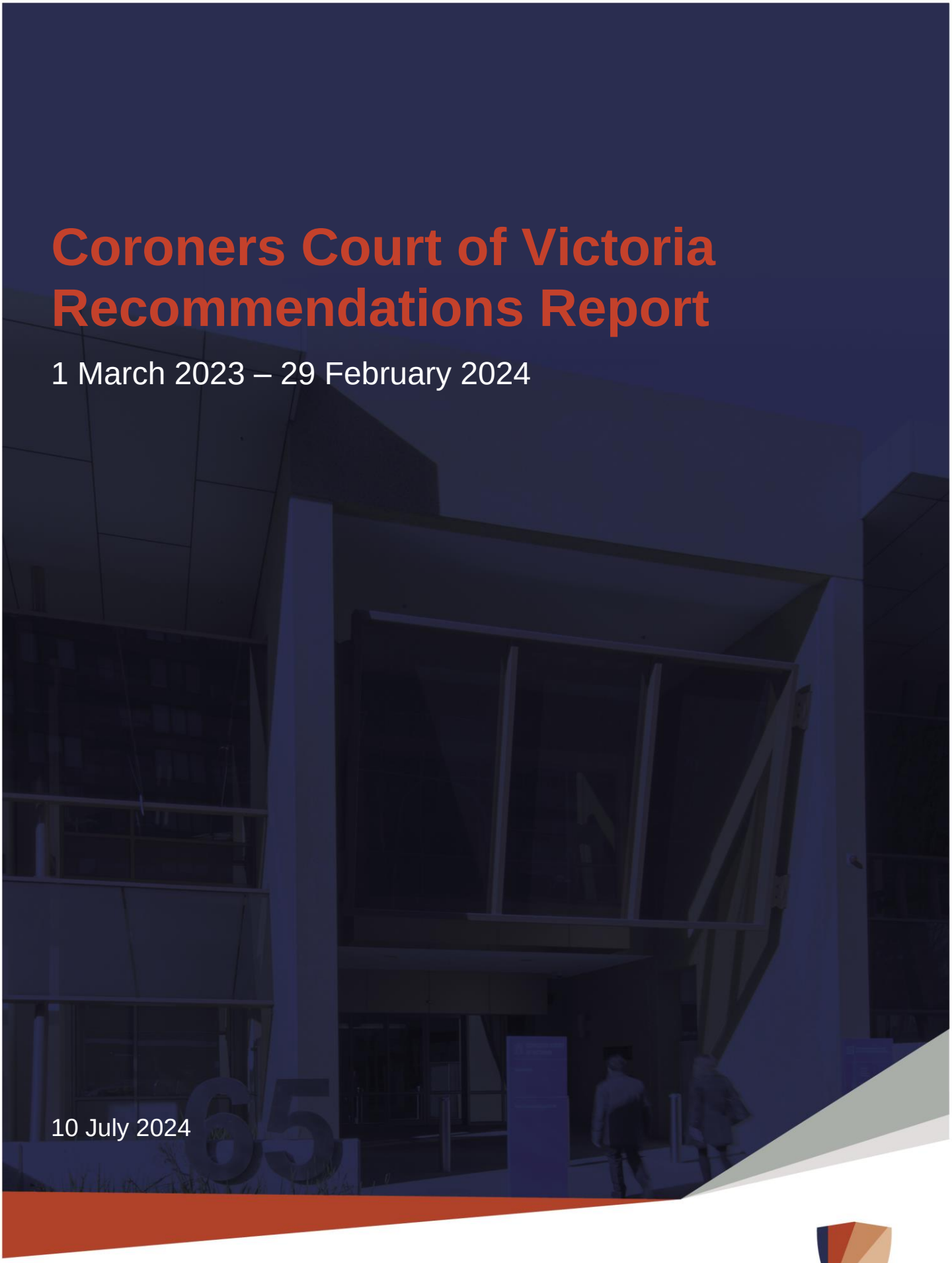
Coroners Court of Victoria Recommendations Report

1 March 2023 – 29 February 2024



10 July 2024

Coroners Court of Victoria

Coroners Court of Victoria

Warning

Aboriginal and Torres Strait Islander peoples are advised that the following report includes names and information associated with deceased persons from events that have occurred in Victoria. Readers are warned that there are words and descriptions that may be culturally distressing.

Acknowledgement

The Coroners Court of Victoria (CCOV) acknowledges the Traditional Owners and continuing custodians of the land on which it is located, the Wurundjeri Woi Wurrung peoples of the Kulin Nation. Furthermore, the CCOV respectfully acknowledges all Traditional Owners across Victoria and pay respect to all Elders both past and present. We acknowledge all families and communities who have been impacted by Sorry Business and provide our deepest condolences 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 12month period and the status of responses received.

This seventh edition covers the period from 1 March 2023 to 29 February 2024. During this period, coroners made 160 recommendations across 78 findings.

Following these recommendations, the Court received:

- 110 responses stating the recommendation was accepted in full.
- 6 responses stating the recommendation was accepted in part or an alternative was proposed.
- 43 responses stating the recommendation remains under consideration.
- 7 responses where the recommendation was not accepted.

In addition to these:

- 3 responses are still being prepared, have been granted an extension or were directed to entities that are not required to respond (awaiting response).
- 1 response has 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 3 responses overdue across 2 findings.

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 July 2024.

Contents

Suicide

Finding into death of JL

Keywords: Mental health, adolescent, major depressive disorder, bulimia nervosa, continuity of care, suicide

Recommendation	Response	Response outcome
To improve access to services and continuity of care for patients deemed to be vulnerable and/or at risk, I recommend the Australian Psychological Society advise its members that when confronted with evidence of a problem or situation beyond their capacity, or when a client is not benefiting from their psychological services, psychologists should take reasonable steps to ensure that the patient has been able to access the recommended alternate services if they choose to do so, and/or provide a handover to another health professional (such as a general practitioner) who can ensure that the patient is able to access the recommended services and can assist them to manage any barriers to accessing appropriate care.	Response from Australian Psychological Society	Accepted in full

Finding into death of Mr W

Keywords: suicide, friend and family support, mental health, mental health treatment

Recommendation	Response	Response outcome
That the Psychology Board of Australia in the development of a national code of conduct for AHPRA registered psychologists consider: - the role partners and family have in a person's care, especially when a client is at greater risk and, - that a client may wish to involve their partner and family at any stage of a therapy and, - that psychologists actively and regularly discuss with a client the appropriate and safe involvement of partner's and family.	Response from Psychology Board of Australia	Accepted in full

Finding into death of David Bramwell Van Vledder

Keywords: Mental health, emergency department presentation, nicotine dependence, smoking status, drowning, absconding, chronic alcohol intake, suicide

Recommendation	Response	Response outcome
In line with the Victorian Network of Smokefree Health Services Guidance for Managing Nicotine Dependence & Withdrawal in Emergency Care Setting, I recommend that Barwon Health considers asking all patients presenting to Emergency Department about their smoking status on each presentation, and, where clinically appropriate, that this trigger a further assessment of nicotine dependence and appropriate management.	Response from Barwon Health	Accepted in full

Finding into passing of Mathew James Luttrell

Keywords: Mildura, Aboriginal passing, suicide, access to mental health services, cultural safety and wellbeing, mental health, complex medical history, family violence

Recommendation	Response	Response outcome
Jointly, to the Hospital and MDAS: As a matter connected with Mathew's passing, I make a recommendation to MDAS and the Hospital to finalise an MoU or other form of agreement that relates to information-sharing, to enable timely and direct communication between MDAS and Hospital treating teams where common patients or clients present in crisis, that allows for the sharing of patient information to assist in timely treatment planning and diagnoses.	Response from Mildura Base Public Hospital Response from Mallee District Aboriginal Services	Accepted in full Accepted in full
To the Hospital, to be led by the Director of Aboriginal Health or as appropriate, I make recommendations aimed at addressing the cultural safety of the Hospital and the way in which the AHU is engaged to support patients, as follows: a) That the cultural awareness training described in the evidence of Ms Johnson is appropriately resourced and rolled out to staff working at the Hospital in the Mental Health Unit, as a matter of priority, with a plan in place for refresher training for all staff on a recurrent basis. This training should be a requirement not only for staff members but for locums and all persons working in the Mental Health Unit. b) That the Director of Aboriginal Health and the staff of the AHU be given the opportunity to be consulted on all policies of the Hospital with the view of improving their cultural safety. Where these policies state that services of an Aboriginal Liaison Officer be offered	Response from Mildura Base Public Hospital	Accepted in full

to Aboriginal patients, consideration should be given to introducing a system in which wards are required to inform the AHU of the presence of an Aboriginal patient and arrange for an AHU staff member to attend to the patient and introduce themselves and make that offer of support directly; c) That the AHU is resourced to ensure that all AHU staff have culturally appropriate clinical supervision arrangements where sought by and agreed to by AHU staff; and d) That all clinicians at the Hospital Mental Health Services be: (i) advised of the role of the AHU upon induction; and (ii) required to document in a patient file the steps made to contact the AHU in relation to Aboriginal patients, including any reason why such contact has not been made.		
Further to the Hospital, I recommend the following: a) That consideration be given to revising Hospital Mental Health Service policies and procedures to clarify: (i) who in the mental health treatment team is responsible for collecting collateral information, and at what stage; and (ii) that the authorised psychiatrist or delegate must always complete authorisations for restrictive interventions where that person is available. b) That the Hospital work with Spectrum: i. To identify appropriate training for clinicians in diagnosis and treatment of Borderline Personality Disorder, which addresses both long term treatment and crisis presentations;	Response from Mildura Base Public Hospital	Accepted in part

ii. Such training should be mandatory for all community and inpatient mental health clinicians; iii. Such training should occur for all new staff as a part of their induction, and for ongoing staff should be regular and repeated. c) That the Hospital engage the Victorian Equal Opportunity and Human Rights Commission to provide education to its staff to assist them to meet their Charter obligations; and d) That the Hospital engage the Victorian Equal Opportunity and Human Rights Commission under section 41(c) Charter to review its policies and practices with a view of strengthening their systems and processes to comply with the Charter.		
To the Secretary to the Department of Health, via its Mental Health and Wellbeing Division or as otherwise appropriate, I recommend: a) That the Department of Health ensures the rollout of the World Health Organisation QualityRights e-training across all designated mental health services as a matter of priority; and b) That the recommendations of the Royal Commission continue to be implemented in full, through the Mental Health and Wellbeing Division of Department of Health or as appropriate, with an update to be provided to the Court in relation to the implementation of recommendations 23, 26, 33, 35, 37, 40, 42, 44, 53, 54, and 55.	Response from Department of Health	Alternative adopted
To the Secretary to the Department of Health, via the Chief Psychiatrist or as otherwise appropriate: I recommend that consideration be given to clarifying the definition of	Response from Department of Health	Accepted in full

'seclusion' in the context of the new Mental Health and Wellbeing Act (including by way of issuing an updated OCA guideline) in order to crystallise whether seclusion relates to: (i) the confinement of a patient alone to an area in which they cannot leave; (ii) the confinement of one or more patients to an area in which they cannot leave; and (iii) whether the definition of seclusion is met if a staff member is present.		

Finding into death of PA

Keywords: Pentobarbitone, veterinary nurse, suicide, multiple suicide stressors, mental health

Recommendation	Response	Response outcome
That Castlemaine Veterinary Clinic ensure that escalation processes are in place regarding deviations from expected practice around the use, storage and monitoring of pentobarbitone.	Response from Castlemaine Veterinary Clinic	Accepted in full
That Castlemaine Veterinary Clinic ensure that all staff are educated around escalation processes if they identify deviations from expected practice around the use, storage and monitoring of pentobarbitone.	Response from Castlemaine Veterinary Clinic	Accepted in full
That the Veterinary Practitioners Registration Board of Victoria encourage its members to identify deviations from legislation and guidelines around the safe use, storage and monitoring of pentobarbitone and escalate these appropriately.	Response from Veterinary Practitioners Registration Board of Victoria	Accepted in full
That the Veterinary Practitioners Registration Board of Victoria encourage its members who operate veterinary practices communicate to their staff the expectations for use, storage and monitoring of pentobarbitone when deviations from policies and expected practice are identified. Such communication should be safety and prevention focused.	Response from Veterinary Practitioners Registration Board of Victoria	Accepted in full

Finding into death of Silin Wang

Keywords: Suicide, terminal illness, fall from a height, major depressive disorder, cancer treatment

Recommendation	Response	Response outcome
That Plenary Health increase the height of the glass balustrades on the rooftop garden on level seven of the VCCC building from 1.8 to 2.2 metres.	Response from Peter MacCallum Cancer Centre	Accepted in full

Finding into death of Amanda Jane Stapledon

Keywords: Mixed drug toxicity, IBAC investigation, witness welfare, suicide

Recommendation	Response	Response outcome
That IBAC review the operation of its legislation, and amend its policies, and procedures, where appropriate to ensure that there is no impediment in appropriate circumstances to advising witnesses as early as possible after a decision has been made, that their conduct is not under contemplation for the purpose of prosecution.	Response from Independent Broad-based Anti-Corruption Commission	Accepted in full

Finding into death of Michael Stephen Delaney

Keywords: Suicide, plastic bag asphyxia, inpatient care, complex mental health history, supported independent living, continuity of care

Recommendation	Response	Response outcome
With the aim of promoting public health and safety and preventing like circumstances, I recommend that Healthscope develop a policy or procedure whereby admitting psychiatrists and/or The Victoria Clinic staff communicate directly (subject to consent) with external health professionals involved in the care of current inpatients to ascertain the outcome of any assessment and/or treatment recommendations.	Response from The Victoria Clinic	Accepted in full

Finding into death of Marcus Caldwell

Keywords: Worksafe investigation, suicide, mental health, schizophrenia, workplace stress

Recommendation	Response	Response outcome
I endorse the recommendation 16 of the Royal Commission into Victoria's Mental Health System with the aim of preventing like deaths: 16. Establishing mentally healthy workplaces The Royal Commission recommends that the Victorian Government: 1. as an initiative of the Mental Health and Wellbeing Cabinet Subcommittee (refer to recommendation 46(2)(a)): a. foster the commitment of employers to create mentally healthy workplaces; b. advise on, develop and provide resources to assist employers and employees across Victorian businesses to: i. promote good mental health in workplaces; ii. address workplace barriers to good mental health; iii. promote inclusive workplaces that are free from stigma and discrimination; and iv. support people experiencing mental illness at work.	Response from Department of Health (Victoria) Response from Department of Premier and Cabinet	Request for redirection of recommendation Accepted in full
Sponsor industry-based trials to demonstrate how to adapt and implement comprehensive mentally healthy workplace approaches in an industry context.	Response from Department of Health (Victoria) Response from Department of Premier and Cabinet	Request for redirection of recommendation Accepted in full

Finding into death of Anuruddha Abeysinghe

Keywords: suicide, asphyxiation, alcohol dependency, termination of employment, mental health

Recommendation	Response	Response outcome
With the aim of preventing like deaths and promoting public health and safety, I recommend that Oceania Glass Pty Ltd review the incident and explore ways to ensure that all relevant managerial staff are familiar with the Enterprise Agreement, particularly to ensure adherence to the disciplinary procedures and drug and alcohol guidelines.	Oceania Glass Pty Ltd	Under consideration

Finding into death of Abdurrahman Coskun

Keywords: Suicide; mental health services, mental health, medical issues, continuity of care

Recommendation	Response	Response outcome
In line with the National Safety and Quality Health Service (NSQHS) Communicating for Safety Standard, that the Monash Health Crisis Assessment and Treatment Team (CATT)/Acute Crisis Intervention Service (ACIS) review their process for communicating critical clinical information on discharge to the accepting practitioner to ensure it includes: a. a detailed and current medication list including details of commencement date and dates of dose changes; b. suggested frequency of monitoring the patient's mental state; and c. clear indications of when a patient requires re-referral to a specialist mental health service and information on how to re-engage.	Response from Monash Health	Accepted in Full

Finding into death of Student XRG; Finding into death of Student AHT; Finding into death of Student HBI; Finding into death of Student KCM; Finding into death of Student FSB

Keywords: Suicide, international student, university, tertiary education, mental health, access to services

Recommendation	Response	Response outcome
I recommend that the Suicide Prevention and Response Office review the Orygen Quality Evaluation Framework (attached as Appendix A) in the context of this finding and its other work relating to international students, and consider whether a resource such as the Quality Evaluation Framework would assist universities to assess and review how they support international student health and wellbeing.	Response from Department of Health	Accepted in Full
I recommend that the Victorian Department of Health consider developing and maintaining a resource of this type to assist Victorian universities in implementing and reviewing their programs targeted at international student wellbeing. The resource could be regularly revised in collaboration with the universities to share new research, program design and ideas for monitoring international student wellbeing and encouraging help-seeking among those who may be experiencing mental health crises or suicidality.	Response from Department of Health	Accepted in Full

Overdose and poisoning

Finding into death of Jodie Marie Overstead

Keywords: Drug overdose, multiple drug toxicity, prescription drugs, multiple prescribing doctors, unintentional, migraine, chronic pain, drug dependence

Recommendation	Response	Response outcome
With the aim of promoting public health and safety and preventing like deaths, I recommend that the Royal Australian College of General Practitioners consider developing further training and education materials to highlight the harms and hazardous effects of tramadol, as well as the adverse interactions of the concomitant use of tramadol and other contraindicated medications.	Response from Royal Australian College of General Practitioners	Accepted in full

Finding into death of Bradley Scott Liefvoort

Keywords: Unintentional death, opioid toxicity, multiple prescribing doctors, SafeScript, medicines and poisons regulation

Recommendation	Response	Response outcome
In the interests of promoting public health and safety and with the aim of reducing the number of deaths in similar circumstances, I recommend that the Medicines and Poisons Regulation Section of the Victorian Department of Health implement suitable measures to identify when prescribers are not complying with requirements to check SafeScript before prescribing target drugs, and impose suitable measures to deter prescribers from similar conduct in future.	Response from Department of Health	Under consideration

Finding into death of Mr P

Keywords: mixed drug toxicity, overdose, music festival, Blue Punisher, high dose MDMA, drug checking services, harm reduction services

Recommendation	Response	Response outcome
The Secretary of the Victorian Department of Health, as the appropriate arm of the Victorian Government, implement a drug checking service in the State of Victoria to minimise the risks and the number of preventable deaths associated with the use of drugs obtained from unregulated drug markets.	Response from Department of Health	Rejected in full

Medical

Finding into passing of BCT

Keywords: Aboriginal Passing, hospital, paediatric, complex medical needs, PEG tube, hypoxic-ischaemic encephalopathy, sepsis, interventional radiology, cognitive bias

Recommendation	Response	Response outcome
I recommend that Monash Health fully implement their outstanding recommendations by: a. Providing a clinical space with the relevant support staff for Interventional Radiology to review patients and gain informed consent before any procedures; and, b. Providing Interventional Radiology a stand-alone bedcard with associated staff to facilitate all hours, in-house, and ward-based care. c. Develop and implement a learning module on Cognitive Bias	Response from Monash Health	Accepted in Full

Finding into death of Armin Schaefer

Keywords: Hospital, community treatment order, temporary treatment order, mental health, hypoxic brain injury, complex medical history, psychiatric unit, cardiac arrest, intensive care unit

Recommendation	Response	Response outcome
I recommend that Northern Health introduce an Emergency Department procedure whereby complex psychiatric patients receiving sedative medications receive appropriate investigations, including a 12-lead ECG and any other clinically indicated measures, where safe to do so prior to discharge.	Response from Northern Health	Accepted in full
I recommend that any Northern Health mental health patient requiring airway support, whether positional or otherwise, receive an urgent medical review and ongoing comprehensive monitoring as clinically indicated.	Response from Northern Health	Accepted in full

Finding into death of Antoinette O'Brien

Keywords: bacterial infection, intra-partum septicaemia, stillbirth, post-partum care, sepsis

Recommendation	Response	Response outcome
That the Victorian Department of Health amend the Health Services Establishments Regulations 2013 to mandate that: • all health facilities, public and private are required to undertake root cause analysis reports of sentinel events and serious adverse patient safety events; and • private hospitals be required to have an independent member on a root cause analysis panel consistent with the requirements imposed on public hospitals.	Response from Department of Health on behalf of the Department of Health and Safer Care Victoria	Accepted in full
That Safer Care Victoria review the effectiveness of the inclusion of the SAPSE legislation in the Health Services Act within 18 months from commencement with particular focus on the cooperation of health services providing reviews and root cause analyses and reports relating to SAPSE's and sentinel events to Safer Care Victoria.	Response from Department of Health on behalf of the Department of Health and Safer Care Victoria	Accepted in full
That Safer Care Victoria give consideration to amending the 'Think Sepsis Act Fast' guideline to include a section on the treatment of maternal sepsis. The amendment should focus on pregnant and post-partem women and include information about recommended antibiotics that should be administered.	Response from Department of Health on behalf of the Department of Health and Safer Care Victoria	Accepted in full
That Safer Care Victoria develop and promote a state-wide tool or tools to assist in the proper handover of patients between health professionals and in transfers between health services. An example of such a tool is the ISBAR	Response from Department of Health on behalf of the Department of Health and Safer Care Victoria	Accepted in full

which captures relevant information in a meaningful and effective way.		

Finding into death of Reginald William Griggs

Keywords: Peter MacCallum Cancer Centre, squamous cell carcinoma, tracheostomy, pneumonia, hospital acquired pneumonia, Advanced Care Plan, Advanced Care Directive

Recommendation	Response	Response outcome
I recommend that the Department of Health works with its relevant stakeholders to raise awareness about the importance of initially ascertaining and properly documenting the existence of an Advanced Care Directive, as well as conducting proper Goals of Care discussions, especially in elderly and vulnerable cohort of patients.	Response from Department of Health	Accepted in full

Finding into death of Gary Ronald Burgess

Keywords: Ileus, bowel obstruction, mental health, disability, complex medical history, treatment order, intensive care unit, hypoxia, cardiac arrest

Recommendation	Response	Response outcome
Pursuant to section 72(2) of the Act, I make the following recommendations directed to Safer Care Victoria: review the details of this case and the recommendations made at Peninsula Health, in order to consider whether some / all / additional process improvements in clinical care for patients taking clozapine should be implemented across all acute care health services state-wide.	Response from Safer Care Victoria	Accepted in full
Consider the utility of developing a guideline focused on education and improved clinical care delivery primarily for non-psychiatric health practitioners for the management of constipation in patients on clozapine (and other antipsychotics), similar to the documents from NSW Health and SA Health.	Response from Safer Care Victoria	Accepted in full

Finding into death of Mr V

Keywords: intracerebral haemorrhage, subarachnoid haemorrhage, emergency department, cognitive bias, stroke treatment, hospital

Recommendation	Response	Response outcome
That Monash Health consider whether their process of ensuring patients receive the right imaging scan can be made more reliable by: i. minimizing work conditions that increase the chances of error – such as addressing access block so that rapid assessments in the waiting room are not necessary; and ii. maximising work conditions which prevent predictable errors from reaching the patient and becoming patient harm – such as by requiring imaging requests to be vetted and approved by the radiology registrar rather than the Medical Imaging Technician (MIT), as the registrar has both a greater understanding of the clinical question being asked in the request and greater authority in discussions with medical staff than an MIT.	Response from Monash Health	Rejected in full

Finding into death of Thelma Annie Ogilvy

Keywords: abdominal sepsis, diverticular abscess, hospital, cardiac arrest

Recommendation	Response	Response outcome
That Monash Health review its processes to ensure timely notification of referring hospitals and doctors with regard to patient outcomes	Response from Monash Health	Accepted in full

Finding into death of Edis Brenner

Keywords: Medical, cardiovascular surgery, post-surgical complication, hospital, valvular disease

Recommendation	Response	Response outcome
With the aim of promoting public health and safety and preventing like deaths, I recommend that St John of God Hospital's clinical governance unit discuss all unexpected deaths that occur in relation to surgery with Safer Care Victoria's Patient Safety Review Team to ascertain whether the incident meets the criteria for a sentinel event notification and make any necessary notifications accordingly.	Response from St John of God Geelong Hospital	Accepted in full

Finding into death of Jeffrey Marsden

Keywords: Fall, spinal injury, WorkSafe, hospital, complex medical history, palliative care, accident, automatic doors, comorbidity, communication failure

Recommendation	Response	Response outcome
With the aim of preventing like deaths and promoting public health and safety, I recommend that the Royal Australian and New Zealand College of Radiologists consider using the death of Jeffrey Marsden as a case study in educational campaigns or materials highlighting the importance of communicating urgent and significant unexpected radiological findings directly to the referrer, in keeping with their Standards of Practice for Clinical Radiology.	Response from Safety, Quality and Standards Committee, RANZCR	Accepted in full
With the aim of preventing like deaths and promoting public health and safety, I recommend that Mercy Hospitals Victoria Ltd develop a system, if they have not already done so, by which they communicate deaths and other serious events to contracted service providers involved in the provision of clinical care to those patients. Such a system would ensure each entity is able to undertake a thorough review of their involvement and implement any necessary restorative and preventative measures in a timely manner.	Response from Mercy Health	Accepted in full

Finding into death of Reginald Benham

Keywords: Fall, hospital, medical, stroke, medication administration error, intercranial haemorrhage, comorbidity, palliative care, radiology, communication error

Recommendation	Response	Response outcome
With the aim of preventing like deaths and promoting public health and safety, I recommend that the Royal Australian and New Zealand College of Radiologists consider using the death of Reginald Benham as a case study in educational campaigns or materials highlighting the importance of communicating urgent and significant unexpected radiological findings directly to the referrer, in keeping with their Standards of Practice for Clinical Radiology.	Response from Safety, Quality and Standards Committee, RANZCR	Accepted in full

Finding into death of Michele Valentino

Keywords: Fall, head injury, hospital, medical, head injury, radiology, communication failure

Recommendation	Response	Response outcome
With the aim of preventing like deaths and promoting public health and safety, I recommend that the Australian and New Zealand College of Radiologists considers using the death of Michele Valentino as a case study in educational campaigns or materials highlighting the importance of communicating urgent and significant unexpected radiological findings directly to the referrer, in keeping with their Standards of Practice for Clinical Radiology.	Response from Royal Australian and New Zealand College of Radiologists (RANZCR)	Accepted in full
With the aim of preventing like deaths and promoting public health and safety, I recommend that Lumus Imaging reiterate to all employed or contracted radiologists the importance of communicating urgent and significant unexpected radiological findings directly to the referrer, by way of educational campaigns or otherwise.	Response from Lumus Imaging	Accepted in full

Finding into death of Mr E

Keywords: Fulminant liver failure, communication issues, facsimile communication, delayed test results, complex medical history

Recommendation	Response	Response outcome
The continued reliance on facsimile communication of critical or important information in the modern era is inappropriate. I therefore recommend that the Practice Manager of Timboon Medical Clinic consider discontinuing the use of facsimile for the receipt of pathology results and instead institute a digital critical test result management system that incorporates closed loop communication (defined as communication that ensures receipt and understanding of the communicated material).	Response from Timboon and District Healthcare Service (TDHS)	Accepted in Full

Finding into death of Md Fakrul Alam Sozon

Keywords: post-surgical complications, liver disease, alcohol dependence, complex medical history, ascitic tap procedure

Recommendation	Response	Response outcome
With the aim of preventing like deaths and promoting public health and safety, I recommend that Western Health develop a formal internal training and credentialling system regarding the use of bedside ultrasound for ascitic taps so that the technology can be used by clinicians other than trained radiology staff where necessary and appropriate.	Response from Western Health	Rejected in full

Finding into death of Mary Morrow

Keywords: Deep venous thrombosis (DVT), thromboembolism (VTE), pulmonary embolism, (PE) anticoagulation, prophylaxis, ankle fracture, delayed surgery

Recommendation	Response	Response outcome
That SCV finalise and publish a Victorian guideline on VTE risk management of patients who are discharged from an Emergency Department with significantly reduced mobility compared to their normal state, having regard to the Australian Commission on Safety and Quality in Healthcare: Venous Thromboembolism Prevention Clinical Care Standard (October 2018) and other state-based guidelines.	Response from Safer Care Victoria	Accepted in full
That Albury Wodonga Health continues to regularly review its system of VTE prevention to ensure compliance with applicable standards, including any newly-released Victorian Guideline for the Prevention of Venous Thromboembolism (VTE) in Adult Hospitalised Patients.	Response from Albury Wodonga Health	Accepted in full

Transport and Road Safety

Finding into passing of Phillip Pierson

Keywords: death in police presence, police intercept, police conduct, police pursuit, motorcycle, collision, high speed

Recommendation	Response	Response outcome
I recommend that the Chief Commissioner of Police give priority to seeking funding to implement the installation of in-car video technology (also referred to as front facing dashcam) in all police vehicles that undertake operational policing duties, along with the associated infrastructure to manage and review the footage. For the purposes of clarity, this technology should record audio and video footage of road policing activities, including roadside intercepts, and relevant metadata from the Police vehicle (speed, GPS location etc). Automatic number plate recognition (as installed across Victoria Police's highway patrol fleet) is not a requirement of this technology.	Response from Chief Commissioner of Police	Under consideration

Finding into death of Trevor Henry McKie

Keywords: coronary artery disease, atherosclerosis, boating, lake, adverse weather conditions, fall overboard, search, lifejacket maintenance

Recommendation	Response	Response outcome
Safe Transport Victoria consider reviewing the current information and safety material provided to mariners to ensure that it includes: a. information about the requirement to conduct an annual service and tests of an inflatable lifejacket to ensure that it is functional. The material should include a step-by-step guide as to how to conduct a check and service of the lifejacket if to be done by the owner, or in the alternative information about third-party contractors who provide do this service; b. information for mariners about the importance of checking and being up to date with the weather forecasts before they leave the shore and whilst on the water. This should include information about where to find the most up to date weather information and the availability of weather mobile applications (including the Boating Vic mobile application) that are available to mariners to check changing weather conditions while they are on the water; and c. information directed to mariners to contact triple zero in the event of an emergency and what information should be communicated to the triple zero call tacker including location information which may be the position expressed by reference to the current latitude and longitude.	Response from Safe Transport Victoria	Accepted in full
Safe Transport Victoria consider providing this information with the annual renewal of the registration of a vessel to ensure that boat owners read and understand this	Response from Safe Transport Victoria	Accepted in full

information. Consideration should be given to the feasibility of developing an online test to be completed prior to renewal of registration		

Finding into death of Mr J

Keywords: motor vehicle collision, motor bike, head-on collision, rigid tray truck

Recommendation	Response	Response outcome
That the Victorian Department of Transport install signage on the approach to both Bullock Road intersections on the Calder Alternative Highway to indicate 'Concealed Road	Response from Department of Transport and Planning	Accepted in full
That the Victorian Department of Transport install signage on Bullock Road at its intersection with Calder Alterative Highway to indicate 'Beware of Turning Vehicles'	Response from Department of Transport and Planning	Rejected in full

Finding into death of Hung Quang Nguyen

Keywords: motorcycle accident, Western Ring Road, motor vehicle, collision, overtaking, dark conditions

Recommendation	Response	Response outcome
That the Victorian Department of Transport take steps to make the start of the traffic island at the Western Ring Road, Keilor Park Drive Exit more visible to motorists, by implementing one or multiple of the following: a. Repainting the traffic island; b. Replacement of the cats eyes; and c. The addition of chevron or similar warning signs to indicate 'TRAFFIC ISLAND AHEAD'.	Response from Department of Transport and Planning	Accepted in Full

Finding into death of Carl Van Der Kaay

Keywords: Cardiomegaly, ischaemic coronary artery disease, train, V/Line, public transport, defibrillators

Recommendation	Response	Response outcome
That V/Line install defibrillators on their trains.	Response from V/Line	Accepted in full.

Finding into death of Yukako Fukuhara

Keywords: Cycling accident, cyclist death, heavy vehicle, multiple injuries, peak hour traffic

Recommendation	Response	Response outcome
In conjunction with the Transport Accident Commission (TAC), consider developing a public awareness campaign to highlight the dangers of cycling around trucks (trailer trucks) in an urban setting).	Response from Department of Transport and Planning	Accepted in full

Finding into death of Angelo Angelino

Keywords: Motor vehicle collision, motorcycle collision, criminal proceedings, traumatic head injury, helmet design

Recommendation	Response	Response outcome
I recommend that the Department of Transport and Planning review the intersection of Ballarat Road and the Ballarat Road Service Road, Deer Park, including the pedestrian crossing, 'keep clear' zone and break in the median strip, and consider updating the road design to enhance safety for motorists and pedestrians.	Response from Department of Transport and Planning	Under Consideration
I recommend that open-faced motorcycle helmets without jaw protection be strongly discouraged by VicRoads, the Transport Accident Commission, motorcycle clubs and motoring groups, for all motorcycle riders utilising highways and at any official motoring functions, or competitions.	Response from Transport Accident Commission (TAC) Response from VicRoads is expected by 12 August 2024	Accepted in Full Awaiting response

Finding into death of Jackson Eales

Keywords: fatal collision, obstructive sleep apnoea, cardiac event, truck driver, disclosure of medical conditions, fitness to drive, heavy vehicle licence, dangerous goods licence, motor vehicle

Recommendation	Response	Response outcome
I recommend that the Secretary of VicRoads and the Department of Transport develop a public awareness campaign around the importance of understanding the fitness to drive guidelines and obligations of individuals to inform VicRoads of any medical conditions that may impair an individual's fitness to drive.	Response from Department of Transport and Planning (DTP)	Accepted in part

Finding into death of Mathew West

Keywords: Heavy vehicles, rear underrun protection, motor vehicle collision, head injury, neck injury, passenger, child

Recommendation	Response	Response outcome
The Commonwealth Department of Infrastructure, Transport, Regional Development, Communications and the Arts consider amending Vehicle Standard (Australian Design Rule 91/00 – Rear Underrun Impact Protection) 2018 to include the regulation of RUIP on Heavy Vehicles.	Response from The Commonwealth Department of Infrastructure, Transport, Regional Development, Communications and the Arts was expected by 30 November 2023	Overdue

Finding into death of Christopher Wrigglesworth

Keywords: Motor vehicle, accident, tree fall, eucalyptus tree, mountain grey gum, tree assessment framework, tree failure, high winds, tree inspection, risk assessment

Recommendation	Response	Response outcome
That Yarra Ranges Shire Council consider incorporating a requirement into the Tree Assessment Framework of the Tree Policy to obtain an independent arborist report in cases where tree failure results in death.	Response from Yarra Ranges Council	Accepted in full

Deaths in custody

Finding into death of Simaile Masila-Liutolo

Keywords: Police contact, use of force, oleoresin capsicum foam, heart disease, substance use, FVIO

Recommendation	Response	Response outcome
The Chief Commissioner of Police bring to the attention and raise awareness for all police members the deployment guidance in respect of OC aerosols (including OC foam) as contained within the Victoria Police Oleoresin Capsicum Manual.	Response from Victoria Police	Accepted in Full
The Chief Commissioner of Police include guidance in relation to the timing of the deployment of bursts of OC foam in police training.	Response from Victoria Police	Rejected in Full

Finding into death of Darren James Fielding

Keywords: Death in custody, methadone toxicity, Schedule 8 medications, Code Black response, aspiration, opioid toxicity

Recommendation	Response	Response outcome
That Correct Care Australasia review its Controlled Substances Management Policy and ensure that the policy provides a clearly articulated procedure for the preparation, labelling and storage of Imprest stock, including in particular, a direction that the Imprest stock bottle should be weighed and the details of the running weight recorded between each dose being drawn from the Imprest stock bottle.	Response from Correct Care Australasia	Accepted in Full
That Correct Care Australasia provide instruction to relevant staff of the importance of maintaining accurate records in relation to Schedule 8 medications and, specifically, that any spill must be contemporaneously recorded, that times entered in relevant registers must be accurate, and that any errors made must be amended in compliance with policy requirements.	Response from Correct Care Australasia	Accepted in Full

Finding into death of Darren Culleton

Keywords: Death in custody, medical treatment, risk assessment, police custody, observation

Recommendation	Response	Response outcome
Victoria Police create a policy and guideline in relation to the appropriate use in custody facilities of coveralls and suicide-resistant gowns.	Response from Victoria Police	Accepted in full
Custody Management Division of Victoria Police engage with MCC and the Custodial Health Service to review the arrangements and requirements for transfer of prisoners from a police station to MCC: (i) To clarify with specificity the documents that are required to be prepared by Victoria Police when the basis of the transfer is that the facilities at the police station are inadequate; and (ii) To clarify the circumstances in which a transfer may occur on medical grounds (ie the health services available at MCC are required) and what documents, if any, are required to be prepared by Victoria Police.	Response from Victoria Police	Accepted in full
Victoria Police review the training provided to police members and Police Custody Officers to guard against perceived hierarchical barriers which may inhibit the communication of relevant and valuable information concerning the welfare of people in custody.	Response from Victoria Police	Accepted in full
Victoria Police review the training provided to police members and Police Custody Officers to ensure that relevant information recorded on the LEAP system relating to the risks attaching to a person brought into custody is efficiently shared	Response from Victoria Police	Accepted in full

with all the officers necessary to appropriately manage that person's welfare and safety.		

Deaths in care

Finding into death of JZA

Keywords: Residential care, GHB toxicity, overdose, support worker handover, monitoring

Recommendation	Response	Response outcome
I recommend that BSV reviews the staff handover process to ensure workers are allocated sufficient paid time to read all relevant materials prior to commencing a shift;	Response from Berry Street Victoria (BSV)	Under consideration
I recommend that BSV considers how to develop a system to better support residential care workers, including new or agency workers, to quickly comprehend a client's key risk factors during handover, for example through extracting key information from incident reports, monthly reports, and care team meeting minutes into a regularly updated crisis management plan;	Response from Berry Street Victoria (BSV)	Accepted in Full
I recommend that BSV and DFFH jointly review the Care Team Meeting process to ensure there is a clear designation of roles and responsibilities, including the taking and dissemination of minutes;	Response from Berry Street Victoria (BSV) Response from Department of Families, Fairness and Housing (DFFH)	Accepted in Full Accepted in Full
I recommend that BSV reviews the delivery of its training modules, particularly with respect to monitoring substance affected youths, and implements measures to ensure that: a. Workers are allocated dedicated, paid time to complete all required training modules; b. Workers are assessed on their comprehension of training content; and	Response from Berry Street Victoria (BSV)	Under consideration

c. Workers receive appropriately spaced refresher training to ensure the substance of training remains at the forefront of a worker's mind.		
I recommend that BSV considers implementing measures to overcome potential knowledge gaps which may be faced by agency workers, including with regard to key policy requirements.	Response from Berry Street Victoria (BSV)	Accepted in Full
I recommend DFFH considers how to enhance its audit function to ensure regular audits of all out of home care residential units.	Response from Department of Families, Fairness and Housing (DFFH)	Under consideration

Finding into death of Catherine Anne Williamson

Keywords: death in care, suicide, asphyxia, private psychiatric hospital

Recommendation	Response	Response outcome
With the aim of preventing like deaths and promoting public health and safety within mental health in-patient units I recommend that the Chief Psychiatrist/Office of the Chief Psychiatrist seek legal advice around the feasibility of implementing “pat-down” searches, including when “pat-down” searches would be appropriate, such as when a patient returns from leave. Such advice should include: • The legal basis on which pat-down searches are conducted • The implications of completing pat-down searches for staff (role changes, training, protection from litigation etc) • The feasibility of pat-down searches across the various inpatient settings within the public mental health sector (for example, PARC, CCU etc) • The implications of Victoria’s proposed new Mental Health and Wellbeing Act 2022 • And with regards to the impacts outlined above.	Response from Department of Health	Accepted in full
And I further recommend that the Chief Psychiatrist review relevant guidelines in light of the outcomes of the advice provided, as outlined above	Response from Department of Health	Accepted in full
With the aim of preventing like deaths and promoting public health and safety within its mental health in-patient units I recommend that Healthscope Operations Pty Ltd seek legal advice around the feasibility of implementing “pat-	Response from Healthscope	Accepted in full

down" searches, including when "pat-down" searches would be appropriate, such as when a patient returns from leave. Such advice should include: • The legal basis on which pat-down searches are conducted • The implications of completing pat-down searches for staff (role changes, training, protection from litigation etc) • And with regards to the impacts outlined above.		
And I further recommend that Healthscope Operations Pty Ltd review relevant guidelines in light of the outcomes of the advice provided, as outlined above.	Response from Healthscope	Accepted in full
With the aim of preventing like deaths and promoting public health and safety within its mental health in-patient units and ensuring that their nursing staff are immediately notified of changes to policies and procedures that go to nursing competencies and standards, I recommend that Healthscope Operations Pty Ltd address the "operational" delay(s) in disseminating such changes as was identified in the investigation into the death of Catherine Ann Williamson	Response from Healthscope	Accepted in full

Finding into death of Ricky James Broughton

Keywords: mental health, disability support, mental health services, psychiatric inpatient care, medication non-compliance, supported living, NDIS, police, restraint, chronic schizophrenia

Recommendation	Response	Response outcome
That, given the recent entry into force of the new Mental Health and Wellbeing Act 2022, the Department of Health consider, in consultation with Victoria Police and Ambulance Victoria, the need to revise the Protocol for the transport of people with mental illness to ensure its guidance to clinical and emergency service responders is sufficiently clear to enable decisions to be made about the conditions under which a mentally unwell person is transported to or from a designated mental health service consistent with the principle of least restrictive practice. In particular, it appears that clarification of the distinction between 'police involvement' and 'police transport' may be required.	Response from Department of Health	Accepted in Full
That the Chief Commissioner of Victoria Police consider the need to clarify, reinforce or enhance the guidance and/or training provided to its members to equip them to respond to life-threatening emergencies in a person in their care or custody, in particular: a. Recognition and response to a deterioration in their state; b. Management of an unconscious person; c. When to commence CPR; and d. Coordination of effort by multiple responding members;	Response from Victoria Police	Accepted in Full

Finding into death of Kieran McGuinness

Keywords: Epilepsy, seizure risk, SUDEP, disability support, complex medical history, NDIS, alcohol dependency

Recommendation	Response	Response outcome
That Dynamic Care Services provide training to staff on epilepsy and seizure management, with a particular emphasis on the circumstances in which it is necessary to call an ambulance.	Response from Dynamic Care Services	Accepted in Full

Finding into death of Ruby-Lee Gold

Keywords: Death in care, release from custody, patient transport, medical transfer, mental health, substance use, suicide, IAO

Recommendation	Response	Response outcome
The Department of Justice and Community Safety and the Department Health implement a system to enable Corrections Victoria (or a suitable contractor) to undertake the role of transporting persons released from custody on an assessment order under the Mental Health and Wellbeing Act 2022 to a designated mental health service.	Response from Department of Justice and Community Safety Response from Department of Health	Rejected in Full Rejected in Full

Aged care

Finding into death of Margaret Alice Cook

Keywords Supported residential services, dementia, pressure ulcer, advance care planning

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 Royal Australian College of General Practitioners consider using Margaret Alice Cook's matter as a case study to highlight the utility of the making of an advance health directive as part of general practice education and general practitioners' obligations under the Medical Treatment Planning and Decisions Act 2016.	Response from Royal Australian College of General Practitioners	Accepted in full

Finding into death of Nickolaos Vlahos

Keywords: Aged care, falls prevention, supervision, head and neck injuries, complex medical history, high falls risk

Recommendation	Response	Response outcome
Hope Aged Care review its staffing arrangements in its dining rooms to ensure that there is adequate supervision of residents during mealtimes.	Response from Hope Aged Care	Under consideration

Family Violence

Finding into death of Emma Gertrude Weidemann

Keywords: Family violence, homicide, fire related death, head and neck injuries, MARAM, family violence risk assessment

Recommendation	Response	Response outcome
That a review is conducted into clinician guidelines to ensure clearer communication between the clinician and patient and/or their supporting family members when assessing a patient's decision-making capacity beyond the ability to refuse treatment; and	Response from Eastern Health	Accepted in full
That clinical guidelines provide for any specific request for assessment of decision-making capacity be documented and communicated to relevant supporting family members where appropriate. If the assessment is only relevant to the decision to refuse treatment, it should not be assumed to apply to other decisions or situations. The assessment should be communicated or clarified to relevant supporting family members where appropriate.	Response from Eastern Health	Accepted in full

Finding into death of Loris O'Meara

Keywords: alcohol dependence, complex medical history, mental health, inadequate care, family violence, general practitioners, medicare

Recommendation	Response	Response outcome
I recommend that the Commonwealth Government consider adding specific Medicare item numbers relating to family violence, to support the identification and management of family violence by General Practitioner's, as envisioned in the draft National Plan to End Violence Against Women and Children 2022-2023.	The Commonwealth Government was invited to respond by 30 July 2023. They were not required to respond and no response has been received to date.	Awaiting response

Child/infant deaths

Finding into death of Callie Griffiths-I'Anson

Keywords: child, medical complications, hospital, caustic liquid ingestion, oesophageal perforation, post-surgical complications

Recommendation	Response	Response outcome
Recognising the inherent challenges in finding a solution, I recommend that the Royal Children's Hospital considers the circumstances in which Callie died and the failure of the process for accessing advice from the on-call General Surgical Registrar about a child who had undergone a recent procedure, with a view to developing a better process.	Response from The Royal Children's Hospital	Accept in full
In developing a better process, I recommend that the Royal Children's Hospital considers: a. The qualifications of the person who takes such calls in the first instance. b. The use of technology to re-route calls. c. Early triaging or differentiation of such calls. d. The use of structured questioning to elicit as good clinical information as possible. e. The particular vulnerability of children living in regional or remote areas. f. The provision of a discharge summary and/or formal handover of the child to the nearest regional hospital for follow-up.	Response from The Royal Children's Hospital	Accept in full

Finding into death of Jacqueline Isabella Vodden

Keywords: motor vehicle collision, police pursuit, unlicensed driver, stolen vehicle, fatal collision

Recommendation	Response	Response outcome
Police vehicles should be fitted with appropriate equipment to undertake pursuits such that estimations of speed are improved, to maximise the mitigation of risks.	Response from Victoria Police	Under consideration
Victoria police should examine ways to improve the operational environment of a pursuit in circumstances where well known issues such as, task loading and the limitation with radio communications, have the potential to affect risks assessments with detrimental consequences.	Response from Victoria Police	Accepted in full
Victoria police training should ensure that there is an emphasis on how higher risk factors are given consideration in the application of the Risk assessment and decision making guide, in order to minimise the risks associated with pursuits.	Response from Victoria Police	Accepted in full

Finding into passing of Sasha

Keywords: Child in care, Aboriginal passing, bicuspid aortic valve, endocarditis, pneumococcal infection, septic shock, heritable disease history, cardiac arrest

Recommendation	Response	Response outcome
That the Department of Families, Fairness and Housing review its Child Protection Manual and other relevant policies or guidelines to include guidance to Child Protection practitioners to seek, where possible, familial medical history that may impact the health of a child in its care.	Response from Department of Families, Fairness & Housing	Under consideration
That the Department of Families, Fairness and Housing implement a means of effective urgent communication with its case-contracting agencies, supported by appropriate policy and procedures, in respect of a child in care. The means adopted should be available at all hours and capable of actively alerting the recipient.	Response from Department of Families, Fairness & Housing	Under consideration
That the Department of Families, Fairness and Housing review its Child Protection Manual and other relevant policies or guidelines to make clear to case-contracting agencies, the circumstances in which it expects to urgently receive information concerning a child in care.	Response from Department of Families, Fairness & Housing	Under consideration
That the Central Gippsland Health Service take all steps as may be required to eliminate facsimile transmission as the sole means of communication of critical clinical information.	Response from Central Gippsland Health Services (CGHS)	Accepted in full

Finding into death of Baby A

Keywords: SIDS, correctional facility, safe sleeping practices, hospital discharge, hospital readmission, methadone, mother in custody, mothers and children unit (MCU), vulnerable neonate

Recommendation	Response	Response outcome
I recommend that the Victorian Department of Health implement a multi-disciplinary approach to discharge throughout hospitals in Victoria, akin to what exists in New South Wales, whereby if any healthcare practitioner holds concerns about the discharge of a baby, having particular regard to the environment into which they will be discharged, the baby is not to be discharged.	Response from The Victorian Department of Health	Accepted in full
Any child who is living in a prison ought to be regarded as being in custody for the purposes of critical incidents and deaths.	Response from Department of Justice and Community Safety	Accepted in full
Children who reside in a correctional facility with their parent or guardian ought to have improved access to healthcare. Currently such children are reliant upon the resources of the prison, and do not have easy access to a team of specialists on-site. I recommend that DPFC consider having an attending neonatologist or midwife on-site every day whenever they have infants residing there. Whilst healthcare is an important and fundamental right of any prisoner, children – and especially vulnerable children – require access to healthcare outside of the structure ordinarily available to prisoners.	Response from Department of Justice and Community Safety	Accepted in full

Finding into death of Refan Al Moarfeg; Finding into the death of Meeram Bano

Keywords: Drowning, pond, public park, Footscray Park, Maribyrnong City Council, child, fencing, visibility, risk mitigation

Recommendation	Response	Response outcome
In the interests of promoting public health and safety and preventing like deaths, I recommend that the Maribyrnong City Council implement the recommendations of SafeT Now, NTT Australia and Life Saving Victoria into any ongoing and future works within Footscray Park.	Response from Maribyrnong City Council	Accepted in full
In the interests of promoting public health and safety and preventing like deaths, I recommend that the Municipal Association of Victoria share with other Victorian local councils the actions taken by Maribyrnong City Council in response to the tragic deaths of Refan Al Moarfeg and Meeram Bano, and encourage other councils to implement similar actions where appropriate, with a view to preventing like deaths in waterways within public parks.	Response from Municipal Association of Victoria	Accepted in full

Finding into death of Eugene Mahauariki

Keywords: Amusement ride safety, Rye Carnival, restraint design, outdated safety standards, safety compliance, ride operation, head injury, ride modifications, lap bar, inadequate operator training

Recommendation	Response	Response outcome
All amusement structures, which are considered plant under relevant regulations, be design registered;	Response from Minister for WorkSafe and the TAC	Under Consideration
There be a requirement that the applicant for a design registration of an amusement structure and the design verifier in relation to that application be located within Australia;	Response from Minister for WorkSafe and the TAC	Under Consideration
WorkSafe be empowered to refuse an application for design registration of an amusement structure where an applicant fails to provide the necessary information or WorkSafe forms the view the design poses a risk;	Response from Minister for WorkSafe and the TAC	Under Consideration
WorkSafe be empowered to cancel plant and/or design registration, where the design of the item of plant or the item of plant is unsafe, a power that they currently do not have.	Response from Minister for WorkSafe and the TAC	Under Consideration
The operator of an amusement ride be required to carry the plant's manual and logbook with the item of plant at all times;	Response from Minister for WorkSafe and the TAC	Under Consideration
The requirement that items of plant be registered should be reintroduced and apply to all amusement structures operating in Victoria;	Response from Minister for WorkSafe and the TAC	Under Consideration
The operator of an amusement ride be required to record and maintain details of training and certification of the operator of an amusement ride;	Response from Minister for WorkSafe and the TAC	Under Consideration

A review be undertaken to improve training standards and accreditation of ride operators and attendants, including whether there should be a minimum standard for the training of amusement ride operators; and	Response from Minister for WorkSafe and the TAC	Under Consideration
Consideration be given to enhancing the National Audit Tool used by WorkSafe Inspectors during annual inspections of amusement rides to address WorkSafe inspectors concerns' that it has limited value for the delivery of safety outcomes.	Response from Minister for WorkSafe and the TAC	Under Consideration

Finding into death of Lachlan McMahon Cook

Keywords: international school excursion, pre-existing medical condition, Type 1 diabetes management, Vietnam, treatment delay

Recommendation	Response	Response outcome
With the aim of promoting public health and safety and preventing like deaths, I recommend that World Challenge Expeditions create and implement a policy directed at improving communication and the sharing of information with the schools they are engaging with.	Response from World Challenge Expeditions.	Accepted in Full
With the aim of promoting public health and safety and preventing like deaths, I recommend that World Challenge Expeditions through its revised/renewed communication and information sharing policy, ensure that they access the respective school's Action and Management Plans for students attending their expeditions and enhance the information they hold on students with medical conditions and/or special needs by holding pre-trip meetings with the trip leaders, attending teachers, parents, a member of the child's medical treating team or the school nurse, and the student.	Response from World Challenge Expeditions.	Accepted in Full
With the aim of promoting public health and safety and preventing like deaths, I recommend that World Challenge Expeditions update the Leader's Manual and pretrip training material to include information about diabetes, hypoglycaemia, hyperglycaemia, ketone testing and safe levels of blood glucose levels.	Response from World Challenge Expeditions.	Accepted in Full
With the aim of promoting public health and safety and improving the sharing of medical information, I recommend that World Challenge Expeditions ensure that medical clearance to attend an expedition is	Response from World Challenge Expeditions.	Accepted in Full

obtained from the student's specialist, if the specialist is attended on a regular basis.		

Finding into death of Lily Grace Arbuckle

Keywords: Family violence, filicide, infant, maternal mental health, train, suicide attempt

Recommendation	Response	Response outcome
With the aim of improving the public health and safety, I recommend that the International Board of Lactation Consultant Examiners review their requirements for lactation consultant accreditation and ensure that they must have undertaken education that includes a demonstrated understanding of postnatal mental health, how to identify mental health risks and making referrals for appropriate supports to qualify for accreditation.	Response from International Board of Lactation Consultant Examiners	Accepted in Part
With the aim of improving the public health and safety, I recommend that the Victorian Department of Health - Maternal and Child Health Services introduce a process to ensure that Supervisors are automatically alerted if a primary caregiver scores 13 or above on a EPDS so that Supervisors can ensure that a plan is in place for managing the risk posed to the primary caregiver and their child.	Response from Department of Health	Under Consideration
With the aim of improving the public health and safety, I recommend that the Victorian Department of Health - Maternal and Child Health Services provide staff with regular training to ensure that they are familiar with the need to query infant safety following completion of question 10 of the EPDS. This education should be supported by ensuring that discussions of client responses to this question forms a part of regular clinical supervision.	Response from Department of Health	Under Consideration
With the aim of improving the public health and safety, I recommend that the Victorian Department of Health - Maternal and Child Health Services	Response from Department of Health	Under Consideration

require health services to engage with secondary carers on at least one occasion in the pre-natal period for the purposes of providing education around signs and symptoms of post-natal depression, anxiety and psychosis and options for support, noting that this engagement should only occur after permission is sought from the primary carer to do so.		
With the aim of improving the public health and safety, I recommend that the Victorian Department of Health - Maternal and Child Health Services introduce an additional consultation into the Key ages and stages framework that requires MCH Nurses to proactively engage with the secondary carer for the purposes of providing education around signs and symptoms of post-natal depression, anxiety and psychosis and options for support, noting that this engagement should only occur after permission is sought from the primary carer to do so.	Response from Department of Health	Under Consideration

Finding into deaths of QJW, KUW, POW, RCW

Keywords: House fire, disconnected smoke alarms, property inspection, rental

Recommendation	Response	Response outcome
The Estate Agents Council consider the efficacy of an amendment to the Estate Agents Act 1980 (or Regulations) to require agreements between rental providers and estate agents for the management of residential properties to specifically authorise estate agents to arrange the urgent repair or servicing of smoke alarms.	Response from Minister for Government Services	Under Consideration

Drowning

Finding into death of Peter Boyle

Keywords: Boat, boating incident, drowning, Parkinson's disease, personal flotation device (PFD)

Recommendation	Response	Response outcome
Safe Transport Victoria consider reviewing the current information and safety material provided to mariners to ensure that it includes: a. information about the requirement to conduct an annual service and test of inflatable lifejackets to ensure that they are functional. The material should include a step-by step guide as to how to conduct a check and service of the lifejacket if it is to be done by the owner or information about third-party contractors who provide this service; b. information about the availability of automatic inflating life jackets which may be a preferable option for people who have a disability or restriction of movement - such a life jacket would automatically inflate if the person entered the water; and c. guidance to mariners about the precautions they should take to protect themselves if they need to enter the water to conduct repair works (for example to clear a line that has become tangled in the propellor) including but not limited to, anchoring the boat if possible, tethering themselves to the vessel before entering the water, advising and briefing other crew members before entering the water.	Response from Safe Transport Victoria	Accepted in full
Safe Transport Victoria consider providing this information with the annual renewal of the registration of a vessel to ensure that boat owners read and understand this information. Consideration should	Response from Safe Transport Victoria	Accepted in full

be given by Safe Transport Victoria to the feasibility of developing an online test to be completed prior to renewal of registration.		

Finding into death of Brad Anthony Godressi

Keywords: Boat, boat incident, marine licence, motor vehicle licence, disqualified driver, drug and alcohol use, cardiomyopathy

Recommendation	Response	Response outcome
That the Secretary for the Department of Transport and Planning consider amending the current legislative framework so that if a person has been disqualified from driving a motor vehicle for offences relating to drug and alcohol use or on medical grounds, the disqualification should also extend to their Marine Licence. Further, consideration should be given as to whether disqualification of a person's marine licence for drug alcohol offences or medical grounds should be extend to their vehicle licence.	Response from Department of Transport and Planning	Under Consideration

Finding into death of Ahedah Hamed

Keywords: drowning, Bushrangers Bay, unpatrolled beach, inability to swim, poor conditions, rocks, large waves, remote location, signage

Recommendation	Response	Response outcome
With the aim of preventing like deaths and promoting public health and safety, I recommend that Parks Victoria consider the installation of signage at Bushrangers Bay that clearly and concisely warns visitor of the hazards present in the area and the need for caution around the water.	Response from Parks Victoria	Accepted in Full

Finding into death of Joyce Tyndall

Keywords: kayaking, Broken Creek, lifejacket, weir, capsize, drowning, signage, safety warning

Recommendation	Response	Response outcome
That GMW consider erecting appropriate safety and warning signage along the banks of Broken Creek that is visible to water users as they approach the Nathalia town weir from downstream.	Response from Goulburn-Murray Water	Under consideration
That GMW reiterates the grave dangers posed to water users by weirs in their annual public awareness campaigns.	Response from Goulburn-Murray Water	Accepted in full
That Safe Transport Victoria consider the publication of a factsheet which warns water users of the significant dangers associated with weirs.	Response from Safe Transport Victoria	Accepted in full

Workplace

Finding into death of Shane Tuck

Keywords: CTE, concussions, sport, AFL, contact training sessions, mental health, suicide

Recommendation	Response	Response outcome
The AFL consider implementing rules and guidelines that limit the number of contact training sessions in the off season, pre-season and during the season with a view to implementing these amended rules and guidelines by the commencement of the AFL and AFLW 2025 pre-season.	Response from Australian Football League (AFL)	Under Consideration
The AFL implement a rule whereby concussions spotters at elite AFL and AFLW games be empowered to mandate that a player be removed from the field of play for a medical assessment based on their live and/or video review of an incident.	Response from Australian Football League (AFL)	Accepted in Full
The AFL employ independent medical practitioners to attend all elite AFL and AFLW games to assist club doctors in the assessment of a player for a suspected or actual head injury. Whilst the decision to enter a player into concussion protocols should be a joint decision by the independent medical practitioner and the club doctor, if a situation arises whereby the club doctor and independent medical practitioner cannot agree, the opinion of the independent medical practitioner should prevail.	Response from Australian Football League (AFL)	Under Consideration
The AFL in consultation with the ALFPA consider how to best improve player awareness and review its current educational material on concussion and repeated head trauma including the risk of CTE to expressly address:	Response from Australian Football League (AFL) Response from Australian Football League Players'	Accepted in Full

a) recognising the acute signs and symptoms of concussion and head trauma; b) responding and managing concussion and head trauma; and c) understanding the short and long-term risks of concussion and repeated head trauma.	Association (AFLPA)	Accepted in Full
The AFL: a) continue to develop and disseminate its educational materials for prospective players and their families on the risk of repetitive head trauma in Australian rules football; b) review existing and develop further educational material, and disseminate it, concerning expressly and explicitly the risk of developing CTE through repetitive head trauma associated with the playing of Australian rules football, and do so expeditiously; c) continue to develop educational material with accessible language, and disseminate it through variety of platforms including in-person and virtual forums, social media platforms and webinars to reach children and the broader community concerning the risk of repetitive head trauma and its consequences by the playing of Australian rules football, and do so expeditiously; d) consider developing and disseminating information targeted at points of transition in the playing of Australian rules football that is specific to the level of transition and including information about heightened risk of repetitive head impacts, including the development of neurodegenerative disease, including CTE; and e) in developing this accessible and informative educational material that	Response from Australian Football League (AFL)	Accepted in Full

further consideration be given to how that educational material can be adopted at all community levels and in all environments in which Australian rules football is played including in suburban competitions, rural settings and through AFL supported competitions such as Auskick. The AFL consider obtaining evidence-based advice with respect to the most appropriate means to reach different community groups with its educational material.		
The Royal Australian College of General Practitioners give consideration to expanding the education programs for general practitioners provided at medical colleges, in medical degrees and within the ongoing professional development and training programs on the short and long-term effects of repetitive head trauma associated with contact sports and the risk of developing serious brain injury and disease, including CTE.	Response from Royal Australian College of General Practitioners (RACGP)	Accepted in Full
The AFL continue to disseminate and develop evidence-based, and easy to understand education materials for concussion and repetitive head trauma for elite AFL and AFLW and community club doctors, coaches, trainers and other volunteers involved in the Australian football community.	Response from Australian Football League (AFL)	Accepted in Full
The AFL take all reasonable steps to promote and extend the use of mouthguard accelerometer technology in elite AFL and AFLW clubs with a view to extending player uptake to 80% for the 2024 AFL and AFLW season. In doing so, the AFL should consider obtaining specialist advice on overcoming any legal and privacy issues which may prevent the AFL from mandating the use of the mouthguard accelerometer technology in elite	Response from Australian Football League (AFL)	Under Consideration

AFL and AFLW clubs and using the data for clinical research purposes.		
The AFL develop and implement standardised neurological baseline testing for all elite AFL and AFLW players. The data obtained from the standardising neurological baseline testing should be linked to the clinical profile of each player and should occur at the beginning of each elite AFL and AFLW season. The data obtained by the AFL should be used to further longitudinal research into player brain health and the impact of repetitive head trauma in the playing of Australian rules football. If a player does not wish for their deidentified data to be used for research purposes, they should be required to opt out.	Response from Australian Football League (AFL)	Under Consideration
The AFL should develop educational material aimed at elite AFL and AFLW players on the benefits of neurological baseline testing and the use of the deidentified data for clinical purposes to further longitudinal research into player brain health and repetitive head trauma in the playing of Australian rules football. Any such educational material should be evidence-based, updated with the current scientific research and disseminated with the assistance of the AFLPA.	Response from Australian Football League (AFL) Response from Australian Football League Players' Association (AFLPA)	Accepted in Full Accepted in Full
The AFL and AFLPA expedite and improve their communications with AFL and AFLW players (past and present) and encourage them to donate their brains at end of life for further research. That encouragement should include concrete information and education about the risks associated with repetitive head trauma including CTE that is delivered throughout a player's career and beyond.	Response from Australian Football League (AFL) Response from Australian Football League Players' Association (AFLPA)	Accepted in Full Accepted in Full

The Commonwealth Department of Health facilitate the adequate funding of brain banks nationally.	Response from Australian Government Department of Health and Aged Care	Accepted in Full
I recommend that the AFL explore with the AFLPA how they may engage the AFLPA in assisting with education and training for players on concussion and the risks associated with repetitive head trauma.	Response from Australian Football League (AFL) Response from Australian Football League Players' Association (AFLPA)	Accepted in Full Accepted in Full
The DJSIR extend the terms of reference for the review of the Board's regulatory framework to include a review of the oversight and regulation of amateur boxing and combat sports in Victoria and that the training and education regimes in amateur and professional boxing and combat sports be aligned and standardised.	Response from Department of Jobs, Skills, Industry and Regions (DJSIR)	Accepted in Full
DJSIR and the Board work with their interstate counterparts to develop a national database of all boxers registered to fight in Australia with a view to making evidence-based processes applicable to all. Without dictating the information or data to be stored on the database, it should include to a minimum of the name, age, trainer, gender, serology results, injuries, medical suspensions and fight history of all registered boxers.	Response from Department of Jobs, Skills, Industry and Regions (DJSIR)	Under Consideration
The Board and DJSIR continue to develop appropriate systems for baseline neurological testing and collection of that data longitudinally to inform changes to the rules and regulations of boxing in Victoria, and	Response from Department of Jobs, Skills, Industry and Regions (DJSIR)	Under Consideration

in research on the brain health of professional boxers overtime.		
As part of the regulatory review, the DJSIR and the Board: a) review the current rules and regulations for professional and amateur boxing in Victoria with a view to restricting persons under the age of 14 years from participating in any boxing activity involving hits to the head. To the extent that requires engagement with amateur boxing and its organisations, the Minister or other appropriate government representative should implement this restriction on registered amateur boxing organisations and/or extend the jurisdiction of the Board to enable it to have regulatory oversight of amateur boxing; and b) utilising the same modalities, develop and disseminate explicit and age-appropriate education to prospective child boxers and their parents/guardians about the risks associated with boxing (including sparring) of repetitive head injury, traumatic brain injury and developing CTE.	Response from Department of Jobs, Skills, Industry and Regions (DJSIR)	Under Consideration
DJSIR and the Board undertake ongoing research to investigate the viability of amending its rules, including reducing the length of rounds, the overall length of a fight, changing the scoring system to reduce scoring based on higher impact, with a view to reducing the amount of head trauma experienced by boxers in their career and the associated risk of CTE and other neurological brain disease.	Response from Department of Jobs, Skills, Industry and Regions (DJSIR)	Under Consideration
The Board explore ways to reduce the amount of sparring for professional boxers including restricting sparring by registered boxers in the lead up to a bout and at training.	Response from Department of Jobs, Skills, Industry and Regions (DJSIR)	Under Consideration

I recommend to the Board that its educational material, including its proposed mandatory training for registration be developed to specifically address not just concussion but the risks associated with repetitive head impact and traumatic brain injury in boxing, and the potential effects of that in the long term on a person participating in boxing, including sparring training, as well as specific reference to the potential long term effects of head knocks in boxing that include the development of CTE and other neurodegenerative diseases.	Response from Department of Jobs, Skills, Industry and Regions (DJSIR)	Accepted in Full
The Board and DJSIR on advice from the Medical Advisory Sub-Committee (MASC): a) develop a longitudinal research project aimed at trialling the use mouthguard accelerometer technology to monitor the number and severity of head knocks sustained by boxers per year. It is a matter for the Board and DJSIR on advice from the MASC (or based on other relevant medical advice) to determine the terms of reference for any such longitudinal research project of that kind; and b) develop and implement specific education and training to boxers, trainers and other boxing stakeholders about the risk of repetitive head injury from sparring, including developing CTE.	Response from Department of Jobs, Skills, Industry and Regions (DJSIR)	Accepted in Part

Recreational activities

Finding into death of John Robert Gregg

Keywords: Scuba diving, scuba diving instruction, PADI, cardiac arrest, dive equipment, resuscitation equipment, AED, heart disease

Recommendation	Response	Response outcome
That consideration be given by Standards Australia and relevant stakeholders to amending the Australian Standards so as to require recreational dive providers to: a. ensure divers under their supervision understand the medical conditions which elevate the risks associated with diving and the importance of accurate and forthright medical screening; b. require all divers over 45 years of age under their supervision to complete and produce a current dive medical for all dives over 18 metres (deep dives). c. require all divers under their supervision to demonstrate an understanding and proficiency in emergency drills for all dives over 18 metres (deep dives), including removal of weights and buddy breathing.	Response from Standards Australia	Under Consideration
That consideration be given by Standards Australia and relevant stakeholders to amending the Australian Standards so as to require recreational dive charter operators to carry: a. adequate medical equipment available at the dive site for immediate use if required. This includes oxygen resuscitation equipment. Oxygen equipment should be capable of providing a spontaneously breathing patient with an inspired oxygen	Response from Standards Australia	Accepted in part

concentration of 100%. The equipment should also facilitate oxygen enriched artificial ventilation of a non-breathing patient. b. an Automated External Defibrillator (AED). I note that the Australian Resuscitation Council, in their 'Guideline 9.3.2 – Resuscitation in Drowning' provides some guidance on the use of AEDs and confirms that defibrillation on a wet surface is usually not dangerous, provided there is no direct contact between the user and the individual when the shock. I also note that PADI requires current CPR and first aid training, including AED training, to be eligible for certification as a Divemaster or Instructor.		

Finding into death of Geunhee Park

Keywords: Port Phillip Bay, spear fishing, boating, recreational vessel, Canadian Bay, Maritime Safety Act, head injury, SCUBA diving

Recommendation	Response	Response outcome
I recommend the Minister for Fishing and Boating and Safe Transport Victoria review the term 'recreational vessel' and amended in relevant legislation and publications to 'vessel'. It may be appropriate to use the term 'private vessel' to create a distinction from 'commercial vessels' if need be.	Response from Safe Transport Victoria Response from the Minister for Fishing and Boating	Under consideration Under consideration
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.	Response from the Minister for Fishing and Boating	Under consideration

Finding into death of Charles Earl Swanson

Keywords: Recreational aviation, microlight aircraft, approved configuration, modifications

Recommendation	Response	Response outcome
That the Sports Aviation Federation of Australia consider circulating to its members a safety notice which reinforces the importance of operating microlight aircraft only in the configuration that has been approved by the manufacturer.	Response from Sports Aviation Federation of Australia	Accepted in full

Finding into death of Edward Schutz

Keywords: Body surfing injury, emergency response access, neck injury, rough conditions, large waves, unpatrolled beach, signage

Recommendation	Response	Response outcome
That the Great Ocean Road Coast & Parks Authority include in its signage at Sandy Gully Beach a warning to swimmers about the possibility of heavy and crashing waves.	Response from Great Ocean Road Coast & Parks Authority	Accepted in full

Homicide

Finding into death of Martin William Sheahan

Keywords: Homicide, interstate recognition of firearm licence, firearm, mental health

Recommendation	Response	Response outcome
That consideration be given by the Minister for Police to the appropriateness of the continued recognition of New South Wales firearm licences and New South Wales acquired firearms in Victoria until such time as the firearms licence application process in that state is of at least an equivalent high standard to that of Victoria.	The Minister for Police was invited to respond by 26 July 2023.	Awaiting response

Finding into death of Joshua Tovey

Keywords: Family violence, homicide, community corrections order (CCO), knife wounds, FVIO, breached bail conditions, substance use, compliance monitoring

Recommendation	Response	Response outcome
To improve processes related to the administration of justice, I recommend that the Attorney General and the Secretary of the Department of Justice and community Safety review funding for the Magistrates Court of Victoria so the Magistrates Court is funded to expand fast-track contravention hearings for breaches of a CCO state-wide. Fast-track approaches should be a standard practice across Magistrates' Courts in Victoria. The ability of a specialised court list to efficiently deal with CCO contravention proceedings involving family violence offending could reduce the time between a contravention of a CCO and proceedings being listed in court thereby reducing the risk of harm or serious injury.	Response from Department of Justice and Community Safety (DJCS)	Under consideration
To improve processes related to the administration of justice, I recommend that Corrections Victoria review case management policies relating specifically to managing non-compliance for CCO offenders and the procedures for contravention action. The policies should provide greater clarity to assist a case manager in determining when a risk to the community has become too high. Such guidance could provide additional assistance to CCS practitioners in better using their discretion to commence contravention action when appropriate. This guidance should also be based on MARAM risk assessments in situations where the offender has contact with an	Response from Department of Justice and Community Safety (DJCS)	Accepted in full

intimate partner or family members in the community.		

Fire Deaths

Finding into death of Vivianne May Rodger

Keywords: House fire, disability, disability support, smoke alarm, personal alarm, MePACS, monitoring, firefighter response, ESTA, incorrect information, delayed response, NDIS

Recommendation	Response	Response outcome
That the National Disability Insurance Scheme Quality and Safeguards Commission ensure that training and information provided to NDIS service coordinators and providers includes information regarding the importance of ensuring appropriate fire safety measures are put in place for clients, including hardwired smoke alarms connected to monitored personal alarm devices.	Response from National Disability Insurance Scheme Quality and Safeguards Commission	Accepted in Full
That Fire Rescue Victoria implement appropriate policies, procedures and training to ensure that firefighters responding to a firecall, where the signs of a fire are not apparent, take appropriate and sufficient steps to identify the correct location associated with the firecall, and that these steps are confirmed with the Fire Rescue Victoria communication centre.	Response from Fire Rescue Victoria	Accepted in Full

Finding into death of Simon Peter Scarff

Keywords: house fire, ESTA, NDIS, alcohol dependency, smoke detector, smoke alarm, rental premises, electrical safety

Recommendation	Response	Response outcome
That the Minister for Government Services/Minister for Consumer Affairs consider amendments to the Residential Tenancies Act 1997 (or other such amendments as may be necessary) so that the safety related activities defined at section 27(2) of the Act [the prescribed terms of which appear in Schedule 3 of the Residential Tenancies Regulations 2021 in respect of electrical, gas and smoke alarm activities], may apply to all existing rental agreements, including rental agreements entered before 29 March 2021.	Response from Department of Government Services	Under Consideration

Responses overdue by more than 12 months

Each edition of the CCOV Recommendations Report covers a 12-month period. This edition includes the period between 1 March 2023 to 29 February 2024.

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 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