that compliance with the Protocol between the Department of Human Services Child Protection Services and the Victorian Aboriginal Child Care Agency can be accurately recorded, reported and reviewed.	Response from Department of Families, Fairness and Housing	Accepted in full
I also recommend that DFFH regularly audit staff compliance with the obligations of the above protocol to ensure that mandated objectives are being met and any concerns identified in specific catchments areas can be addressed in a timely manner.	Response from Department of Families, Fairness and Housing	Accepted in full
I recommend that the Victorian Government, in line with their commitment to the Wungurilwil Gapgapduir: Aboriginal Children and Families Agreement and Strategic Action Plan, review current funding provisions for Victorian ACSASS [Aboriginal Child Specialist Advice and Support Service] programs and ensure that adequate resourcing is provided to meet current and projected demand.	Response from Department of Families, Fairness and Housing Response from Victorian Government	Accepted in full

Finding into death of MRE

Keywords: Traumatic head injuries, worksite, agricultural machinery, workplace

Recommendation	Response	Response outcome
WorkSafe Victoria and the Transport Accident Commission, in consultation with the Victorian Farmers' Federation and Kidsafe Victoria, consider engaging farming families and/or conducting a public awareness campaign aimed at farming families highlighting the risks of allowing children to operate farm machinery and/or drive vehicles such as tractors and incorporating how to keep children safe on farms.	Response from Victorian Farmers Federation Response from WorkSafe Victoria Response from Kidsafe Victoria Response from Transport Accident Commission	Accepted in full Accepted in full Under consideration Accepted in full

Finding into death of Jordan White

Keywords: hypoxic ischaemic encephalopathy, neck compression, infant, equipment fault

Recommendation	Response	Response outcome
The Victorian Department of Health and Human Services and Kidsafe Victoria, together develop and implement a strategy to increase public awareness of the potentially fatal dangers of parents using faulty or damaged 'baby care equipment' such as portacots with a view to reducing, if not eradicating accidental deaths such as that of Baby Jordan caused by such use.	Response from Kidsafe Victoria Response from Consultative Council on Obstetric and Paediatric Mortality and Morbidity Response from Department of Health Safe Sleeping Checklist produced by Red Nose (appendix 1 to Department of Health response) Infant Safe Sleeping – Clinical Guidance (appendix 2 to Department of Health response)	Under consideration Accepted in full Accepted in full

Finding into death of Seth James Haddow

Keywords: motor vehicle incident, head injury, child

Recommendation	Response	Response outcome
The Victorian Department of Health and Human Services, Kidsafe Victoria, the Transport Accident Commission and the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (the Organisations) together consider the circumstances of Seth Haddow' s death and undertake research to identify the factors that contributed to it and to like deaths between 2015 and 2019.	Response from Kidsafe Victoria Response from Department of Health Response from Consultative Council on Obstetric and Paediatric Mortality and Morbidity Response from Transport Accident Commission	Under consideration Under consideration Under consideration Accepted in full
That the Organisations together develop a strategy aimed at reducing, if not eradicating such deaths and increase the public awareness of the identified factors, their associated dangers and developed strategies.	Response from Kidsafe Victoria Response from Department of Health Response from Consultative Council on Obstetric and Paediatric Mortality and Morbidity Response from Transport Accident Commission	Under consideration Under consideration Under consideration Accepted in full

Finding into death of Catherin D'Rozario

Keywords: acute asthma, allergic response, anaphylaxis

Recommendation	Response	Response outcome
That, in order to reduce the risk of harm associated with food allergies and anaphylaxis that the Royal Australian College of General Practitioners, the Royal College of Physicians and in consultation with the Australian Society of Clinical Immunology and Allergy work collaboratively towards educating their members and fellows of the dangers and that they consider referring all patients (especially children and young persons) who present with food allergies to a specialist immunologist or immunology clinic such as that at the Royal Children's Hospital for assessment and management of such allergies.	Response from the Royal Australian College of General Practitioners Response from the Royal Australasian College of Physicians Response from Australasian Society of Clinical Immunology and Allergy	Under consideration Accepted in full Accepted in full
That the Australian Society of Clinical Immunology and Allergy, the Victoria Department of Education and the Victorian Department of Health consult widely and work collaboratively towards establishing an educational program directed to parents, teacher and students of school and universities alerting them to the potentially fatal consequences of food allergies and anaphylaxis.	Response from the Royal Australian College of General Practitioners Response from the Royal Australasian College of Physicians Response from Australasian Society of Clinical Immunology and Allergy	Under consideration Under consideration Accepted in full

Finding into death Infant A

Keywords: blind cords, infant, Consumer Affairs Victoria, hypoxic ischaemic encephalopathy

Recommendation	Response	Response outcome
I make the following recommendations: a) Since 2010, it is apparent that the initiation of the Consumer Affairs Victoria blind cord safety campaign has been beneficial. However, in the period 2019-20, following three years of no accidental deaths relating to curtain and blind cords, four infants have died in these tragic circumstances. b) It is paramount that public safety authorities continue to provide ongoing information and warning campaigns to inform those with young children and their family and friends of the risks associated with curtain and blind cords and the need for vigilance in relation to installation and maintenance. c) I acknowledge and commend Consumer Affairs Victoria for the initiatives undertaken in the past decade, and urge that they continue their campaign of curtain and blind cord product safety; publicising this risk on all media platforms by distributing information regularly to the entities already targeted. d) Further, I encourage Consumer Affairs Victoria to increase promotion of their blind cord safety kits.	Response from Department of Justice and Community Safety	Accepted in full

Finding into death of Baby M

Keywords: drowning, infant death, pool fence, safety

Recommendation	Response	Response outcome
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: (a) that certain grades of materials be used in spring-based self-closing hinges; or (b) that self-closing gate hinges employ a prescribed class of mechanisms.	Response from Standards Australia	Under consideration

Finding into death of Baby C

Keywords: myocarditis, viral infection, emergency department, triage

Recommendation	Response	Response outcome
I recommend that Sunshine Hospital implement a policy to ensure all patients who present to the Paediatric Emergency Department have a full triage assessment performed as per the standards set out by the ETEK guide by a triage nurse. Such an assessment should include obtaining a brief history of presenting complaint and a complete set of vital signs observations taken, which comprises of heart rate, respiratory rate, temperature, blood oxygen level, and blood pressure measurements. If an initial attempt to obtain a complete triage assessment is unsuccessful, triage staff should be required to attempt to obtain the remainder measurements while the patient is in the waiting room within an appropriate timeframe, which can be determined by the Emergency Department staff at Sunshine Hospital.	Response from Western Health	Accepted in full

Home maintenance

Finding into death of Cheryl Taylor; Finding into the death of Sarah Michelle Kajoba

Keywords: Balcony collapse, deck, building standards, inadequate supports, residential maintenance

Recommendation	Response	Response outcome
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.	Response from the Victorian Building Authority	Accepted in full
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.	Response from the Victorian Building Authority	Accepted in full
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.	Response from the Victorian Building Authority	Rejected in full
That the Victorian Building Authority considers developing a system for: (a) the certification of newly constructed balconies as to their maximum distributed load capacity;	Response from the Victorian Building Authority	Rejected in full

and (b) 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.		

Finding into death of JM

Keywords: Rollover, ride-on lawnmower, steep incline, mechanical asphyxia, seatbelt

Recommendation	Response	Response outcome
That Product Safety Australia issue an updated product safety alert of ride-on lawnmowers. The alert could consider reiterating advice to riders to wear a seatbelt if there is a rollover protection system, not to mow on steep angles nor travel downhill with the gearbox in neutral.	Response from Australian Competition & Consumer Commission	Accepted in full

Homicide

Finding into death of Barry Gray

Keywords: homicide, psychosis, community corrections

Recommendation	Response	Response outcome
To the Department of Justice and Community Safety, I recommend: That Justice Health give consideration to the creation of a concise discharge summary, to include diagnoses, medications and treatment plans, which can be generated from a prisoner's health records, similar to a patient summary electronically generated by GPs from a patient's medical record (discharge summary).	Response from the Department of Justice and Community Safety	Accepted in full
To the Department of Justice and Community Safety, I recommend: A formal process should be considered to give an offender the opportunity to consent to provision of the above-mentioned discharge summary, or similar, to Community Correctional Services staff who are conducting an assessment for a Community Correction Order and case managing an offender, and who is being released from prison onto a Community Corrections Order (through their lawyer or as appropriate).	Response from the Department of Justice and Community Safety	Under consideration
To the Department of Justice and Community Safety, I recommend: A formal process should be considered to give an offender the opportunity to consent to provision of the above-mentioned discharge summary to an Area Mental Health Service to which a person has been referred upon their release from prison (through their lawyer or as appropriate).	Response from the Department of Justice and Community Safety	Under consideration

To the Department of Justice and Community Safety, I recommend: A formal process should be established whereby the consent of an offender should be sought (through their lawyer or as appropriate), to provide any previous psychiatric or psychological reports on the Court file to Community Correctional Services and Forensicare where the Court requests a pre-sentence psychiatric report (and any refusal recorded).	Response from the Department of Justice and Community Safety	Under consideration
To the Department of Health, I recommend: The Department of Health should consider increasing its allocation of funding for Forensic Clinical Specialist roles attached to Area Mental Health Services, and training packages available to Area Mental Health Service clinicians to promote expertise in working with patients transitioning out of a forensic setting, including optimal ways to engage such patients in voluntary treatment.	Response from Department of Health	Accepted in full
To the Office of the Chief Psychiatrist, I recommend: The Office of the Chief Psychiatrist should coordinate a forum with Corrections Victoria, Justice Health and Forensicare to review current discharge processes to ensure the timely communication of critical information about discharge plans for a prisoner with a serious mental illness who is being released to the community and includes: (a) For the receiving Area Mental Health Service, details of any Community Corrections Orders entailing assessment for treatment of mental health; and (b) For Community Correctional Services and its	Response from Department of Health	Accepted in full

	case managers, a system for notifying the Community Correctional Services of a mental health service or practitioner to whom the prisoner has been referred as part of any Forensicare Discharge Plan.		

Finding into death of Ashley Phillips

Keywords: homicide, community corrections order

Recommendation	Response	Response outcome
Corrections Victoria: I endorse the recommendation of Deputy State Coroner English in her findings into the death of Kylie Cay 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 noncompliances are logged.	Response from Justice Services Response from Corrections Victoria	Under consideration Under consideration

Finding into deaths of Matthew Po Chuan Si, Thalia Hakin, Ysuke Kanno, Jess Mudie, Zachary Matthew Bryant and Bhavita Patel

Keywords: homicide, Bourke Street, bail, hostile vehicle, vehicle-borne attack, critical incident management

Recommendation	Response	Response outcome
That Victoria Police, in consultation with the DJCS, investigates the feasibility of Victoria Police-issued body-worn cameras being used to record all out-of-sessions bail/remand hearings.	Response from Victoria Police	Accepted in full
That Victoria Police reviews its training and supervision of members involved in bail/remand proceedings to improve members' skills and knowledge concerning: a) proper preparation of the bail/remand brief b) identification of the available grounds upon which to oppose bail c) identification and presentation of the evidence relevant to opposing bail d) information about obtaining all relevant information and seeking an adjournment if necessary e) information about the circumstances around when and how to appeal a decision to grant bail.	Response from Victoria Police	Accepted in full
That Victoria Police develops force-wide policies and procedures to: a) ensure that notifications of failure to report on bail are forwarded to a Position-Based Email Account, such as the Officer-in-Charge of the police station, in addition to the informant b. provide guidance on the actions to be taken by the informant and Officer-in-Charge upon receipt of such notification.	Response from Victoria Police	Accepted in full

That Victoria Police reviews its training, policies and procedures on bail and remand with respect to high-risk recidivist offenders to ensure members: a) conduct a timely risk analysis using the ROPT, POINTER or similar tool b) consider the need for and, if appropriate, implement a Priority Target Management Plan or Offender Management Plan within the meaning of Victoria Police Manual Tasking and Coordination or other suitable oversight plan designed to detect and disrupt further offending while on bail.	Response from Victoria Police	Accepted in full
That Victoria Police reviews its training, policies and procedures that govern the roles, responsibilities and coordination between the criminal investigation units and other supervisory units to eliminate role confusion and ambiguities concerning operational command in all areas, including criminal investigations, incident response and planned operations.	Response from Victoria Police	Accepted in full
That Victoria Police conducts a review of its policies, procedures, training and infrastructure in respect of the management of critical incidents or emerging critical incidents and the proper and effective use of police communications, so that: a) there is, to the maximum extent possible, continuity of command in planned operations and critical incidents, particularly in circumstances where: i. the operation or incident crosses Divisional or Regional boundaries and may involve a change of radio channel ii. the operation or incident may involve the use of dedicated (TAC) radio channels. b) there is to the maximum extent possible, continuity of involvement of police communications personnel performing the role of channel operator during a critical incident or emerging critical incident	Response from Victoria Police	Accepted in full

c) all police members that may be impacted or become involved in an operation or incident are afforded the best possible situational awareness and clarity of command, plans, roles and responsibilities.		
That Victoria Police reviews its criminal investigator and investigator management training program with a view to incorporating a curriculum on risk evaluation, transition to incident management and the identification and management of critical incidents. Such training should incorporate an immersive, interactive training environment to support decision-making in critical incidents and emerging critical incidents.	Response from Victoria Police	Accepted in full
That Victoria Police Professional Development Command develops and implements appropriate operational safety training on hostile vehicles and vehicle-borne attacks that incorporates simulation or Hydra experience training to enhance the skills and operational decision-making of frontline operational members (including uniform, criminal investigation units and the Critical Incident Response Teams) who may be called upon to act in response to a hostile vehicle or vehicle-borne attack.	Response from Victoria Police	Accepted in full
That Victoria Police Professional Development Command incorporates regular annual or biennial refresher training on the Victoria Police Manual Hostile Vehicle Policy and on vehicle-borne attacks to ensure members' knowledge and skills remain up to date.	Response from Victoria Police	Accepted in full

Finding into deaths of Sestilio Malaspina and Hassan Khalif Shire Ali

Keywords: homicide, Victoria Police, person of interest, national security, terrorism

Recommendation	Response	Response outcome
That Victoria Police review and, if necessary, amend any SIU Standard Operating Procedures (SOPs) to ensure they provide specific guidance about all aspects of its management of NSPOIs including: a. prescription of timeframes for the completion of tasks as well as procedures to ensure that outstanding tasks on a NSPOI file come to the attention of the relevant Team Manager to action and follow up; b. mechanisms to ensure that the SIU reviews all active files at regular intervals irrespective of an absence of evidence of escalating behaviours or the NSPOI's determined threat/risk level; c. when a fresh ANZCTC assessment should occur in response to new intelligence received about a NSPOI; d. procedures relating to access and circulation of information received via ASNET to ensure that ASNET information relating to a NSPOI comes to the attention of the relevant Team Manager, and any other decision-maker (including CVE Unit member), in an accurate and detailed form; e. a process for the documentation on ASNET of classified security information communicated to the SIU verbally; f. a process for the referral of NSPOIs to the CVE Unit for de-radicalisation intervention(s);	Response from Victoria Police	Accepted in full

g. a process involving senior SIU management to consider the appropriateness of managing a NSPOI as though s/he poses a lower level of risk in circumstances where the ANZCTC tool is regarded as having overemphasised the NSPOI's threat profile before the final treatment option is validated by (or as part of an enhanced process within) the NSPOI Allocation Meeting; and h. expectations about consultation with partner agencies.		
That Victoria Police deliver training to all (temporary and permanent) SIU staff about the SIU's SOPs and raise awareness among them about the procedures used by its CTC partners, particularly the CVE Unit.	Response from Victoria Police	Accepted in full
That Victoria Police develop and deliver training and/or a policy to ensure that information regarding disputed address details is recorded on LEAP by the member who makes that assessment and that such information is easily accessible to any police members verifying identification details via LEAP.	Response from Victoria Police	Under consideration
That Victoria Police review, and if necessary amend, any policy relating to the use of annotations on NSPOI and other LEAP warning flags, including the circumstances in which flags should be annotated, by whom and how they may be tailored to address specific information/intelligence gaps identified by SIU where general duties members may be able to provide assistance.	Response from Victoria Police	Accepted in full
That Victoria Police develop and implement a review where an actual or attempted terrorist incident has occurred to identify any opportunities for improvement in national security intelligence collation, analysis and	Response from Victoria Police	Accepted in full

assessment, and NSPOI management.		
That Victoria Police and its national security intelligence partners consider developing a joint review process where an actual or attempted terrorist incident has occurred to identify any opportunities for improvement.	Response from Australian Federal Police Response from Victoria Police Response from Australian Security Intelligence Organisation	Under consideration Under consideration Under consideration

Responses overdue by more than 12 months

Each edition of the CCOV Recommendations Report covers a 15-month period. This edition includes the period between 1 October 2020 and 31 December 2021.

This chapter outlines responses that fall outside this edition's reporting period, but which have been reported in previous editions and remain overdue.

Finding into death of Samuel Alexander Chilton

Key words: road fatality, cyclist, collision, road safety

Recommendation	Response	Response outcome
With the aim of promoting public health and safety, I recommend that VicRoads and the City of Warrnambool review cycling infrastructure along Princes Highway and into Allansford town centre	Response from Regional Roads Victoria	Accepted in full
I recommend that Allansford Football Netball Club and Allansford Cricket Club each publish a notice in their newsletter reminding people who cycle to the Allansford Recreation Reserve not to enter Zeigler Parade via the Princes Highway merging ramp, as doing so is unsafe and does not comply with the road rules	Allansford Football Netball Club and Allansford Cricket Club were expected to respond by April 2020.	Overdue

Finding into death of Ora Holt

Keywords: family violence, mental health, intimate partner homicide and suicide.

Recommendation	Response	Response outcome
That the Royal Australian College of General Practice (RACGP) should review the currency of the 2008 Abuse and violence, Working with our patients in general practice guiding document and documents that reference it. After development of the above document, the RACGP should work with Primary Health Networks and local family violence hubs to provide awareness and education for members.	RACGP was expected to respond by 26 September 2020	Overdue
The RACGP should also develop guidance and examples of an index of suspicion for general practitioners who are working with potential perpetrators of family violence	RACGP was expected to respond by 26 September 2020	Overdue

Finding into death of Swee Chuan Ho

Keywords: drowning, abalone fishing, water safety, recreational fishing

Recommendation	Response	Response outcome
I echo the recommendations made by Deputy State Coroner English, given that they address the core prevention issue raised by the death of Swee Chuan Ho: a) Life Saving Victoria updates its public awareness messaging to include abalone fishing and promote this messaging through targeted education, social media channels, and other relevant websites. b) Life Saving Victoria work with recreational fishing organisations and agencies that promote recreational fishing to include safe practices for abalone fishing. c) The Victorian Fisheries Authority update the Victorian Recreational Fishing Guide and its other resources to include information about abalone fishing safety and the risk of drowning whilst abalone fishing.	Response from Life Saving Victoria Response from Victorian Fisheries Authority	Accepted in full Accepted in full
I recommend that Mornington Peninsula Shire Council work with Life Saving Victoria, the Victorian Fisheries Authority and any other relevant bodies to provide messaging about the risk of drowning whilst abalone fishing, and to promote safe practices for abalone fishing, in the Mornington Peninsula Local Government Area.	Mornington Peninsula Shire Council was expected to respond by 29 December 2020	Overdue

Finding into death of Xu Zhou

Keywords: drowning, inexperienced swimmer, water safety, abalone fishing

Recommendation	Response	Response outcome
Life Saving Victoria updates its public awareness messaging to include abalone fishing and promote this messaging through targeted education, social media channels, and other relevant websites.	Response from Life Saving Victoria	Accepted in full
Life Saving Victoria work with recreational fishing organisations and agencies that promote recreational fishing to include safe practices for abalone fishing.	Response from Life Saving Victoria	Accepted in full
The Victorian Fisheries Authority update the Victorian Recreational Fishing Guide and its other resources to include information about abalone fishing safety and the risk of drowning whilst abalone fishing.	The Victorian Fisheries Authority was expected to respond by 18 November 2020.	Overdue