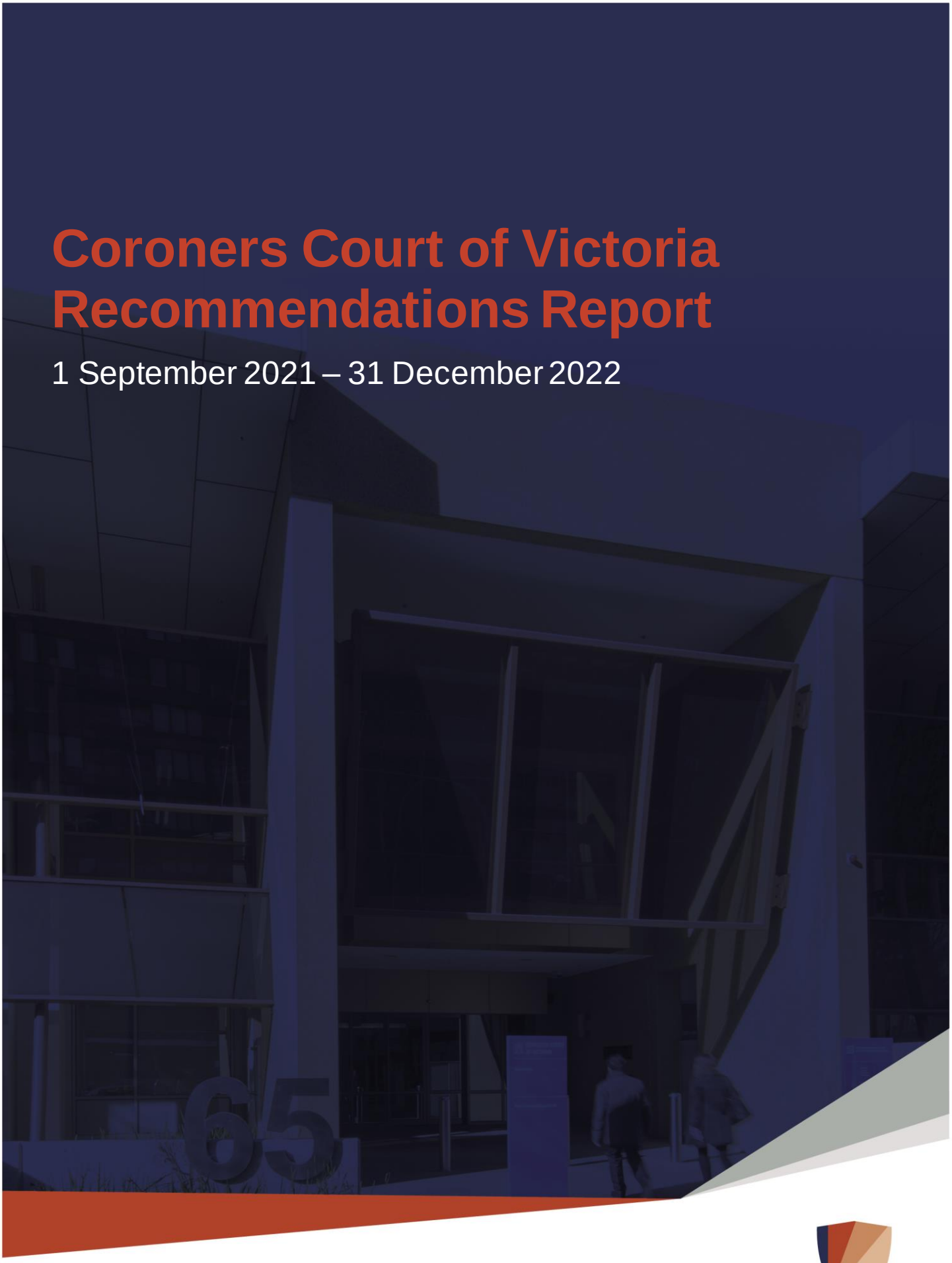
Coroners Court of Victoria Recommendations Report

1 September 2021 – 31 December 2022



Coroners Court of Victoria

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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, where appropriate, 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 publication collating all recommendations made over a 15-month period and the status of responses received.

This fifth edition covers the period from 1 September 2021 to 31 December 2022. During this period, coroners made 292 recommendations across 121 findings.

Following these recommendations, the Court received:

- 170 responses stating the recommendation was accepted in full
- 44 responses stating the recommendation was accepted in part or an alternative was proposed
- 67 responses stating the recommendation remains under consideration
- 29 responses where the recommendation was not accepted

In addition to these:

- 7 responses are still being prepared, have been granted an extension or were directed to entities that are not required to respond (awaiting response)
- 4 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 six responses overdue across eight 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 9 June 2023.

Contents

Suicide

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 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.	Response from Grampians Health	Accepted in full
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.	Response from Grampians Health	Under consideration

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.	Response from the Office of the Chief Psychiatrist	Under consideration
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.	Response from the Office of the Chief Psychiatrist	Under consideration

Finding into death of Boe Luke Memery

Keywords: Aboriginal passing, suicide, access to mental health services

Recommendation	Response	Response outcome
With the aim of promoting public health and safety and preventing like deaths, I recommend that the Secretary of the Department of Health consider the feasibility of establishing drug and alcohol rehabilitation and detoxification facilities in the Mildura local government area that are appropriately resourced and meet demand for such services in the Mildura community.	Response from Department of Health	Accepted in full
To ensure continuous, quality, and culturally safe mental health care is available to the Aboriginal community in Mildura, I recommend the Department of Health work with the Victorian Aboriginal Community Controlled Health Organisation and Mallee District Aboriginal Services in Mildura to identify mechanisms to: a. Attract and retain qualified clinicians; b. Upskill current staff to become qualified clinicians through scholarships; and c. Provide access to a psychiatrist at MDAS wellness centre.	Response from Department of Health	Accepted in full
To improve the quality of care provided and promote consumer safety, I recommend Mallee District Aboriginal Services focus on documentation and record keeping by: a. Reviewing current file and electronic health record systems to ensure they encourage and facilitate contemporaneous documentation of important clinical information such	Response from Mallee District Aboriginal Services was expected by 1 December 2022	Overdue

as suicide risk assessment and management; and b. Ensuring current staff are aware of and understand their responsibilities in keeping accurate and complete healthcare records in line with the National Safety and Quality Primary and Community Healthcare Standards.		
I recommend Mallee District Aboriginal Services in Mildura ensure all staff working in mental health programs have training in evidence-based and culturally appropriate suicide risk assessment and management practices.	Response from Mallee District Aboriginal Services was expected by 1 December 2022	Overdue

Finding into death of Mr CLX

Keywords: suicide, palliative care, terminal illness, myelodysplasia

Recommendation	Response	Response outcome
I recommend Cohuna District Hospital provides psychosocial supports for residents in the aged care and palliative care programs.	Response from Cohuna District Hospital	Accepted in full
I recommend Cohuna District Hospital strengthen staff training in the assessment of suicide risk for aged care and palliative patients.	Response from Cohuna District Hospital	Accepted in full
I recommend Cohuna District Hospital develop a flowchart outlining access to mental health services for residents in the aged care and palliative programs	Response from Cohuna District Hospital	Accepted in full
I recommend Cohuna District Hospital update the suicide risk procedure for aged care and palliative programs.	Response from Cohuna District Hospital	Accepted in full

Finding into death of YGE

Keywords: suicide, mental health, mental health support, ligature, family violence supports

Recommendation	Response	Response outcome
Family Safety Victoria review the data regarding the suicide of people who inject drugs and who are perpetrators of family violence and use this data to inform the development and review of perpetrator interventions going forward.	Response from Family Safety Victoria	Accepted in full

Finding into death of LKV

Keywords: suicide, mental health, voluntary inpatient, psychiatric facility, major depression

Recommendation	Response	Response outcome
The Victoria Clinic and the Healthscope National Mental Health Committee review the Risk Assessment and Observation Levels – Patient (Policy 9.07) in relation to the visual observation requirements to ensure it reflects contemporary practice, including expected engagement with a patient.	Response from Healthscope Operations Healthscope Operations (Attachment A)	Accepted in full

Finding into death of Mr EBG

Keywords: suicide, asphyxiation, helium toxicity, helium, plastic bag asphyxia

Recommendation	Response	Response outcome
That the ACCC make 20 per cent oxygen dilution of helium in balloon kits mandatory, as well as the possibility of the addition of an aversive agent similar to aerosol cans of compressed air used for dusting electronic equipment.	Response from the Australian Competition and Consumer Commission	Accepted in full
That the ACCC and the gas industry reconsider the feasibility of introducing mandatory modifications to helium cylinders in order to limit the ability of individuals to produce a steady flow to enact suicide plans.	Response from the Australian Competition and Consumer Commission	Rejected in full
That the ACCC continue to work with industry and commercial operators to inform any potential regulatory or other interventions that they may consider in the future to reduce the risk of inert gas inhalation involving balloon helium.	Response from the Australian Competition and Consumer Commission	Accepted in full
That Consumer Affairs Victoria consider what regulatory approaches to reducing the accessibility of helium as a means of suicide might be feasible in the regulatory environment of the State of Victoria, including requiring helium to be mixed with other gases for sale as balloon gas as well as approaches already considered by the ACCC at the Commonwealth level.	Response from Consumer Affairs Victoria	Under consideration

Finding into death of Dane Warren Simpson

Keywords: suicide, mental health, mental health triage

Recommendation	Response	Response outcome
The Royal Australian College of General Practitioners consider reviewing advice to their members in relation to treating those with Obsessive Compulsive Disorder and to reiterating the utility of gathering collateral information from families and involving family members in treatment, in particular where obsessive thinking and compulsive behaviour may carry the risk of self-harm.	Response from the Royal Australian College of General Practitioners	Accepted in part
The Australian Psychology Society consider reviewing advice to their members in relation to treating those with Obsessive Compulsive Disorder and to reiterating the utility of gathering collateral information from families and involving family members in treatment, in particular where obsessive thinking and compulsive behaviour may carry the risk of self-harm.	Response from the Australian Psychology Society	Accepted in full
That the Royal Australian and New Zealand College of Psychiatrists consider reviewing advice to their members in relation to treating those with Obsessive Compulsive Disorder and to reiterating the utility of gathering collateral information from families and involving family members in treatment, in particular where obsessive thinking and compulsive behaviour may carry the risk of self-harm.	Response from the Royal Australian and New Zealand College of Psychiatrists	Under consideration

Finding into death of Melissa Gaultier

Keywords: suicide, mental health, pregnancy, motor vehicle collision, pedestrian

Recommendation	Response	Response outcome
With the aim of promoting public health and safety and preventing like deaths, I recommend that Latrobe Regional Health implement a patient continuity of care transfer admission policy for its inpatient mental health ward, which aims to rectify the circumstances associated with Melissa Gaultier's transfer admission from Monash Health, by ensuring that appropriately qualified clinician(s)/inpatient consulting psychiatrist receiving handover details from another hospital are rostered and available to continue with that patient's care on admission.	Response from Latrobe Regional Hospital	Accepted in full

Finding into death of Mr HP

Keywords: suicide, firearm, mental health, firearm licensing

Recommendation	Response	Response outcome
I recommend that the Secretary, Department of Justice and Community Safety consider the issues raised in this finding, including amending the Firearms Act 1996 to require all firearm licence applicants to provide a medical report from a current treating medical practitioner setting out their medical history and factors relevant to their fitness/ suitability to hold a firearms licence and possess firearms.	Response from Department of Justice and Community Safety	Rejected in full

Finding into death of Mandy Jane Hawkey

Keywords: suicide, mixed drug toxicity, chronic pain, mental health

Recommendation	Response	Response outcome
That the Australian Health Practitioner Regulation Agency (AHPRA) consider these findings in relation to Dr Robson's prescribing practices and assist Dr Robson to improve his prescribing practices and understand the significance of obtaining relevant permits to prescribe Schedule 8 medications.	Response from Australian Health Practitioner Regulation Agency (AHPRA)	Accepted in part
That the Medicines and Poisons Branch of the Department of Health, Victoria consider these findings in relation to Dr Robson's failure to comply with the regulations relating to permits.	Response from Department of Health	Accepted in full

Finding into death of Mr J

Keywords: suicide, mental health, sharp object, mental health supports

Recommendation	Response	Response outcome
I endorse the following Royal Commission recommendation with the aim of preventing like deaths: Recommendation 9: Developing 'safe spaces' and crisis respite facilities of the Royal Commission into Victoria's Mental Health System: *The Royal Commission recommends that the Victorian Government:* 1. *invest in diverse and innovative 'safe spaces' and crisis respite facilities for the resolution of mental health and suicidal crises which are consumer led and, where appropriate, delivered in partnership with non-government organisations.* 2. *in collaboration with the new agency led by people with lived experience of mental illness or psychological distress (refer to recommendation 29) and nongovernment organisations that deliver wellbeing supports, establish:* a. *one drop-in or crisis respite facility for adults and older Victorians per region (refer to recommendation 3(3)); and* b. *four safe space facilities across the*	Response from Victorian Government	Under consideration

state *3. establish a crisis stabilisation facility, in consultation with people with lived experience, led by a public health service or public hospital in partnership with a non-government organisation that delivers wellbeing supports.*		
I further recommend that the Victorian Government ensure such safe spaces are available 24/7 to allow for out-of-hours and overnight access as this is not explicitly stated in the above recommendation.	Response from Victorian Government	Under consideration
I further endorse the following Royal Commission recommendation with the aim of preventing like deaths: Recommendation 8(3): *improve emergency department's ability to respond to mental health crises by:* a. *establishing a classification framework for all emergency departments and urgent care centres, based on their capability to respond to people experiencing mental health crises;* b. *using the classification framework to ensure that health services are appropriately resourced to perform their role in a regional network of emergency departments and urgent care centres; and* c. *ensuring there is at least one highest-level emergency department suitable for mental health and alcohol and other drug treatment in each region.*	Response from Victorian Government	Under consideration

Finding into death of CJ

Keywords: suicide, trauma, mental health, addiction

Recommendation	Response	Response outcome
That Peninsula Health improves the quality of the referral information between acute mental health services for same-day contact requested as a safeguard in the discharge planning of a person assessed by a mental health services in the Emergency Department by ensuring that: a. Initial verbal referral for same-day contact includes a patient's contact details and a secondary or next of kin contact, subject to consent of the patient and the secondary contact. b. Critical clinical and/or comprehensive assessment information in written form is communicated proximate to and as soon as practicable to the verbal referral to enable the receiving service to arrive at their own informed assessment of the acuity of the patient and to plan the appropriate clinical response.	Response from Peninsula Health	Accepted in full

Finding into death of BJ

Keywords: suicide, hypoxia, hanging, mental health, hospital, inpatient care

Recommendation	Response	Response outcome
That Monash Health develop a procedure that addresses the need for scene preservation and/or recording, in circumstances where a serious suicide attempt has taken place in an inpatient facility, in anticipation of a foreseeable coronial investigation. Such a procedure could also assist the health service to undertake its own internal review or root cause analysis (whether mandate or otherwise) and to comply, more broadly, with its duty of care obligations.	Response from Monash Health	Accepted in full

Finding into death of Taylor Zachary Oliver

Keywords: suicide, mental health, support services, post-discharge follow-up, sharp object

Recommendation	Response	Response outcome
To improve patient safety and responsiveness of BMHS to clients in crisis, Ballarat Health Services embed in relevant policies/ procedures /protocols/ guidelines a requirement for ED staff to notify BMHS when a current client of BMHS presents to ED with mental health concerns, including when they leave without being seen, unless the patient has a current clinical risk management plan indicating that routine notification of such presentations is contraindicated.	Response received from Grampians Health	Under consideration

Finding into death of BL

Keywords: suicide, public mental health services, post discharge follow up

Recommendation	Response	Response outcome
For clients that are being discharged from inpatient/acute settings, MBH [Mildura Base Hospital] implement a formal process to ensure communication with general practitioners regarding admission details, medication and follow up arrangements.	Response from Mildura Base Hospital	Accepted in full
MBH implement a formalised process to ensure that discharge summaries are completed and provided to relevant stakeholders within a timely fashion.	Response from Mildura Base Hospital	Accepted in full
MBH ensure staff are aware of the requirements to document all clinical contacts relating to clients, with documentation to include adequate mental state examinations and descriptions of risk.	Response from Mildura Base Hospital	Accepted in full

Finding into death of Mr P

Keywords: suicide, mental health, poor physical health

Recommendation	Response	Response outcome
The Royal Australian College of General Practitioners highlight to its Fellows and members the higher prevalence of suicide by males than females in the community and in particular the increase in prevalence as men age. That the College recommend to its Fellows and members the desirability of proactive timely follow-up of males who present with suicide ideation, a history of such ideation, indicators of depression or a history of suicide attempts and that if a timely follow-up is unavailable refer such patients to an appropriate service which can facilitate such a timely follow-up.	Response from The Royal Australian College of General Practitioners	Accepted in full

Finding into death of Carol Austin

Keywords: suicide, asphyxia, mental health, mental health care, access to supports

Recommendation	Response	Response outcome
I make the following recommendation to Dr Brendan Murphy, Secretary of the Department of Health: To improve the access of people in a community who require mental health specialist treatment within the Better Access Initiative, I recommend that eligibility for access to the Better Access Telehealth Services for people in rural and remote areas be extended to those areas with combined ratings of MM3, a district of workforce shortage for psychiatry and a distribution priority area for general practitioners.	The Minister for Health and Aged Care was invited to respond by 3 August 2022	Overdue

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 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 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 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 all Australian online retailers of	Response from Department of	Accepted in full

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 Jessica Higgins

Keywords: unintentional overdose, ketamine infusion, opioid, oxycodone, methadone, naloxone, SafeScript, mixed drug toxicity, chronic pain, hypoxic brain injury

Recommendation	Response	Response outcome
I recommend that the Royal Australian College of General Practitioners and the Faculty of Pain Medicine reiterate to their members the importance of considering buprenorphine in chronic pain management in appropriate cases.	Response from Royal Australian College of General Practitioners Response from Australian and New Zealand College of Anaesthetists	Accepted in full Accepted in full
I recommend that the Royal Australian College of General Practitioners and the Faculty of Pain Medicine reiterate the risks associated with patients who are prescribed multiple and concurrent medications with sedative properties, and that frequent reviews of patients ought be undertaken in a face-to-face setting to assess for adverse signs and symptoms.	Response from Royal Australian College of General Practitioners Response from Australian and New Zealand College of Anaesthetists	Accepted in full Accepted in full
I recommend that the Royal Australian College of General Practitioners and the Faculty of Pain Medicine reiterate to their members the importance of practitioners ensuring that all interactions with their patients, especially those with multiple providers, are documented in clear, written form in the patient's medical record, and that all patients are instructed in clear, written terms regarding their medication usage and doses to avoid potential adverse outcomes.	Response from Royal Australian College of General Practitioners Response from Australian and New Zealand College of Anaesthetists	Accepted in full Accepted in full

Finding into death of Mr P

Keywords: unintentional overdose, mixed drug toxicity, MDMA, ketamine, methylphenidate, novel psychoactive substances, synthetic cathinones

Recommendation	Response	Response outcome
That the Department of Health, as the appropriate arm of the 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 non-fatal harms) associated with the use of drugs obtained from unregulated drug markets.	Response from Department of Health	Under consideration
That the Department of Health, as the appropriate arm of the 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 non-fatal harms) associated with the use of drugs obtained from unregulated drug markets.	Response from Department of Health	Under consideration

Finding into death of Mr S

Keywords: Unintentional overdose, mixed drug toxicity, ethanol, etizolam, flubromazolam, cocaine, novel psychoactive substance

Recommendation	Response	Response outcome
That the Department of Health, as the appropriate arm of the 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 nonfatal harms) associated with the use of drugs obtained from unregulated drug markets. That the Department of Health, as the appropriate arm of the 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 non-fatal harms) associated with the use of drugs obtained from unregulated drug markets.	Response from Department of Health	Under consideration

Finding into death of FJL

Keywords: Unintentional overdose, mixed drug toxicity, novel psychoactive substances

Recommendation	Response	Response outcome
That the Department of Health, as the appropriate arm of the 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	Rejected in full

Finding into death of Leeanne Matheson

Keywords: Unintentional overdose, mixed drug toxicity, prescribed medication, pain management, opioid dependency

Recommendation	Response	Response outcome
That Eastern Health consider implementing a policy requiring direct verbal communication between the hospital treating team and a patient's authorised prescriber in instances where a patient's opiate prescriptions have been changed during their inpatient stay.	Response from Eastern Health Eastern Health Attachment A Eastern Health Attachment B	Accepted in full

Medical

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 Sotirios Temopoulos

Keywords: surgical complications, sepsis, ischaemic heart disease, hospital, post discharge care, medication error

Recommendation	Response	Response outcome
I recommend that the Federal Health Minister conducts a feasibility study for the introduction of a national incident and near miss reporting mechanism for medication errors.	Response from Minister for Health and Aged Care	Accepted in full

Finding into death of Heather Jean Lucas

Keywords: Anaphylaxis, chemotherapy, ischaemic heart disease, cancer, carboplatin

Recommendation	Response	Response outcome
Cabrini Health review the grading scale utilised in the Platinum Hypersensitivity Reaction Guidline and consider implementing a recognised scale includes reference to more detailed signs and symptoms for each grade so as to facilitate a more accurate assessment of any reaction and grading with a view to reducing the possibility of underestimation of severity of assessment.	Response from Cabrini Health	Accepted in full
Cabrini Health review their procedures to ensure that when a patient undergoes 'rechallenge' that an appropriately qualified, trained and equipped medical practitioner is at the bedside at least for administration of the drug and for a period within which any adverse reaction would be expected to manifest taking into account that any patient who has previously experienced grade 2 or greater reactions will not be re-challenged.	Response from Cabrini Health	Accepted in full
Cabrini Health review its record keeping processes and procedures including the Adverse Drug Reaction System and ensure that all adverse drug reactions are recorded in a timely fashion on all databases, written and electronically held including in the patient's medical record that are accessible by clinical staff and explicitly considered before any re challenge	Response from Cabrini Health	Alternative adoped
The Patient Assessment Tool – Day Oncology tool be amended to allow explicit recording of allergic reactions so that staff are not required to only rely on a patient informing them of a previous allergic	Response from Cabrini Health	Accepted in full

reaction		
Cabrini Health implement these processes and procedures across all its campuses.	Response from Cabrini Health	Alternative adopted

Finding into death of Warren Douglas Frazer

Keywords: Video assisted thoracoscopic surgery, cancer, adenocarcinoma, post-surgical complications, neurological complication

Recommendation	Response	Response outcome
The Northern Hospital draw and implement a formal policy describing how family members and next of kin of those undergoing surgery are to be kept informed about the progress of the surgery particularly when the surgery takes longer than prior estimates provided to family and next of kin.	Response from The Northern Hospital	Accepted in full
The Northern Hospital seek to formalise arrangements for transferring patients to St.Vincent's Hospital or The Austin Hospital and engross those arrangements in a protocol the terms of which are agreed upon by the hospitals. See paragraph 30 of Dr Ferguson's statement	Response from The Northern Hospital	Accepted in full
The Northern Hospital audit compliance with the Cancer Optimal Care Pathway in relation to patients' peri-operative investigations and planning. See paragraph 37 of Dr Ferguson's statement	Response from The Northern Hospital	Accepted in full
The Northern Hospital audit the effectiveness of the Head of Thoracic Surgery and the then newly appointed full time Thoracis Surgeon providing timely assistance and support to thoracic and other surgeons operating at the Northern Hospital.	Response from The Northern Hospital	Accepted in full

Finding into death of Helen Welsh

Keywords: sepsis, e-coli, comorbidities, complex medical history, hospital

Recommendation	Response	Response outcome
That Austin Health consider implementing the SCV clinical sepsis pathway.	Response from Austin Health	Accepted in full

Finding into death of Cindy Jane Martin

Keywords: Aboriginal passing, obstructive sleep apnoea, obesity, mental health, complex medical history, cardiac arrest, hospital

Recommendation	Response	Response outcome
To improve the safety of patients who have obstructive sleep apnoea and who for reasons of distress, or lack of consent or willingness, will not use their own or a provided CPAP machine, NWMH build on its work with the Royal Melbourne Hospital Department of Respiratory Medicine to: a. Explore the options for improving the safety of patients in such circumstances; and b. Develop a guideline/advice for the monitoring of patients including any identified indicators of concern.	Response from Northern Health	Accepted 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 invited to respond by December 2021 They were not required to respond and no response has been received to date.	Awaiting response

Finding into death of Ruth Ann McKenna

Keywords: surgical complications, complex medical history, gynaecological surgery

Recommendation	Response	Response outcome
I recommend that Goulburn Valley Health: a. Considers a review of its policies and procedures to ensure that patients are not placed on the waiting list for surgery until final sign off of all investigations requested during the pre-anaesthetic consultation; b. work with echocardiography services to streamline assessments for patients with reduced exercise tolerance and possible underlying cardiac problems; and c. review the system of communication between the pre-anaesthetic clinic and surgical teams to ensure surgeons are apprised of the outcome of PAC review, management plans and (where necessary) requests for further investigations and the outcome of same, in advance of the surgery date.	Response from Goulburn Valley Health	Accepted in full
I recommend that the Royal Australian and New Zealand College of Obstetricians and Gynaecologists liaise with the Department of Health to explore the possibility and feasibility of developing a laparoscopic surgery database within Victoria to enhance quality and accountability in laparoscopic gynaecological surgery. Such a database could enable health authorities to access live outcome data, provide feedback to clinicians, target training, and make recommendations to clinicians and services regarding service capability.	Response from Royal Australian and New Zealand College of Obstetricians and Gynaecologists Response from Department of Health	Under consideration Rejected in full

Finding into death of Susan Mary Royals

Keywords: cancer, hospital, complex medical history, Whipple procedure, surgical complications, central venous catheter

Recommendation	Response	Response outcome
Safer Care Victoria develops a standardised approach for CVC insertion which encourages the use of ultrasound guided insertion (and other methods of confirming venous placement) to reduce the likelihood of instances of arterial puncture.	Response from Safer Care Victoria	Accepted in full

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.	Response from the Royal Australian College of General Practitioners	Under consideration

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	Accepted in full

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 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 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 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	Response from Royal Australian and	Under consideration

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.	New Zealand College of Radiologists	
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 implement a training and certification programme for	Response from Royal Australian and New Zealand College of Radiologists Response from Australian Society of Medical Imaging and Radiation Therapy	Rejected in full Accepted in full

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.	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 form requiring witnessing by an appropriate person (radiographer or radiologist) and which includes 153	Response from Future Medical Imaging Group (FMIG)	Accepted in full

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 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	Response from Royal Australian and New Zealand College of Radiologists	Under consideration

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 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.	Response from Australian Commission on Safety and Quality in Health Care	Accepted in full

(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 Accreditation Standards, in particular Standard 2.1.	Response from Future Medical Imaging Group (FMIG)	Accepted in full
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.	The Commonwealth Minister for Health was invited to respond by 22 February 2022. They were not required to respond and no response has been received to date.	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.	The Commonwealth Minister for Health was invited to respond by 22 February 2022. They were not required to respond and no response has been received to date.	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 the Australian Competition and Consumer Commission	Rejected in full
That the Royal Australian College of General Practitioners (RACGP) and the Australasian Faculty of Occupational & Environmental Medicine (AFOEM) of the Royal 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.	Response from Royal Australian College of General Practitioners	Accepted in full
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,	Response from Royal Australian College of General Practitioners	Accepted in full

nor any information specific to the patient, has been reviewed.		
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 Robert Albert Burns

Keywords: multiorgan dysfunction syndrome, surgical complications, sepsis, transfer delay, complex medical history, comorbidities, anastomotic leak, surgeon to surgeon communication

Recommendation	Response	Response outcome
I recommend that South West Health Care (SWHC) conduct a review of their approach to both the deteriorating and 'not progressing' post-operative colorectal surgical patient with a view to reliably and consistently applying the recommendations of the Victorian Surgical Consultative Council.	Response from South West Healthcare	Accepted in full
I recommend that South West Health Care implement multi-disciplinary consultant ward rounds or management meetings in ICU, particularly with regards to unstable or deteriorating patients with multiple potential problems who are failing to respond to treatment as expected.	Response from South West Healthcare	Accepted in full
I recommend that South West Health Care implement a policy of surgical 'peer review' of deteriorating or non-progressing patients.	Response from South West Healthcare	Accepted in full
I recommend that South West Health Care implement a policy whereby failed attempts by junior medical staff to transfer a patient to a higher level of care are escalated to a consultant to ensure timely transfer by discussion between peers at the sending and receiving hospital.	Response from South West Healthcare	Accepted in full
I recommend that South West Health Care implement a policy of direct surgeon to surgeon communication when a complicated and/or deteriorating patient is in need of transfer for care by another	Response from South West Healthcare	Accepted in full

surgeon at another hospital.		

Finding into death of Paul Turner

Keywords: surgical complications; perioperative care, post-operative care; heamorrhagic stroke, anticoagulation therapy, hospital

Recommendation	Response	Response outcome
I recommend that Safer Care Victoria establish a multi-disciplinary working group (made up of Anaesthetics, Cardiology, Haematology, Pharmacy, Surgery) to develop state-wide guidelines for the management of anticoagulation therapy for peri and post-surgery for patients with Atrial Fibrillation and assist with the dissemination and roll out of a program to increase practitioner awareness, knowledge and performance.	Response from Safer Care Victoria	Under consideration

Finding into death of Trevor Anthony Peterson

Keywords: surgical complications, sepsis, ischemic bowel, complex medical history

Recommendation	Response	Response outcome
In light of the circumstances of Mr Peterson's death already identified by Western Health reviews, and with the aim of promoting public health and safety and preventing like deaths, I recommend that Western Health identify and implement actions to improve communication with patients, their families, and their General Practitioners to ensure that preventative measures, particularly as part of post-procedure treatment, are understood and preventative options are maximised.	Response from Western Health	Accepted in full

Finding into death of David Charles Shaw

Keywords: Ischaemic and valvular heart disease, complex medical history, medical alarm service

Recommendation	Response	Response outcome
The Chief Executive Officer of Peninsula Health consider reviewing and limiting the time-frame within which enquiries must be made and concluded into the condition of patients who have not triggered MePACS electronic devices as expected. This review should incorporate consideration of introducing a schedule of criteria setting-out the minimum bases of and concomitant supporting evidence by which MePACS staff may consider themselves satisfied that such patients are not in need of urgent medical attention.	Response from Peninsula Health	Accepted in full

Finding into death of HYR

Keywords: elective surgery, surgical complications, internal bleeding

Recommendation	Response	Response outcome
That Northern Hospital reports HYR's death to Safer Care Victoria as a sentinel event.	Response from Northern Health	Accepted in full
That Northern Hospital conducts an external review of the capacity and capability of its interventional radiological service to monitor patients and provide resuscitation, including fluids and reports the results of the external review to Safer Care Victoria.	Response from Northern Health	Accepted in full
That Northern Hospital undertakes open disclosure with HYR's family in accordance with the Australian Open Disclosure Framework.	Response from Northern Health	Accepted in full

Finding into death of Melissa Cunningham

Keywords: lung abscess, complex medical history, sleep apnoea, obesity, Down's syndrome

Recommendation	Response	Response outcome
I recommend that Annecto develop a policy and procedure for residents with CPAP machines to ensure that carers: i. conduct an assessment as to whether the resident is able to independently use, operate and/or clean the CPAP machine. Such an assessment should be undertaken in conjunction with the resident's treating clinicians. An initial assessment should be completed when the CPAP machine is implemented, and reviewed at regular intervals and earlier if there is a substantive change in the resident's condition which may affect their capacity to use, operate and/or clean the CPAP machine. ii. document the results of the assessment in the resident's specific health management plan, along with, as appropriate: 1. strategies used to support the person to perform this procedure are detailed in the resident's specific health management plan; and/or 2. provide directives to carers as to the use, operation and cleaning of the CPAP machine as necessary; and iii. where carers are required to assist in the use, operation and cleaning of the CPAP machine, that this assistance is documented and recorded in the resident's daily case notes.	Response from Annecto – part 1 Response from Annecto – part 2	Accepted in full
I recommend that Annecto conduct an audit of resident's individual care plans to ensure that all residents	Response from Annecto – part 1	Accepted in full

who utilise a CPAP machine have been appropriately assessed to ascertain whether the resident has capacity to independently use, operate and clean the CPAP machine and that where appropriate: i. strategies used to support the person to perform this procedure are detailed in the resident's specific health management plan; and/or ii. where the resident is unable to independently use, operate and/or clean the CPAP machine, this is documented in the resident's specific health management plan and directives given to carers as to the use, operation and cleaning of the CPAP machine as necessary.	Response from Annecto – part 2	
I recommend that Annecto provide internal education to staff about the expectations and requirements for: i. documenting information received at medical appointments, such as equipment cleaning schedules, in the resident's care plans to ensure such information is adequately provided to other carers at the facility; ii. adequately documenting instructions provided by family members or clinicians on utilising medical equipment, including CPAP machines, in the resident's health management plan; and iii. complying with Annecto's 'Specific Health Management Policy'.	Response from Annecto – part 1 Response from Annecto – part 2	Accepted in full

Finding into death of YLM

Keywords: abdominal aortic aneurysm, referral criteria, communication failure

Recommendation	Response	Response outcome
The Victorian Department of Health consider amending the wording of the Statewide Referral Criteria regarding aortic aneurysms to clarify which patients should be discussed with the vascular registrar or sent to an emergency department, including the significance of transient symptoms.	Response from Department of Health Update from Department of Health	Accepted in full
FMIG Imaging remind their radiologists of their obligations to contact referring doctors directly to discuss any significant unexpected, urgent, or critical clinical radiology findings.	Response from FMIG Imaging	Accepted in full

Finding into death of Ann-Maree Manno

Keywords: Pulmonary thromboembolism, obesity, complex medical history, surgical complications, post-surgical care

Recommendation	Response	Response outcome
I recommend Safer Care Victoria develop an evidence-based guideline for VTE prophylaxis for bariatric surgery patients, which is consistent to the Queensland Health guideline, with the aim that it be incorporated into a standard care pathway for bariatric surgery to ensure that appropriate consideration of VTE prophylaxis is given to all patients according to their level of risk.	Response from Safer Care Victoria	Accepted in full

Finding into death of HI

Keywords: Acute myocardial infarction, iron deficiency, ischaemic heart disease, giant cell arteritis

Recommendation	Response	Response outcome
Royal Australian College of General Practitioners (RACGP) The RACGP consider either endorsing the NHF Guidelines (and future revisions) or produce their own.	Response from Royal Australian College of General Practitioners	Under consideration

Finding into death of Nilofer Nezami

Keywords: overseas, unascertained cause of death, surgical complications, overseas cosmetic procedures, overseas medical care standards

Recommendation	Response	Response outcome
I recommend that the Victorian Chief Health Officer publish an alert/advisory regarding the risks of medical tourism, including but not limited to advice that the standard and quality of medical care provided in other countries may not be of the same standard as that provided in Australia.	Response from Department of Health was expected by 28 June 2022	Overdue

Transport and Road Safety

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 Shawn James Marion

Keywords: motor vehicle collision, pedestrian, Aboriginal and Torres Strait Islander passing

Recommendation	Response	Response outcome
With the aim of promoting public health and safety and preventing like deaths, I recommend that Maribyrnong City Council consider installing additional street lighting at the location at which the collision occurred.	Response from Maribyrnong City Council	Under consideration

Finding into death of John Jacob Beirouti

Keywords: police pursuit, substance use, family violence, motor vehicle collision

Recommendation	Response	Response outcome
Considering the ambiguity still present within the policy framework traversed above, I recommend that the Chief Commissioner reconsider and amend the new VPM *Road Policing – Operations* policy to provide clear guidance on operational policing decisions, specifically but not limited to the direction that 'police members are required to discontinue the attempted intercept and not follow the vehicle'.	Response from Victoria Police	Accepted in full

Finding into death of Mr V

Keywords: neck injury, motor vehicle collision, single vehicle, speed, poor road conditions

Recommendation	Response	Response outcome
Hazard/warning signage should be installed at the relevant section of Rifle Butts Road, Whoorel pending elimination of the dip, described by investigators as a sunken part of the road surface approximately 21 metres long.	Response from Colac Otway Shire	Accepted in full
Colac Otway Shire investigate the cause of the dip in the road and make repairs to eliminate the dip.	Response from Colac Otway Shire	Accepted in full
Permanent hazard/warning signage should be installed at the relevant section of road should the dip become a recurring issue following the repairs.	Response from Colac Otway Shire	Accepted in full
The speed limit for the relevant section of road, including the lead-up to the crest, should be reduced.	Response from Colac Otway Shire	Accepted in full

Finding into death of Ludmila Sezonenko

Keywords: Motor vehicle collision, pedestrian, lighting, freeway

Recommendation	Response	Response outcome
I recommend that VicRoads install lighting under the Heatherton Road overpass to improve visibility on this section of the Monash Freeway.	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	Alternative adopted
With the aim of promoting public health and safety and preventing like deaths, I recommend that Boroondara City Council introduce a more contrasting grey coloured pavement marking on the raised safety platform.	Response from Boroondara City Council	Accepted in full

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 Rejected in full

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 Department of Jobs, Precincts and Regions	Accepted in full Under consideration Accepted in full
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)	Response from Department of	Alternative adopted

encourage and support driver behaviour change programs by way of a public campaign to increase heavy vehicle driver awareness to look for bike riders.	Transport	
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 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 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.	Response from Victoria Police	Alternative adopted
(b) Those employees of emergency	Response from	Accepted in full

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.	Victoria Police	
(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 Response from Victoria State Emergency Services (ESTA) Response from Victoria SES	Accepted in full Accepted in full Alternative adopted

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 deaths of Maxwell Quartermain, Greg De Haven, Glenn Garland, John Washburn and Russell Munsch

Keywords: Air-crash, aviation, Essendon Airport, aircraft, pre-flight checks

Recommendation	Response	Response outcome
CASA [Civil Aviation Safety Authority] consider redoubling emphasis of the essential nature of check-list discipline especially to older pilots perhaps as a part of the increased obligations for more frequent IPCs borne by pilots older than 65.	Response from Civil Aviation Safety Authority	Under consideration
CASA consider promulgating explicit directions to the effect that if a rudder trim tab function test is undertaken as a part of pre-flight check that subsequently and prior to take-off the position of the rudder trim tab be checked on more than one occasion.	Response from Civil Aviation Safety Authority	Accepted in part
CASA consider instigating a formal 'audit trail' for NCNs and their acquittal.	Response from Civil Aviation Safety Authority	Accepted in part
CASA consider requiring pilots to have IPCs conducted by a variety of testers. The extent of variety of testers and time periods within which such variety is required may be best determined by CASA itself.	Response from Civil Aviation Safety Authority	Accepted in part

Deaths in custody

Finding into death of Mladen Jovanoski

Keywords: suicide, corrections, Fulham Correctional Centre, medical concerns, medical care, prisoner transfer

Recommendation	Response	Response outcome
That Corrections Victoria consider further updating its procedures to require that any decision to cancel a medical transfer must, where relevant, first involve referral to the Health Services Manager at the prisoner's home prison or a clinician who is best placed to advise on the priority to be given to the case.	Response from Department of Justice and Community Safety	Accepted in full
That Corrections Victoria implement a policy to require all persons involved in a decision to cancel a medical transfer to record: the circumstances; the reasons; and the persons involved, and implement a system for doing so.	Response from Department of Justice and Community Safety	Accepted in full
That Corrections Victoria and Justice Health develop a tool to guide persons in an operational setting so that an anticipated cancellation of a transfer may be properly escalated in advance of the potential loss of the scheduled medical appointment.	Response from Department of Justice and Community Safety	Accepted in full
That Corrections Victoria investigate the feasibility of adding a warning flag (not containing any medical information itself) in the Prisoner Information Management System (PIMS) or other system to highlight the need for priority of a medical transfer where clinically indicated.	Response from Department of Justice and Community Safety	Accepted in part
That Corrections Victoria investigate the feasibility of adding an alternate intermediate location in the PIMS where the circumstances relating to	Response from Department of Justice and	Accepted in part

the individual prisoner allow.	Community Safety	
That Corrections Victoria re-establish its quarterly governance forum or comparable process capable of monitoring its response to issues identified, and recommendations made, by JARO, Justice Health or similar entities.	Response from Department of Justice and Community Safety	Accepted in full

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 onsite services.	Response from Department of Health	Accepted in full
To the Secretary of the Department of Health, via the Chief Psychiatrist,	Response from Department of	Accepted in full

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.	Health	

Finding into death of Bazouni Bazouni

Keywords: death in custody, substance use, medical treatment, communication failure, hypoxic brain injury

Recommendation	Response	Response outcome
That Corrections Victoria considers developing and implementing a training program, to be undertaken by correctional staff and medical staff together (i) to enhance their mutual understanding of each other's respective roles in Victoria's prison system; and (ii) to encourage a co-ordinated, timely and effective sharing of information between them, including in relation to circumstances requiring medical assessments and observations of prisoners and assessments of security risks posed to staff by prisoners requiring medical attention.	Response from Department of Justice and Community Safety	Accepted in full

Finding into deaths of Wiki Raymond Lowe and Noel Thomas

Keywords: death in custody, suicide, ligature, risk assessment

Recommendation	Response	Response outcome
That the Secretary to the Department of Justice and Community Safety investigate the viability and utility of prisons in Victoria each centrally and remotely monitoring the vital signs of prisoners who have undergone risk assessment for suicide or self-harm including the extent to which any such monitoring may reduce the need for prisoners allocated S1 ratings being held in 'Muirhead type' cells.	Response from Department of Justice and Community Safety	Accepted in full
That when prison authorities consider transferring a prisoner from one prison to another, that such authorities explicitly consider whether there is any reasonable alternative for dealing with the perceived need for such transfer.	Response from Department of Justice and Community Safety	Accepted in full
The Secretary to the Department of Justice and Community Safety ensure that Victorian prisons have timely access to 'interstate' medical records of prisoners in custody in Victoria.	Response from Department of Justice and Community Safety	Accepted in full
The Secretary to the Department of Justice and Community Safety facilitate the 'step down' management plan for prisoners whose S rating is reduced from S3 to S4 as foreshadowed in the JARO Report into Mr Thomas's death including the use of annexure six to that Report.	Response from Department of Justice and Community Safety	Accepted in full
The Secretary instigate auditing of the utility and effectiveness of the referral process set out in the JARO Report into Mr Thomas's death for prisoners thought to be struggling	Response from Department of Justice and Community Safety	Alternative adopted

with issues to 'Offending Behaviour Programs'.		
The Secretary ensure that a clear line of responsibility is in place for rescheduling cancelled medical appointments in Victorian Prisons taking into account respective prison authorities and all relevant medical services providers. Further that the operation of that 'line of responsibility' is audited for efficient, effective operation.	Response from Department of Justice and Community Safety	Accepted in full

Finding into death of Naser Vukovic

Keywords: death in custody, self-harm, suicide, sharp object

Recommendation	Response	Response outcome
Corrections Victoria and Justice Health ensure Risk Review Teams, when considering Risk Management Plans, document consideration of access to means (in addition to hanging points) for example, razor blades, when requiring prisoners to be placed in a BDRP compliant cell. This is to occur for all Melbourne Assessment Prison prisoners required to be placed in a BDRP compliant cell as part of the Risk Management planning process in the Risk Review Teams.	Response from Department of Justice and Community Safety	Accepted in full
Corrections Victoria and Justice Health, in consultation with Forensicare, update the Melbourne Assessment Prison 'At Risk' Local Operating Procedures that makes provision for Risk Management Plans to specify 'modified' cell conditions, including removal or supervised use of sharps, razors and other suicide and self-harm means, to remove the reference to cell modifications including restriction on access to sharps and razors, as this cannot be practically implemented or achieved.	Response from Department of Justice and Community Safety	Accepted in full
Given eliminating access to means is recognised as a significant suicide prevention method, Corrections Victoria and Justice Health, in consultation with Forensicare investigate and, if possible, develop and implement an 'in between' unit within the Victorian prison system in which access to suicide or self-harm means, such as razors and sharps, can be	Response from Department of Justice and Community Safety	Alternative adopted

practically restricted where necessary, for example where a prisoner has a history of self-harm by that method, to manage and reduce suicide and self-harm risk.		
Corrections Victoria and Justice Health implement a system to ensure prisoners are aware of their right to consent to disclosure of their health information. Such a system should include a provision for information and consent forms at key stages, for example, on reception to prison. Consent forms should also be available for family and friends when visiting a prisoner. Whilst it will always remain the prisoner's right to provide or decline consent, those who would most benefit from permitting a supporter to be involved in their health care will likely need assistance to navigate a system for providing their consent.	Response from Department of Justice and Community Safety	Accepted in full
As part of the above system for the provision of consent to disclose health information, Justice Health should work with Forensicare to develop a system whereby prisoners who require mental health care and treatment can nominate a support person to provide non-legal advocacy for prisoners experiencing mental ill health. Consideration should be made to implementing a system similar to the nominated person provisions in the Mental Health Act 2014.	Response from Department of Justice and Community Safety	Accepted in full
The Department of Justice and Community Safety review the mental health resources available at the Melbourne Assessment Prison where all male prisoners with a serious psychiatric condition requiring intensive and/ or immediate care (P1 rated) in	Response from Department of Justice and Community Safety	Accepted in full

Victoria are generally housed. Given the shortfall for forensic mental health beds is a systemic issue, the review should include: (a) the resources required to provide contemporary mental health assessment and care in a high volume, high acuity custodial setting be it bed-based assessment beds or clinical teams that have the time to undertake comprehensive assessments and reviews; and (b) the impact on the Melbourne Assessment Prison of the demand for finite Thomas Embling Hospital beds, and how it influences decision-making on the housing of prisoners with a mental illness.		

Finding into death of Charles Bertram Squires

Keywords: death in custody, fall, intercranial haemorrhage, head injury

Recommendation	Response	Response outcome
To the Secretary, Department of Justice and Community Safety: That Justice Health reports into prisoners' deaths detail the materials relied on, and specifically reference any applicable Guidelines relevant to medical care and compliance or otherwise. As all deaths in custody are reportable to the coroner, Justice Health should conduct interviews with staff involved and consider the forensic pathologist's report, so the Justice Health review has accurate details regarding the prisoner's cause of death.	Response from Department of Justice and Community Safety	Accepted in full
To Correct Care Australasia: That Correct Care Australasia ensures the Induction Program for nursing staff employed in Victorian correctional facilities includes education and advice about the relevant and applicable Guidelines including Emergency Guidelines.	Response from Correct Care Australasia Response from Department of Justice and Community Safety	Accepted in full

Finding into death of Michelle Hughes

Keywords: death in custody, suicide, ligature, mental health management

Recommendation	Response	Response outcome
The Secretary of the Department of Justice and Community Safety investigate the viability, utility and implementation of a process by which vital signs of prisoners at the Dame Phyllis Frost Centre who are assessed as S1 – S3 can be continually remotely electronically monitored and recorded 'in real time' and in such a manner that prison guards are immediately alerted to aberrant fluctuation.	Response from Department of Justice and Community Safety	Accepted in full

Deaths in care

Finding into death of Stuart Brant Garten

Keywords: Suicide, mental health, inpatient care, hospital

Recommendation	Response	Response outcome
I recommend Latrobe Regional Hospital Secure Extended Care Unit review its discharge planning to include as fundamental, routine, and real-time discussion between SECU and community mental health staff that is representative of a patient's concerns and goals.	Response from Latrobe Regional Hospital	Accepted in full
I recommend Latrobe Regional Hospital Secure Extended Care Unit review the content of the Consumer Safety Plan for opportunities to include practicable and agreed access to means controls.	Response from Latrobe Regional Hospital	Accepted in full

Finding into death of Kira Shae James

Keywords: death in custody, suicide, ligature, mental health, involuntary patient

Recommendation	Response	Response outcome
That Forensicare amend its policy on Patient Counts to include an escalation process that is applicable in circumstances where the clinician allocated to conduct the count is unable to complete it within the required timeframe. This escalation process should enable the task to be reallocated to an available clinician.	Response from Forensicare	Accepted in full

Finding into death of Christopher Traill

Keywords: suicide, hospital, psychiatric unit, ligature, addiction, mental health, compulsory inpatient care

Recommendation	Response	Response outcome
With the aim of preventing like deaths and promoting public health and safety within a mental health in-patient unit, I recommend that on admission to the in-patient Unit, Bendigo Health mandate the removal of all personal items that could be used for self harm as described as "Dangerous Items" in the Chief Psychiatrist's Guideline.	Response from Bendigo Health	Accepted in full
With the aim of preventing like deaths and promoting public health and safety within a mental health in-patient unit, I recommend that Bendigo Health review their processes related to identifying personal items that have the potential to be used for harm and without identifying all the specifics that should be considered within that review, I recommend it should include reference to whose responsibility it is to make the assessment, to document the assessment and whose responsibility it is to implement the removal of said identified items	Response from Bendigo Health	Accepted in full
With the aim of preventing like deaths and promoting public health and safety within a mental health in-patient unit, I recommend that Bendigo Health implement a practice of providing patients alternative items to replace any personal items removed for risk minimising purposes.	Response from Bendigo Health	Accepted in full

Aged care

Finding into death of Ms F

Keywords: bed poles, neck compression, haemothorax, complex medical history, home care

Recommendation	Response	Response outcome
The Victorian Department of Health, as part of their responsibility to support independent living for the State's older people, provide clear public advice to Victorians about the potential risk to life of the KA524 bed pole or similar style, and of the risks posed by improperly used bed poles in particular	Response from Department of Health	Accepted in full

Finding into death of Phillip Charles Hodges

Keywords: Choking, food bolus, aged care, inadequate training, complex medical history

Recommendation	Response	Response outcome
In the interests of promoting public health and safety and with the aim of preventing similar deaths, I recommend that the Federal and State Government Health Departments create a legislative mandate requiring annual drills for residential aged care staff to enable the staff to develop the necessary skills to abate the medical emergency risks presented by choking incidents.	Response from Minister for Ambulance Services Response from Minister for Health and Aged Care	Rejected in full Under consideration
In the interests of promoting public health and safety and with the aim of preventing similar deaths, I recommend that the Federal and State Government Health Departments include a training module to cover emergency procedures in choking incidents as part of any standing First Aid Response training in residential aged care.	Response from Minister for Ambulance Services Response from Minister for Health and Aged Care	Rejected in full Accepted in full
In the interests of promoting public health and safety and with the aim of preventing similar deaths, I recommend that the Federal and State Government Health Departments devise or develop a training module for staff employed in residential aged care to be trained to safely provide feeding assistance at all times to residents with modified texture diets.	Response from Minister for Ambulance Services Response from Minister for Health and Aged Care	Alternative adopted Accepted in full

Finding into death of Gwenyth Evelyn Miles

Keywords: aged care, fall, exposure, absconding

Recommendation	Response	Response outcome
Arcare Brighton consider reviewing staffing and infrastructure arrangements at the front door of their premises with a view to having doors which open automatically to allow people to enter the facility and there-by allow residents to leave, directly monitored by staff.	Response from Arcare Aged Care	Accepted in full
Arcare Pty. Ltd. consider such a review at other of their facilities with the view to maximising residents' liberty and at the same time optimising their safety.	Response from Arcare Aged Care	Accepted in full

Family Violence

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	Response from Victoria Police	Rejected in full

listed is common to a prohibited person or person whose firearms licence has been cancelled and if so, the Permit should not be granted and an investigation commenced.		
That Victoria Police update their policies and procedures so that upon notification of a change of postal, residential or storage address by a licence holder, LRD must establish whether the proposed address listed is common to a prohibited person or person whose firearms licence has been cancelled and if so an investigation should be commenced.	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 under the Firearms Act 1996 with every license renewal and upon issuing a new permit to acquire a firearm.	Response from Victoria Police	Accepted in full
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.	Response from the Victorian Attorney General's office	Under consideration
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 and New Zealand College of Psychiatrists	Alternative adopted

Finding into death of Alicia Maree Little

Keywords: Family violence, intimate partner homicide, separation, dangerous driving

Recommendation	Response	Response outcome
With the aim of promoting public health, preventing deaths, and supporting mental health practitioners to address family violence, I recommend that the National Federation Reform Council (NFRC) review the current registration standards required of registered psychologists. Measures should be considered to introduce family violence mandatory CPD for registered private psychologists and private psychiatrists to provide for an occupation-specific level of family violence understanding and referrals for further support where a patient/client is identified as experiencing or suspected to be experiencing family violence.	Response from the office of the Prime Minister of Australia	Under consideration

Finding into deaths of Claire, Anna, Matthew and Katica Perinovic

Keywords: Filicide, family violence, suicide, mental health

Recommendation	Response	Response outcome
With the aim of promoting public health and safety and preventing like deaths, I recommend that the Royal Australian and New Zealand College of Psychiatrists review and update the Clinical Practice Guidelines for the Management of Schizophrenia and Related Disorders to improve best practice in clinical care provided to patients diagnosed with First Episode Psychosis in community mental health practices and in light of the circumstances of Katica and her children's deaths.	Response from Royal Australian and New Zealand College of Psychiatrists	Under consideration

Finding into death of Fatima Batool

Keywords: Intimate partner homicide; CALD; family violence, family violence intervention order, FVIO, mental health

Recommendation	Response	Response outcome
With the aim of promoting public health, preventing deaths and supporting medical practitioners to address family violence, I recommend that the National Federation Reform Council (NFRC) review the current registration standards required of medical practitioners with a view to updating CPD requirements for General Practitioners. A specific portion of CPD training undertaken by General Practitioners should be dedicated to family violence to reach an occupation-specific level of family violence understanding and referrals for further support where a patient is identified as experiencing or suspected to be experiencing family violence.	Response from the office of the Prime Minister of Australia	Under consideration
I recommend that similar measures be taken to introduce family violence mandatory CPD for registered psychologists and psychiatrists to provide for an occupation-specific level of family violence understanding and referrals for further support where a patient/client is identified as experiencing or suspected to be experiencing family violence.	Response from the office of the Prime Minister of Australia	Under consideration

Finding into death of Mr A

Keywords: Intimate partner homicide; family violence, sharp object

Recommendation	Response	Response outcome
With the aim of improving the administration of justice, preventing deaths and supporting police members address family violence, I recommend that Victoria Police update current family violence policies and procedures to require service on respondents who are incarcerated within 48 hours of the order being made to prevent delays in FVIO protection applying to protected persons.	Response from Victoria Police	Alternative adopted
With the aim of improving the administration of justice, preventing deaths and supporting prison systems to address family violence, I recommend that Corrections Victoria monitor phone calls of prisoners who are respondents to a FVIO for breaches including specifically "using another to do something they are not permitted to do" and report these in a timely manner to Victoria Police for investigation.	Response from Department of Justice and Community Safety	Rejected in full

Finding into death of PFS

Keywords: family violence, suicide, Victoria Police, reported family violence, FVIO, intimate partner violence

Recommendation	Response	Response outcome
That the Council of Australian Governments and Minister for Families and Social Services consider making counsellors and social workers subject to the National Registration and Accreditation Scheme or a similar scheme so that their practices are regulated and underpinned by standards, guidelines and an educational framework facilitating family violence best practice, as it develops over time.	Response from Minister for Families and Social Services Response from Australian Health Practitioner Regulation Agency	Under consideration Rejected in full

Finding into death of Patricia Jocelyn Eve Grant

Keywords: Elder abuse, family violence, carer, declining health

Recommendation	Response	Response outcome
I recommend that RACGP [Royal Australian College of General Practitioners] amend the Standards for General Practices and the relevant RACGP clinical guides, the White and Silver Books, to encourage GPs to consider taking further action to address risks to patients who do not respond to reminders in their practice management software where those patients have chronic conditions requiring ongoing monitoring and are at risk of elder abuse including neglect.	Response from Royal Australian College of General Practitioners Response from Royal Australian College of General Practitioners (Attachment A)	Accepted in part

Child/infant deaths

Finding into death of YOA

Keywords: drowning, river, child, camping, water safety, supervision, water hazard

Recommendation	Response	Response outcome
I recommend that the DELWP install appropriate signs at the Wood Point campsite to warn visitors of the dangers of swimming in the river, including the dangers OF sudden floods and strong currents.	Response from Department of Environment, Land, Water and Planning (DELWP)	Accepted in full
I recommend that the DELWP liaise with Snowy Hydro to establish a real-time warning system to notify DELWP employees and relevant personnel about water releases from the Jindabyne Dam.	Response from Department of Environment, Land, Water and Planning (DELWP)	Alternative adopted
I recommend that the DELWP liaise with the appropriate authorities to conduct a feasibility study of installing/improving mobile phone reception and coverage in the and around the area of the Wood Point camping ground to allow for prompt emergency notifications if required.	Response from Department of Environment, Land, Water and Planning (DELWP)	Accepted in part

Finding into death of Timothy Dale Fehring

Keywords: international school excursion, overseas tour, Hypoxic-ischaemic encephalopathy, acute gastritis, acute bilateral bronchopneumonia, cardiac arrest

Recommendation	Response	Response outcome
The Department of Education and Training increase the staff to student ratios on international trips, so the chaperones have more flexibility in accommodating student or staff illness whilst managing the remaining students.	Response from Department of Education and Training	Accepted in full
The Department of Education and Training revisit the DET Excursions Policy considering these Findings.	Response from Department of Education and Training	Accepted in full

Finding into death of HC

Keywords: infant, CALD, perinatal asphyxia, global cerebral ischaemia, labour complications

Recommendation	Response	Response outcome
I recommend that Werribee Mercy Hospital finalise and submit the business case for an African Liaison position at the hospital.	Response from Mercy Health Mercy Health (Attachment A) Mercy Health (Attachment B) Mercy Health (Attachment C) Mercy Health (Attachment D)	Accepted in part
I recommend that Werribee Mercy Hospital develop an information package for staff on the roles of support people and how to communicate with them effectively, with guidance on how to escalate issues that may impact on safe birthing outcomes.	Response from Mercy Health Mercy Health (Attachment A) Mercy Health (Attachment B) Mercy Health (Attachment C) Mercy Health (Attachment D)	Accepted in full
Werribee Mercy Hospital documentation on partograms should include all findings to allow for accurate assessment and help with recognition of an abnormal labour process.	Response from Mercy Health Mercy Health (Attachment A) Mercy Health (Attachment B) Mercy Health (Attachment C) Mercy Health (Attachment D)	Accepted in full

I recommend that Werribee Mercy Hospital consider the use of stickers for the documentation of an abnormal CTG as stipulated in the Intrapartum Fetal Surveillance Clinical Guideline.	Response from Mercy Health Mercy Health (Attachment A) Mercy Health (Attachment B) Mercy Health (Attachment C) Mercy Health (Attachment D)	Accepted in full
I recommend that Werribee Mercy Hospital encourage staff to attend the Fetal Surveillance Education Program offered by RANZCOG on a regular basis.	Response from Mercy Health Mercy Health (Attachment A) Mercy Health (Attachment B) Mercy Health (Attachment C) Mercy Health (Attachment D)	Accepted in full

Finding into death of Master S

Keywords: asthma, SafeScript, Aboriginal passing, child protection, hospital access

Recommendation	Response	Response outcome
That the Victorian Department of Health expand the scope of drugs monitored by the SafeScript real-time prescription monitoring program, to include all prescription medications that are prescribed and dispensed throughout Victoria without exception.	Response from Victorian Department of Health	Rejected in full

Finding into death of Master S

Keywords: Aboriginal passing, chroming, volatile substances, child protection, poisoning, substance abuse, family violence exposure, contact with justice system

Recommendation	Response	Response outcome
That the Department of Health review and update the contents of its booklet titled About Inhalant Abuse: For Health and Community Workers in light of what is now known about volatile substance misuse and related harms, to ensure that youth workers and others who work with young people at risk of volatile substance misuse have access to the best and most contemporaneous advice to support this vulnerable group. The booklet should be re-launched when the update is complete.	Response from Department of Health	Accepted in full
That the Department of Health undertake a review of what is known about volatile substance misuse, how it has evolved as a public health issue in Victoria over the past 15 years, and what strategies have worked both here and internationally to reduce associated harms. The review would ideally include engagement with manufacturers of products that are strongly implicated in volatile substance misuse, to gain a better understanding of how product re-design might contribute to harm reduction in this area. Upon completing the review, the Department of Health should consider what resources it might produce for relevant audiences (for example educators, parents, police) who might be in a position to identify and address volatile substance misuse among young people in our community.	Response from Department of Health	Accepted in full

Finding into death of Oliver Vincent Paul Cronin

Keywords: Gaming disorder, behavioural issues, mental health, video games, teenager, misadventure

Recommendation	Response	Response outcome
To help prevent psychological harms to adolescents and young adults from gaming platforms and online gaming, I recommend the Office of the eSafety Commissioner raises awareness in adolescents and young adults of the risks of gaming on their psychological wellbeing and promote the inclusion of information about gaming and psychological wellbeing in school based digital health programs.	Response from Office of the eSafety Commissioner	Accepted in full
To help develop a reliable evidence-base about gaming and adolescents and young adults in Australia, which will inform strategic and local policies, the standardisation of advice on the risks of psychological harms and online gaming, prevention strategies, and the development of contemporary and evidence-based interventions, I recommend the Office of the eSafety Commissioner promote research that establishes the incidence and prevalence of psychological harms to adolescents and young adults from online gaming.	Response from Office of the eSafety Commissioner	Alternative adopted

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 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 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 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 Master J

Keywords: blind cord, neck compression, child, hypoxia

Recommendation	Response	Response outcome
With the aim of improving Victoria's uptake of blind cord safety kits and preventing like deaths, I recommend that the Minister for Consumer Affairs, Gaming and Liquor considers mandating that blind cords in current residential rental properties are affixed to the wall.	Response from Minister for Consumer Affairs, Gaming and Liquor Regulation	Under consideration
With the aim of emphasizing and enhancing the role of real estate agency staff in detecting broken blind cord safety devices, I recommend that the Minister for Consumer Affairs, Gaming and Liquor incorporates reference to 'blind cord affixed to the wall' in its condition report for residential rental properties.	Response from Minister for Consumer Affairs, Gaming and Liquor Regulation	Under consideration

Finding into death of Hunter Patrick Boyle

Keywords: drowning, child, dam, water hazard

Recommendation	Response	Response outcome
In accordance with the response of LSV [Life Saving Victoria], I recommend that water safety campaigns run by relevant organisations such as Farmsafe, KidSafe, LSV and local government in Victoria, continue to promote public awareness of: i. how quickly children can get into danger around water, with a particular focus on waterbodies around the home and the differences between rural and urban water hazards; ii. the importance of fencing and/or safety barriers where appropriate to restrict access to water hazards and serve as a visual and physical barrier for children; iii. the wearing of high visibility clothing for children on rural properties to aid the visibility of children when on the property and to potentially decrease the search time for victims; iv. the removal of any items floating in dams that may attract children into the water and; v. having an emergency action plan in place where inland water bodies are present.	Response from Department of Jobs, Precincts and Regions Joint response from Farmsafe Australia, Kidsafe Victoria and Life Savings Vitoria	Accepted in full Accepted in full

Finding into death of DVR

Keywords: fire, child, charcoal, smoke inhalation, sprinklers, fire hose

Recommendation	Response	Response outcome
I recommend that the Department of Families, Fairness, and Housing (DFFH) consult with relevant organisations and conduct a feasibility study into whether fire sprinkler systems could be installed in all current (and future) public housing premises.	Response from Homes Victoria	Under consideration
I recommend that the DFFH ensure that all technicians who perform inspections and testing of fire systems, and any other essential safety measures work, be required to hold appropriate licences so that servicing is performed to the requisite standard.	Response from Homes Victoria	Accepted in part
I recommend that the DFFH considers the potential role of MCHN services or other services in identifying and improving the fire safety practices of parents of young children, particularly those facing social and financial disadvantage.	Response from Homes Victoria	Accepted in full

Missing persons

Finding into death of Mr GFE

Keywords: Missing person, drowning, sailing, lifejacket, personal floatation device (PFD), Emergency Position Indicating Radio Beacon (EPIRB), yacht, hypoxic episode

Recommendation	Response	Response outcome
I recommend that Marine Safety Victoria and the Department of Transport develop legislation mandating that solo operators in enclosed and coastal Victorian waters must wear a PFD Type 1 with an attached registered EPIRB.	Response from Department of Transport Response from Safe Transport Victoria	Rejected in full Alternative adopted
I further recommend that Marine Safety Victoria and the Department of Transport develop legislation mandating that any recreational vessel that has an LPG system on board in an enclosed area must have an operable gas detecting system.	Response from Department of Transport Response from Safe Transport Victoria	Rejected in full Alternative adopted

Drowning

Finding into death of Michael John Hanratty

Keywords: drowning, recreational boating, fishing, sandbar, capsize, personal floatation device (PFD)

Recommendation	Response	Response outcome
With the aim of promoting public health and safety and preventing like deaths, I recommend that the Maritime Safety Division of Transport Safety Victoria highlight and disseminate the circumstances in which Mr Hanratty drowned in their upcoming educational materials and safety promotional campaign.	Response from Transport Safety Victoria	Accepted in full

Finding into death of David Andrew Coulter

Keywords: drowning, capsize, boating, fishing, recreation, large waves

Recommendation	Response	Response outcome
In the interests of public health and safety and with the aim of preventing like deaths, I recommend that the Maritime Safety Division of Transport Safety Victoria highlight and disseminate the circumstances in which Mr Coulter drowned in its upcoming educational materials and safety promotional campaign.	Response from Safe Transport Victoria	Accepted in full
In the interests of public health and safety and with the aim of preventing like deaths, I recommend that the Maritime Safety Division of Transport Safety Victoria produce and disseminate awareness campaign such as the "Life Jacket Label-Read It" campaign as advanced by the National Safe Boating Council of the United States.	Response from Safe Transport Victoria	Alternative adopted

Finding into death of Terry John Chandler

Keywords: drowning, boating, inexperience, intoxication, fishing, large waves, capsize

Recommendation	Response	Response outcome
In the interests of public health and safety and with the aim of preventing like deaths, I recommend that the Maritime Safety Division of Transport Safety Victoria highlight and disseminate the circumstances in which Mr Chandler drowned in its upcoming educational materials and safety promotional campaign.	Response from Safe Transport Victoria	Accepted in full
In the interests of public health and safety and with the aim of preventing like deaths, I recommend that the Maritime Safety Division of Transport Safety Victoria produce and disseminate awareness campaign such as the "Life Jacket Label-Read It" campaign20 as advanced by the National Safe Boating Council of the United States.	Response from Safe Transport Victoria	Alternative adopted

Finding into death of Choon Jie Chai

Keywords: drowning, pool, hotel pool, pool safety

Recommendation	Response	Response outcome
In the interests of public health and safety and with the aim of preventing similar deaths, I recommend that Emergency Management Victoria review and extend the Safer Public Pools Code of Practice to include pools in Residential Class 3 buildings, including specifically hotels, motels, camping grounds and caravan parks.	Response from Department of Justice and Community Safety	Under consideration
As an alternative to recommendation 1, I recommend that Emergency Management Victoria lead the development of a new Safer Hotel, Motel, Camping Ground and Caravan Park Pools Code of Practice to be modelled on the existing Safer Public Pools Code of Practice.	Response from Department of Justice and Community Safety	Under consideration
I recommend that when producing the revised (recommendation 1) or new (recommendation 2) Code of Practice, Emergency Management Victoria consider the circumstances in which Choon Jai Chai drowned, and the issues relating to signage and pool supervision and emergency communication. All operators of swimming pools situated within hotels, motels, caravan parks and camping grounds should be encouraged to explore the options and means for best communicating with patrons who have English language challenges and ensuring that these patrons inform a staff member if they are not a confident swimmer before entering the water.	Response from Department of Justice and Community Safety	Under consideration
In the interests of public health and safety and with the aim of	Response from Department of	Under consideration

preventing similar deaths, I recommend that Emergency Management Victoria convene an advisory group that includes representatives drawn from the hotel, motel, camping ground and caravan park industries, along with Life Saving Victoria, to assist with developing, launching and disseminating the Code of Practice and supporting these industries to implement its advice.	Justice and Community Safety	

Finding into the death of Ross Powell; Finding into the death of Andrew Francis Powell

Keywords: drowning, volunteer lifesaving, dangerous conditions, rescue attempt, capsize, communication, coordinated rescue response

Recommendation	Response	Response outcome
I commend Life Saving Victoria for conducting an independent and thorough review of the events of 21 April 2019. I strongly support all of the recommendations made and I recommend Life Saving Victoria take immediate action to complete the implementation of all of the recommendations made in the Critical Incident Review Report, dated July 2019. To that end, Life Saving Victoria's response to this recommendation pursuant to section 72(3) of the Coroners Act 2008 should provide an update regarding the implementation of the 32 individual recommendations made in the Critical Incident Review Report.	Response from Life Saving Victoria	Accepted in part
I recommend Parks Victoria work with Life Saving Victoria to develop adequate signage warning of risks of swimming along the Port Campbell coastline. Particular consideration should be paid to size, location, audience, and the provision of information in languages other than English. Signs should also provide unique emergency location markers or codes to quote to emergency services in the event emergency services are required.	Response from Parks Victoria	Under consideration
I recommend Parks Victoria consider providing rescue/ flotation aids along non-patrolled areas of the Port Campbell coastline so that they can be deployed while patients await the assistance of a Marine Search and Rescue service	Response from Parks Victoria	Under consideration

Finding into death of Thi Minh Tam Ngyuen

Keywords: drowning, boating, accident, rough conditions, water ingress, capsize, sinking

Recommendation	Response	Response outcome
To the Secretary, Department of Transport, I recommend: that a vehicle inspection process at the time of registration and acquisition, or transfer, of vessel ownership be developed and implemented to proactively identify deficiencies and carry out remedial work where required, akin to relevant sections in the Road Safety (Vehicles) Interim Regulations 2020 (Vic).	Response from Department of Transport	Under consideration
To the Secretary, Department of Transport, I recommend: that all boats fitted with electrical bilge pumps in enclosed bilge areas have automated switches or floats, or alarms if a manual bilge pump exists.	Response from Department of Transport	Under consideration
To the Secretary, Department of Transport, 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 Department of Transport	Under consideration

Finding into death of Robert Wayne Edwards

Keywords: drowning, boating, boat accident, collision, fishing

Recommendation	Response	Response outcome
That the Minister for Fishing and Boating consider the introduction of a new indictable offence to cover situations where the operator of a vessel breaches the COLREGs or operates a vessel in a manner that is unsafe and causes serious injury or death. The new offence would apply where more than one vessel operator may have contributed to the death or serious injury and would not require the prosecution to prove that the accused solely or substantially caused the death or serious injury.	The Minister for Fishing and Boating was invited to respond by 16 March 2023 They were not required to respond and no response has been received to date.	Awaiting response

Workplace

Finding into death of Cameron James Ferry

Keywords: crush injury, tip truck, improper alignment, modified truck body

Recommendation	Response	Response outcome
That the National Heavy Vehicle Regulator consider amending the Vehicle Standards Bulletin (VSB6) or issue a Vehicle Standards Guide to provide clearer guidance on best practice when installing and working with body props on trucks fitted with a tipper body.	Response from National Heavy Vehicle Regulator	Under consideration

Finding into death of Matthew Duncan Gordge

Keywords: traumatic asphyxia, workplace incident, scissor lift, crushing hazard, mobile elevated work platform (MEWP)

Recommendation	Response	Response outcome
WorkSafe Victoria consider the viability of including a provision in the Industry Standard – Elevating work platforms that requires all EMPs to be fitted with secondary guarding technology.	Response from WorkSafe	Alternative adopted

Finding into death of Dominic Salvatore Mele

Keywords: Ride-on lawnmower; mechanical asphyxia; gradient gauge; rollover protection structure, slope gradient

Recommendation	Response	Response outcome
I recommend that Product Safety Australia consider updating the mandatory safety standard to ensure that ride-on lawnmowers be fitted with an inbuilt gradient gauge or alarm to allow operators to easily assess the gradient risk.	Response from Australian Competition and Consumer Commission	Alternative adopted
I recommend that WorkSafe Victoria implement a safety communication campaign specific to ride-own lawnmowers and the risk of roll-over to ensure better education and to highlight the risk to operators.	Response from WorkSafe Victoria	Accepted in full

Finding into death of Ivica Andrijasevic

Keywords: neck compression, crush injury, mobile elevated work platform (MEWP), faulty device, poor maintenance

Recommendation	Response	Response outcome
In the interests of public health and safety and preventing like deaths, I recommend that the Victorian WorkCover Authority revise Part 6 of its Industry Standard for the Safe Use of Elevating Work Platforms to require mandatory pre-start operational checks of MEWPs.	Response from WorkSafe Victoria	Accepted in part
In the interests of public health and safety and preventing like deaths, I recommend that the Victorian WorkCover Authority review Part 6 of the Industry Standard for the Safe Use of Elevating Work Platforms to consider which elements of the MEWP inspection should be undertaken more regularly than only before the start of each shift or first daily use. The evidence in this matter supports a view that the testing of directional switch controls should occur throughout the day whenever there is a new incident or episode of MEWP operation. I adopt this view.	Response from WorkSafe Victoria	Accepted in full
In the interests of public health and safety and preventing like deaths, I recommend that the Victorian WorkCover Authority review Part 6 of the Industry Standard for the Safe Use of Elevating Work Platforms to consider the role of the supervisor in the inspection process. At present, the inspection process described in the Industry Standard addresses only the MEWP operator's role, and the example of a pre-operational inspection checklist does not include any supervisor input. The	Response from WorkSafe Victoria	Rejected in full

Victorian WorkCover Authority must consider the need for supervisors to countersign logbook entries completed by operators, and the need for supervisors to conduct weekly audits of logbooks to ensure the maintenance of complete and accurate.		
In the interests of public health and safety and preventing like deaths, I recommend that the Victorian WorkCover Authority review Part 2.1 of the Industry Standard for the Safe Use of Elevating Work Platforms to consider recommendations about ongoing training and the regular reinforcement of safety messages.	Response from WorkSafe Victoria	Accepted in full
In the interests of public health and safety and preventing like deaths, I recommend that Standards Australia engage the appropriate experts to review AS 2550.10-2006. I recommend that the review includes a consideration of the circumstances in which Ivica Andrijasevic died, and my Findings regarding his untimely and preventable death.	Response from Standards Australia	Accepted in full

Recreational activities

Finding into death of Rosy Loomba

Keywords: fall, signage, fencing, cliff, lookout, rock ledge

Recommendation	Response	Response outcome
I recommend that Parks Victoria install additional signage at the Boroka Lookout warning people of the dangers of a fall and to stay within the safety fencing. The sign should expressly state that people have been seriously injured and died at this location.	Response from Parks Victoria	Under consideration

Finding into death of MD

Keywords: deer attack, accidental death, pet deer, adult buck, pet registration

Recommendation	Response	Response outcome
I recommend that Agriculture Victoria circulate a safety warning and/or information sheet for pet deer owners to remind them that it is best practice for deer to be de-antlered prior to mating season.	The Minister for Agriculture was invited to respond by 24 November 2022. They were not required to respond and no response has been received to date.	Awaiting response
I further recommend that, given that deer owners are not required to register their pets, vets in rural and regional communities display information relating to deer handling safety.	The Minister for Agriculture was invited to respond by 24 November 2022. They were not required to respond and no response has been received to date.	Awaiting response
Given there is currently no requirement to register pet deer, I recommend that local councils in rural and regional communities consider compulsory registration of pet deer to ensure that owners can be made aware of the dangers related to holding pet deer.	The Minister for Agriculture was invited to respond by 24 November 2022. They were not required to respond and no response has been received to date.	Awaiting response

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; and	Response from the Victorian Building Authority	Rejected in full

(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 John Disley

Keywords: Fall, ladder, roof, gutters, elderly

Recommendation	Response	Response outcome
In light of the continuing dangers posed by individuals working on ladders in the domestic context, especially amongst the elderly, I recommend that the Australian Competition and Consumer Commission (ACCC) and the Victorian Department of Health continue their Ladder Safety Matters campaign, including the dissemination of updated messages via relevant media, including social media channels.	Response from Australian Competition and Consumer Commission Response from Minister for Health	Accepted in full Accepted in full
With a view to promoting public health and safety and preventing like deaths, I recommend that the ACCC and the Victorian Department of Health review the impact and effectiveness of the Ladder Safety Matters campaign.	Response from Australian Competition and Consumer Commission Response from Minister for Health	Accepted in full Under consideration

Homicide

Finding into death of Anthony James Georgiou

Keywords: Loss prevention officer, security staff, use of force, physical restraint, methamphetamine, training

Recommendation	Response	Response outcome
Bunnings consider including in their training of Store Managers instruction in relation to the supervision of LPO's, particularly when such Officers are involved in a physical confrontation with a customer. Bunnings consider include in such training instruction about when Store Managers should become directly involved in actively managing LPO's involved in any such confrontation.	Response from Bunnings Group	Accepted in part
Bunnings record the details, including the names of LPO's involved, of all interactions between LPO's working at Bunnings Stores and customers. That Bunnings periodically audit those records, reviewing the performance of LPO's and provide a copy of those audits and reviews to the direct employers of LPO's operating at Bunnings Stores.	Response from Bunnings Group	Accepted in full
That the Bunnings Training for LPO's as referred to in paragraph 92 of this Finding include the kind of 'refresher training' recommended by Dr Zalewski and set out in his reports provided to the Court in this Inquest. (Exhibits 11 and 12 of this Inquest).	Response from Bunnings Group	Rejected in full

Finding into death of Gabriel Messo

Keywords: police intervention, mental health, body worn camera, police firearm, mental health care, mental health supports

Recommendation	Response	Response outcome
I recommend that the Chief Commissioner of Police reviews the feasibility of acquiring technology facilitating the automatic activation of members' Body Worn Camera upon a police-issued firearm being withdrawn from its holster (for example the Axon Signal–Sidearm technology).	Response from Victoria Police	Under consideration
The NDIS Quality and Safeguards Commission should conduct a review of the outsourcing arrangements to ensure that outsource providers of NDIS services have appropriate policies guidelines and training for staff to manage clients suffering mental health conditions who make threats of self-harm or harm to others. The policies and guidelines and training should include identifying a client's deteriorating mental health, and concerning behaviours, and guidelines on the management, escalation and/or referral to appropriate services including escalation to police in appropriate cases.	Response from NDIS Quality and Safeguards Commission	Rejected in full

Finding into death of Vlado Tomislav Micetic

Keywords: police pursuit, gunshot wound, police firearm

Recommendation	Response	Response outcome
In the interests of promoting public health and safety and with the aim of preventing similar deaths, I recommend that the Chief Commissioner of Police develop and maintain a system to ensure that Victoria Police remains adequately informed about their members' fitness for duty. In particular, the system so devised or developed must ensure that their members are both physically and psychologically fit for duty without violating individual rights to privacy, amongst others.	Response from Victoria Police	Under consideration

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	Response from the Department of	Under consideration

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).	Justice and Community Safety	
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 case managers, a system for notifying the Community Correctional Services of a	Response from Department of Health	Accepted in full

	mental health service or practitioner to whom the prisoner has been referred as part of any Forensicare Discharge Plan.		

Finding into death of Elizabeth Judith Robyn Wilms

Keywords: Homicide; intimate partner family violence; interstate arrest warrant; missing person investigation

Recommendation	Response	Response outcome
That New South Wales Police Force and Victoria Police independently and collaboratively review and if necessary amend any police, guidelines or processes relating to the management of warrants (including interstate warrants) to ensure that they are executed in a timely manner.	Response from Victoria Police Response from New South Wales Police Force	Accepted in full Accepted in full

Finding into death of Maria James

Keywords: historical homicide, cold case, stabbing, police investigation, re-opened

Recommendation	Response	Response outcome
Victoria Police should immediately conduct a complete and thorough physical search for the lost exhibits, namely Mrs James' clothing and the pillowslips. This is the minimum Victoria Police should do reflecting the gravity of the consequences of the lost exhibits and the importance of clarifying the factual situation regarding their whereabouts.	Response from Victoria Police	Accepted in full
Victoria Police should review the use of Interpose and, given the evidence Interpose could be used for this purpose, implement a documented process therein for the purposes of recording Major Decisions and the Reasons for those decision in all Homicide investigations. The purpose of this is to enable the progress and trajectory of an investigation to be followed on the basis that it is never known at the outset of an investigation which case will remain unsolved.	Response from Victoria Police	Accepted in full
Victoria Police should review and, if necessary, amend any Victoria Police Manual policy or guideline relevant to investigation case management, particularly investigations in which Interpose is used, to ensure Major Decisions and the Reasons for those decisions are recorded by the Primary Investigator (or his/her nominee) and compliance with this requirement is monitored and enforced by the Primary Investigator's Supervisor.	Response from Victoria Police	Accepted in full

Responses overdue by more than 12 months

Each edition of the CCOV Recommendations Report covers a 16-month period. This edition includes the period between 1 September 2021 and 31 December 2022.

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*

***** as of 31 May 2023, RACGP has undertaken to respond by 31 August 2023.

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 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